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WIN

Journal of the
Irish Nurses and
Midwives Organisation

World of Irish Nursing & Midwifery

Latest INMO CPD education programme
See page 29

Pandemic payment red tape criticised
page 8

Who's who on the new Executive Council
page 16

Cost of living crisis
page 19

Nursing challenges in a time of war
page 20-23

A firm step forward

Restoration of 37.5 hour week a significant gain

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On the cover this month
(l-r): Jan Hailey Reyes, RANP, Emergency Care and Dianne Lopez, CNM1, Emergency Department, Naas General Hospital

NEWS & VIEWS

FEATURES

CLINICAL

LIVING

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Will HIQA ED findings fall on deaf ears?

HIQA in its recent report on the unannounced inspection at the ED in University Hospital Limerick describes very difficult conditions on a daily and nightly basis for staff and patients alike. It states that patients interviewed during its inspection remarked on how staff were "run off their feet", how they had concerns about the lack of privacy and confidentiality, and how "everyone could hear their diagnoses".

HIQA found that: "Notwithstanding the efforts of staff, patients on trolleys had little to no privacy or dignity. Staff were observed by inspectors to be kind and caring towards patients in the ED and tried to respond to their individual needs, which was challenging in the context of an overcrowded and understaffed department."

In its report, HIQA make several observations including the already known facts that:

- Lack of privacy in medical circumstances are a breach of the human rights-based model of care expected
- It is estimated that there is one extra death for every 82 admitted patients whose transfer to an inpatient bed is delayed beyond six to eight hours from the time of arrival at ED
- Insufficient nurse staffing levels significantly impacts on the delivery of safe, quality care
- Overcrowding in hospitals has been shown to increase the risk of the spread of infections which is particularly concerning in the context of Covid-19.

HIQA was not satisfied that in this hospital, management was adequately planning, organising and managing its nursing workforce in the ED and found that nurse staffing levels were insufficient to meet the needs of the numbers of patients attending the ED.

It also found that the physical congestion caused by extra trolleys throughout the department posed a significant risk to the delivery of quality and safe care and was also an infection prevention and control risk for patients and staff. Noting the pattern of insufficient nursing staff levels in the ED, HIQA indicated that the staff levels were a risk that should have been included on the hospitals corporate risk register.

You might ask, was this a surprise to the HSE? Was it not aware? More importantly what mitigation measures had the HSE introduced since becoming aware, if any? The INMO draws attention to the negative effects of overcrowding daily. We have raised the issue at Oireachtas committees and given evidence on its effects. We have raised it with the HSE, the Department of Health, HIQA and the Health and Safety Authority. They have all been too slow in responding.

We acknowledge the HIQA inspection and its recommendations. We now ask the that the Oireachtas committee invites the HSE to explain why it did not act following the independent report into this situation in 2019? The HSE wrote to the Department of Health at the time (Nov 17, 2020) saying that the findings of the review were "largely predictable and reflective of key work already underway". Incredibly, it went on in this letter to state that "the HSE has taken a decision not to proceed to finalisation and publication of a report that has no relevance".

No relevance? A pattern of Human rights violations for patients, lack of a dignified death, lack of privacy, additional likelihood of dying unnecessarily, exposed pressure-cooker environments for staff, heightened mental health and safety risks for staff and their patients, has no relevance? The HSE knew the issues in 2020 but nothing changed and the situation worsened. What is the point in healthcare delivery unless it is centred around every conceivable effort to treat patients and mitigate all risks to them and to ensure that coming to the hospital is not of itself a risk? The point is that, when alerted to high-risk situations in a hospital, something concrete must be done immediately to address those risks. The role of the HSE in perpetuating the lack of urgent action to address the risks identified at UHL, which are experienced by patients and staff in most of the 29 EDs in Ireland daily, must be scrutinised and addressed. It is not good enough to constantly blame Covid, cyber-attack and larger than expected volumes of attendance, and allow these horrific situations to become normalised.

Phil Ní Sheaghdha
General Secretary, INMO

INMO Professional

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with any queries relating to the CPC Section

A positive focus with the president

Karen McGowan, INMO president

Welcome recognition

I WAS delighted to receive the Cathaoirleach Award in Longford on behalf of the INMO in recognition of the work of nurses and midwives during the pandemic. The nomination was made by then cathaoirleach Senator Michael Carrigy. Our first-vice president Mary Tully also attended a civic ceremony in Cavan to celebrate our award for the centenary celebration. Second-vice president Caroline Gourley attended the RCN NI conference which featured similar motions to our own ADC. The issues for nursing and midwifery are not confined to one place but recur nationally and internationally.

The ICN/APN NP conference is taking place in UCD on August 21-24. I encourage those who are interested to register soon. I want to thank the IAANMP for its collaboration in hosting this face-to-face event. 2022 marks 26 years of advanced nursing and midwifery practice in Ireland. It is a wonderful opportunity to showcase and celebrate advancements in nursing and midwifery practice.

Importance of inclusion in healthcare

THIS month I spoke with Eibhlín Collins, an advanced nurse practitioner (ANP) in inclusion health who is based in the Mercy University Hospital, Cork. An RGN by background, Ms Collins later gained a degree in cognitive behavioural therapy as well as training in tropical and infectious diseases and women's health. Most recently she completed an MSc in advanced nursing practice at UCC.

Eibhlín Collins, ANP in inclusion health at MUH Cork

Inclusion health recognises marginalisation in society and within healthcare settings due to being, for example, homeless, affected by addiction, being a prisoner, living with a stigmatised illness, being a Traveller/Roma, identifying as LGBT+, being an undocumented migrant or refugee. Under this broad umbrella most of the patients requiring input a on a day-to-day basis are people affected by homelessness and/or addiction.

Ms Collins's prior practice settings have included in-patient tropical and other infectious disease clinics, HIV outpatients, a HIV prevention programme in Angola, and a primary care clinic in London for those who are homeless or affected by addiction. She has a particular interest in the concept, practice and promotion of trauma-informed care (TIC). TIC recognises the pervasiveness of trauma in society and the influence of adverse childhood experiences in people being affected as adults by homelessness and addiction. It also appreciates the effect of patients' trauma on staff providing care.

Ms Collins's experience with patients is that "they cope with extraordinary resilience in the face of adversity". The inclusion health role at the hospital aligns closely with the patient, community providers and services and disciplines within the hospital to identify the patient's needs, refer to or reconnect with appropriate services, and to co-ordinate patients' discharge from hospital. "The role has been warmly welcomed in Mercy University Hospital and the way in which diverse roles and disciplines work together for the patient's best outcome makes this a very enjoyable role," she said.

The inclusion health role is complemented by an addiction CNS attached to the liaison psychiatry service. The role at the Mercy Hospital arose from director of nursing, Margaret McKiernan's vision for inclusive care, which aligns with the hospital being part of the Cork City of Sanctuary Movement.

Executive Council update

THE INMO's new Executive Council met and had their induction in head quarters on June 17. It was a very productive meeting and the priorities for this term have been set in line with motions from ADC. Holding a seat on the Executive Council is an important role and we will support each other as we progress through the coming months.

The format of meetings was discussed and subcommittees were formed. When we meet in person, it's our opportunity to gel as a cohesive committee which will ensure efficiency of meetings. The role of the Executive Council is a valued one and one that holds great responsibility in decision making terms.

The Executive Council received an update on the national pay talks which ended at the Workplace Relations Commission without agreement. The current proposal fell far short of the projected inflation for the next year – the pay being discussed covers this year and next year. What was offered was not enough to be put to members so, as it stands, we are available for negotiations and both sides have voiced their availability to re-engage. It is hoped that fresh talks will take place soon and that we can conclude the business of the current agreement and the outstanding business from our strike settlement.

Some members of Executive Council attended protests in Dublin, Cork and Galway on the cost of living. This issue is high on the agenda for all our members and will become more evident as the budget will be based around the cost of living.

I look forward to our next meeting, which is due to be held on September 5, 2022.

See pages 16-17 of this issue of WIN for profiles of the Executive Council 2022-24.

Get in touch

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

Red tape must be removed to pay pandemic bonus to health workers

THE INMO has called on the Minister for Health to ensure that the long-awaited Pandemic Recognition Payment to nurses, midwives and other frontline workers is paid.

This call came last month when only two hospitals (Beaumont Hospital and University Hospital Waterford) had paid the bonus to workers since it was signed off on.

INMO general secretary Phil Ní Sheaghdha said: "Despite government announcements and statements directly to the media that the pandemic recognition payment for frontline workers would be paid immediately, those who work in healthcare settings are still waiting for the bonus to be paid.

"This payment has only been made to staff in two hospitals, with many hospitals stating that they are waiting on the HSE to give them the funds to allow them make the payment. The red tape around this payment must be removed and the promised payment made.

"This announcement was made back in January, yet the Minister's own department still has not made any moves to ensure payment to Section 39 employees, agency staff and those who worked in private nursing homes. This is despite several calls from the National Staff Panel of Trade Unions requesting the Department to do so.

"This is a matter of prioritising the implementation of agreements. Unfortunately, all too often we see the practice of delayed implementation of agreements and this in turn leads to an increase in numbers of nurses and midwives expressing their intention to leave the profession. Our health service must do everything possible to retain the workforce and this dismissive constant delay mentality must be corrected."

Queues in EDs nationwide need cross-government action even more urgently than airport queues

IN LIGHT of extremely high trolley figures for the time of year, the INMO made repeated calls for the HSE Emergency Department Taskforce to urgently convene last month. The call came early in the month when there were over 540 admitted patients without a bed in Irish hospitals and was repeated at the end of the month when figures reached a high of 608 trolleys on June 28.

INMO general secretary Phil Ní Sheaghdha said: "Unless action is taken we are going to continue to see high numbers of patients without a bed in our hospitals.

She stressed that the problem was not isolated to University Hospital Limerick (UHL) which received much coverage recently following a HIQA inspection report *(see page 12)*. "We are also seeing huge numbers of patients without a bed in Cork University Hospital, University Hospital Galway, Sligo University Hospital, St Vincent's University Hospital, University Hospital Kerry and St Luke's Hospital, Kilkenny.

The INMO is seeking three immediate actions:

- The HSE Emergency Department Taskforce must urgently convene to put a hospital-by-hospital plan in place in the short, medium and long-term. This is time to plan for the winter. The outcome of the Minister of Health's request to examine and issue recommendations in University Hospital Limerick must be provided to the Taskforce without delay
- A national meeting with the Health and Safety Authority, as the union is concerned about the lack of focus and attention to the legal requirement of HSE and voluntary hospitals to provide a healthy and safe workplace to workers
- For the Workplace Relations Commission to set a date to urgently hear the referral from the INMO on the breach of the Emergency Department Agreement and the implication for stable industrial relations of same.

"Patients are being constantly let down when it comes to timely access to healthcare. Long term implications of these inhumane waiting times are reported on but ignored. Long waits for care in inappropriate locations cause patients to have much poorer outcomes – why are we still waiting for a plan to deal with this vital issue? The same all-government approach is needed to fixing the current trolley crisis as was applied to the long queues over one weekend in Dublin Airport," Ms Ní Sheaghdha said.

"The Emergency Taskforce must immediately convene. The HSE and Minister for Health cannot continue to ignore the importance of this body when it comes to tackling the root causes of the chaotic scenes we are seeing in EDs across the country."

No let-up in overcrowding this summer

A total of 8,680 patients went without a bed in Irish hospitals in May according to the INMO end-of-month Trolley Watch analysis. The most overcrowded hospitals of May 2022 include:

- University Hospital Limerick (1,823 patients)
- Cork University Hospital (896 patients)
- Sligo University Hospital/ Galway University Hospital (761 patients)
- St Luke's Hospital, Kilkenny (637 patients)
- St Vincent's University Hospital (509 patients).

INMO general secretary Phil Ní Sheaghdha said: "May is traditionally a time in our hospitals where pressure begins to ease but our members have had no reprieve. Nurses right across the country are reporting high levels of burnout. The HSE Emergency Taskforce should convene in Limerick, so all members can see first-hand the suboptimal conditions that healthcare staff are working in and make recommendations on improving conditions in the country's most overcrowded ED. The Minister for Health must make good on his proposed expert review of UHL. Nurses and other healthcare staff cannot be expected to sustain this type of pressure."

GP nurses deserve pandemic bonus

INMO backs practice nurses in fight for fair pay and conditions

GENERAL practice nurses need collective bargaining power in order to ensure fair pay and terms and conditions for all, INMO director of professional services Tony Fitzpatrick said at the recent conference of the Irish General Practice Nurses Educational Association (IGPNEA) held in Waterford.

Mr Fitzpatrick took part in a panel discussion on *'Delivering the Capacity in the General Practice Setting to Enable Equitable Access to Healthcare'*, along with speakers from the Department of Health, the Irish College of General Practitioners, the Irish Medical Organisation, and the Nursing and Midwifery Board of Ireland (NMBI).

As well as clinical items such as the impact of Covid-19 on older people and the management of childhood obesity, depression and anxiety in general practice, the agenda focused on difficulties with the recruitment and retention of GP nurses, particularly in rural areas. This issue was raised with all panellists and is an issue that the INMO will continue to pursue.

As a sponsor of the event, INMO officials took the opportunity to meet and discuss issues with practice nurses from around the country. The practice nurses raised their concerns about burnout following Covid-19 as well as the failure of the government to provide a mechanism for general practice nurses to receive the €1,000 pandemic recognition payment.

Mr Fitzpatrick gave his assurances that the INMO is continuing to advocate on behalf of INMO practice nurse members to the Minister for Health and the Department of Public Expenditure and Reform in order to establish some way to pay general practice nurses the pandemic recognition payment.

Pictured above at the Irish General Practice Nurses Educational Association's recent conference were (l-r): Tony Fitzpatrick, INMO director of professional services; Georgina Bassett, deputy chief nursing officer; David Cullinan TD, Sinn Féin health spokesperson; Mary Jordan, chair IGPNEA; Roisin Doogue, IGPNEA; Dr Brendan O'Shea, GP; and Denis McAuley chair of IMO GP Committee
(right) Grainne Walshe, INMO IRE, is pictured with Tony Fitzpatrick

"It is unacceptable to us that general practice nurses would be overlooked in recognition of their dedication on the front-line throughout the pandemic", he said. "The theme of the IGPNEA conference, together with the INMO, is clearly of the view that it is now time to get general practice nurses organised in order to ensure that they are recognised for the valuable work that they do. The INMO's view is that it is now time to recognise, organise, resource and reward general practice nurses.

"General practice nurses are highly skilled, experts in clinical care; they are super coordinators of care, including other professionals, and are essential to the running of the primary care service. General practice nurses have a huge impact on health outcomes, but the true value of the role has never been recognised. They also create significant value in terms of leadership, networked approach and improved diversity of access,while supporting and enabling self-care.

"Resources are obviously required to ensure that there is appropriate education and training investment for practice nurse courses; but investment is also needed in a nursing professional support infrastructure for practice nurses.

"In order to ensure recognition, resourcing and reward, it is vitally important that GP practice nurses, via the INMO, organise to form a campaign to raise the profile of general practice nurses and establish collective bargaining power.

"It is necessary now that there is an established pay negotiation structure that will allow for the standardisation of pay and terms and conditions such as maternity leave and sick leave. This will be a key item on the agenda for the INMO GP Practice Nurse Section and proper recognition will only be achieved through the collective power of general practice nurses and the INMO.

"We wish to grow our relationship with the IGPNEA and organise our members to win appropriate recognition, reward and terms and conditions of employment."

INMO GP nurse members will be updated on all issues through email updates and in future issues of *WIN*.

The INMO's GP Practice Nurses Section is a very active section. To become involved, contact section chairperson, Sonja Corrigan, secretary Sharon Kinsella or INMO section officer Jean Carroll. All can be contacted through jean.carroll@inmo.ie

INMO director of industrial relations **Albert Murphy** updates members on

ED Safe Staffing Framework needs to be fast-tracked to EDs nationwide

THE report on Phase 2 of the 'Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings in Ireland' was formally launched by Minister for Health Stephen Donnelly in June 2022.

This is the second report of the Framework for Safe Staffing and Skill Mix – the policy for determining nurse staffing levels and skill mix in Irish care settings.

Drawn up by Prof Jonathan Drennan of UCC, the report sets out the methodology to determine the appropriate number of nurses and healthcare assistants required for EDs and injury units based on the number of patients presenting and their care needs.

Research from the report shows that the Framework and its underpinning principles actively promote a better working environment for nurses in EDs and better patient outcomes. The Framework led to the development of a systematic approach to determine nurse staffing levels based on patients' triage score, ensuring that the clinical nurse manager in charge was in a completely supervisory role and that the skill-mix reflected patient need (in emergency settings 85% of staffing is by nurses, with 15% by HCAs).

The Framework was rigorously tested through a pilot test which took place across three EDs – at Mater Misericordiae University Hospital, Cork University Hospital, South Tipperary University Hospital – and one injury unit – in Mid-Western Regional Hospital, Ennis.

INMO general secretary Phil Ní Sheaghdha attended the launch. The INMO is now seeking that the roll out of the ED Framework is fast-tracked in the remaining EDs around the country. It is clear that there is a safety crisis in EDs due to overcrowding. The data shows that attendances in all EDs have increased in the first six months of this year. Recent data released from the HSE shows that the average national wait in EDs is 11.2 hours. Regionally, the data highlighted waiting times of:

- 21.6 hours at the Mercy University Hospital, Cork
- 18.4 hours at Tallaght University Hospital
- 14.7 hours at University Hospital Limerick
- 11.1 hours at Our Lady's Hospital, Navan

Planned closure of Navan ED

The ED at Our Lady's Hospital, Navan was set to close with effect from June 2020, following a decision made by the Board of the HSE to reconfigure services at the hospital.

Following a briefing which the Minister for Health received on June 14, 2022, senior clinicians, Dr Colm Henry and Mr Gerry McEntee stated that their view was that the hospital was not safe. This follows a 2014 report on small hospitals of which Navan is the last one, in its current structure.

The INMO is concerned that there has been no engagement in relation to the effect of the decision to close the ED on the nearest hospitals which will receive additional patients.

The INMO and the HSE know from experience, on reconfiguration previously in the Northeast and also similar experiences in the Mid-West, that closure of smaller hospitals will result in increased attendances in already overburdened nearby larger hospitals.

As stated above, the evidence shows that ED attendances are up on last year and this is also the case with the nearest EDs to Navan at Our Lady of Lourdes Hospital, Drogheda, Connolly Hospital and Beaumont Hospital.

Therefore, the unions are requesting a high level engagement with the HSE to devise a plan which is adequately resourced, including additional posts into these receiving hospitals. The INMO is also seeking that staff currently working in Navan ED will be protected.

In the meantime, the unions are calling for the assurance that there will be no changes to the current service being provided by Our Lady's Hospital, Navan, until urgent engagement takes place. In addition the INMO has requested a meeting of the WRC ED Oversight Body to be reconvened.

Special leave with pay still needed for long Covid

MINISTER for Health Stephen Donnelly gave a commitment at the INMO annual delegate conference in May 2022 that there would be no cliff edge with regards to the matter of changes in Special Leave with Pay (SLWP) arrangements for those who are unable to return to work due to long Covid.

The arrangements for SLWP were altered with effect from February 2022, and a further set of proposals from the Department of Finance was issued and was due to take effect from July 1, 2022. These Department of Finance proposals would mean that all employees who were absent from work due to long Covid would now be classified as being on 'ordinary' sick leave.

This is a matter of grave concern to the INMO as there are a number of members who are in this position and are facing financial hardship as a result of this vital support being removed.

The HSE declined to attend the Workplace Relations Commission on this issue on June 16, 2022 and the health sector unions have written to the HSE to request that the current arrangements remain in place pending engagement at the WRC.

Matters took a negative turn on June 15, 2022 when the HSE issued a draft circular which also gave effect to these changes.

Given the fact that the HSE issued the circular when the matter had been referred to the WRC – which the HSE had refused to attend – this is an inflammatory situation, which the INMO considers to be deplorable.

recent national issues

Restoration of 37.5 hours a significant achievement

The restoration of the Haddington Road Hours is due to take effect from July 1, 2022. The HSE issued a Principles Document to the system on June 14, 2022 which sets out the principles for the application of the reduction in hours across nursing and midwifery.

This is a major achievement for nursing and midwifery and other public servants who mainly voted for the Building Momentum Agreement because of this provision.

Building Momentum also provides for a fund for replacement costs. The INMO has sought that this funding is ringfenced for these replacement costs and is not subsumed into other spending.

A bespoke recruitment and retention initiative is needed for nursing and midwifery and the INMO is pursuing this with the HSE.

DoH drags its heels on sanctioning pandemic bonus for all frontline HCWs

DESPITE numerous direct requests from the unions, the Department of Health has failed to issue a circular to clarify the situation regarding payment of the pandemic bonus to agency and private nursing home staff. Such a circular would release funding for payment for those agency staff who worked in the HSE and Section 38 establishments during the Covid-19 pandemic.

It is regrettable that the Department of Health has dragged its heels on this issue, given that the government gave sanction for this on January 10, 2022. The INMO will continue to press for the circular to be released so that members in these employments will get paid in line with their other colleagues.

The INMO has been very critical of the employer's tardiness in releasing the circular which will enact payment of the pandemic bonus. What should be a good news story is being stretched out by the employer which is not considerate of all healthcare workers who valiantly worked on the frontline during the Covid-19 pandemic.

The INMO recently secured clarification for those employees who worked additional hours during the pandemic period. It is agreed that payment can be based on hours worked as opposed to contracted hours, subject to a maximum payment of €1,000 per person.

Eligibility of employees will be assessed based on actual hours worked, subject to the minimum four-week threshold during the period March 1, 2020 to June 2021. In relation to those employees who work on a contract/relief basis, the actual hours worked between the period of March 2020 to June 2021 should be the basis for calculating entitlement. This will mean that staff who worked more than their contracted hours may qualify for a €1,000 bonus rather than a €600 payment. This is a significant improvement on the original scheme and should benefit these employees.

In addition, an appeals mechanism has been agreed. A Special Pandemic Recognition Award Resolution Committee has been established to deal with appeals and matters arising from the original circular.

The deadline for submission of appeals is August 31, 2022. It should be noted that the dispute resolution committee is limited to interpreting the terms of the HSE HR circular 12/2022 and all decisions of the Dispute Resolution Committee will be binding, and no further appeal will be allowed.

It is open those who wish to make an appeal by setting their grounds for the appeal, in writing, to the Special Pandemic Recognition Appeals Dispute Resolution Committee. The option of requesting an in-person hearing is also available to those who wish to make an appeal.

For ongoing updates on industrial relations issues see **www.inmo.ie**

South-east update

Claim for location allowance on UHW surgical day ward

The INMO is pursuing a claim for payment of the location allowance to INMO members working in the surgical day ward of University Hospital Waterford, following the temporary expansion and effective re-purposing of this unit last year. It is the INMO position that this ward now operates on a 24/7 basis providing care to medical/surgical inpatients in addition to day-surgery patients, and therefore believes that the location allowance should apply to our members working in this unit. The opening of the unit on a 24/7 basis was a measure introduced by the hospital last year to alleviate overcrowding in the emergency department. While negotiations with local management are ongoing, the INMO is hopeful that this INMO claim will be resolved soon without the necessity of WRC intervention.

St Brigid's, Carrick-on-Suir

Further to the HSE's decision to close St Brigid's Hospital in Carrick-on-Suir to inpatients, the INMO referred a dispute to the Workplace Relations Commission in which several joint union claims were made on behalf of members who had worked in the hospital before its closure.

The closure resulted in INMO members being redeployed to work in other HSE services in the South-East, some of whom suffered a reduction in their access to premium shifts in their new work location, thereby suffering a loss of earnings. A compensation claim has been lodged with the HSE South (East), in line with the provisions of the Public Service Stability Agreement, and the INMO has sought that full payment of this monetary compensation to our members will be made as soon as possible.

– Liz Curran, INMO IRO

HIQA report on UHL ED vindicates repeated concerns raised by members

THE Health Information and Quality Authority (HIQA)'s recent report on its unannounced inspection of University Hospital Limerick's emergency department vindicates the serious concerns that the INMO has been raising repeatedly about safety in the ED, which impacts the hospital as a whole.

The HIQA report, published on June 17, lays out a number of critical issues in the hospital and focused on three key issues:

- Staffing levels
- Capacity and patient flow
- Respect, dignity and privacy for patients in the ED.

The report highlighted significant capacity issues, with around 40% of patients in the ED being treated on trolleys. It described staffing levels as "insufficient to meet the needs of people attending the department", leading to a significant impact on safety and safe care.

The INMO stated that overall, the report reflected its concerns on overcrowding in the hospital which has a significant impact on the retention of nurses in such unsafe workplaces despite the significant recruitment efforts of nurse managers.

The INMO also welcomed the quality and workforce review mentioned in the report, and will be seeking engagement on this over the coming weeks.

INMO assistant director of IR Mary Fogarty: *"Our members welcome the publication of the report as a first step, but it's important that it leads to action"*

INMO assistant director of IR Mary Fogarty said: "The report is a fair analysis of the situation our members are facing on the ground. However, it needs to be noted that when things are this bad it is harder to keep nurses in unsafe workplaces, which makes it harder to ensure safe staffing numbers.

"The report shows that nursing staff are doing everything they can in a desperate situation, but that it's not possible to keep patients safe in these conditions.

"Our members have been drawing attention to these issues for years and we requested that HIQA investigate the situation in UHL. Our members welcome the publication of the report as a first step, but it's important that it leads to action.

"It would be wrong to wait for a winter surge or the next healthcare emergency to act on this. The report's recommendations must be implemented urgently or the crisis in the midwest is only going to get worse. Decisions based on patient safety and staff safety must now be made. We are seeking to engage urgently with the HSE senior hospital management on all aspects of the HIQA report."

The full 'Report of the unannounced inspection of the ED at UHL against the National Standards for Safer Better Healthcare' is available at: **www.hiqa.ie/reports-and-publications/inspection-reports**

Key observations made by HIQA

HIQA make a number of observations in its report including the known facts that:

- Lack of privacy in medical circumstances are a breach of the human rights based model of care expected
- It is estimated that one extra death occurs for every 82 admitted patients whose transfer to an inpatient bed is delayed beyond six to eight hours from the time of arrival at the ED
- Insufficient nursing staffing levels significantly impacts on the delivery of safe, quality care
- Overcrowding in hospitals has been shown to increase the risk of infection and is of particular concern in the context of Covid-19

In this inspection:

- HIQA was not satisfied that this hospital's management was adequately planning, organising and managing its nursing workforce in the ED and the inspectors found that the nursing staffing levels were insufficient to meet the needs of the volume of patients
- The physical congestion caused by extra trolleys throughout the department posed a significant risk to the delivery of safe, quality care and was an infection prevention and control risk for patients and staff
- Noting the pattern of insufficient nursing staff levels in the ED, this is a risk that should have been included on the hospitals corporate risk register

Interim agreement reached for UHL theatre nurses

THE INMO has secured an interim agreement in respect of excessive theatre overruns in University Hospital Limerick and also on the separate requirement under the Organisation of Working Time Act 1997 for compensatory rest time.

Nurses in UHL theatres are regularly unable to leave work on time as the elective theatre lists are oversubscribed. A process has now been agreed to include the escalation to line management of identified overruns and payment of on-call without standby per case.

On a separate matter, arrangements have also been agreed for the rostering of additional nurses at weekends on an interim basis to ensure that following call out the nurse can avail of 11 hours compensatory rest time.

The agreement will be reviewed in August as management is securing additional nurses to populate weekend rosters and is to present proposals on new rosters to the INMO.

– Mary Fogarty, INMO assistant director of IR

Cavan civic reception for INMO members: *Pictured at the civic reception were: (left) members of the INMO Cavan Branch and (above, l-r): Tony Fitzpatrick, INMO director of professional services; Karen Clarke,INMO IRE; Mary Tully, PHN, chair of the Cavan Branch and INMO first vice president; and David Miskell, INMO professional and regulatory services officer*

Cavan CC pays tribute to nurses and midwives

AS PART of the centenary celebrations for the INMO, Cavan County Council held a civic reception on June 9, 2022 to honour and recognise the contributions made by nurses and midwives and the INMO over the years to the county of Cavan.

The event, which was held in Cavan Council Offices, was attended by a number of nurses and midwives, as well as management from both acute and community services.

Representing the INMO were: Tony Fitzpatrick, director of professional services; David Miskell, professional and regulatory services officer; and Karen Clarke, industrial relations executive for Cavan.

Cavan CC cathaoirleach Clifford Kelly hosted the event alongside his colleague Tommy Ryan, chief executive. Addressing the gathering, Mr Kelly expressed his thanks and gratitude on behalf of the people of Cavan, to the nurses and midwives in the county, acknowledging the contributions the profession and the INMO have made over the past 100 years and the positive impact the profession has had on the wider Cavan community, particularly during the challenging times of the pandemic.

Members of the INMO Cavan Branch, Mary Tully (chair) Karen Eccles (vice chair), Roisin Lynch (secretary), Mary Gaffney and Bernadette Fitzpatrick (treasurers) were presented with a plaque to recognise the work of the professions and to mark the centenary of the INMO.

The event was coordinated by Mary Tully, PHN who as well as being chair of the Cavan Branch is INMO first vice president. Ms Tully was presented with a bouquet of flowers at the event in recognition of her recent election as first vice president to the INMO.

Also present on the evening to honour the contributions of the nurses and midwives in Cavan were a number of councillors as well as Brendan Smith, TD for Cavan-Monaghan, and Senator Joe O'Reilly.

Speaking at the event on behalf of the INMO, Mr Fitzpatrick thanked the county council and all present for recognising the work of the professions and the INMO. He spoke about the history of the Organisation and how, over the past 100 years, it has grown from strength to strength for not only the benefit of members but also for the patients they care for on a daily basis.

Mr Fitzpatrick went on to describe the work undertaken on a national, European and international level by the INMO on behalf of the members, also recognising the work and contributions the professions have made and continue to make during the course of the pandemic.

In her speech Ms Tully thanked the county council for hosting the event. She spoke about how in 1919, 20 nurses came together in South Anne Street in Dublin to form the Irish Nurses Union (INU), showing remarkable courage and how the union, now the INMO, has grown from strength to strength with over 42,000 members today.

Ms Tully went on to express her thanks to members of the Cavan Branch for their commitment and dedication. She concluded: "This evening is an extraordinary expression of confidence and support that we receive from patients and people who use our service, their wider families, and our fellow professions."

– Karen Clarke, IRE

Mid-west update

- A PILOT scheme has commenced on segregated roles on one unit in St Camillus Hospital, Limerick. Any issues arising can be addressed at a review meeting after six weeks and all going well the segregation will roll out in the other four units. CHO3 hopes to have segregated HCA/MTA roles in all nine sites in older persons services within 12 months.
- ENGAGEMENT has been sought with management in older persons services on the proposed reconfiguration of North Tipperary services for the older person. A working group has to be set up with nurse management/HR/INMO and SIPTU to deal with members' queries and concerns regarding loss of long-term residential services in Dean Maxwell CNU, which plans to deliver respite and day services only.
- Members in CHO3 are reminded to check their salary point of scale/payslips to ensure their entitlements are being met. At a recent information session in older persons services the INMO met members who had not applied for the enhanced nurse salary scale despite meeting the criteria. A verification form must be completed with your line manager. For any queries on entitlements, contact inmolimerick@inmo.ie

– Karen Liston, INMO IRE

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

Vatican: Kennedy outlines nurses' role in fight against human trafficking

AT A recent international conference on human trafficking held in Vatican City, former ICN president Annette Kennedy met with Pope Francis and spoke about the importance of nurses recognising human trafficking and taking action to prevent it.

Ms Kennedy was a moderator at the event, which was run by Santa Marta Group, a partnership between the Catholic Bishops' Conference of England and Wales and police chiefs, set up in 2014 aimed at eliminating human trafficking.

The conference heard of trafficking and forced labour in supply chains, including of medical supplies to the NHS and other health systems. The problem is thought to earn the criminals behind it over $150 billion annually. Up to 40 million people suffer various abuses worldwide, including sexual exploitation, forced criminality, domestic servitude, and the selling of children for their organs or for barbaric rituals.

The conference heard that a high proportion of trafficked people come into contact with a healthcare professional, echoing discussions at ICN's 2019 Congress, where the important role nurses can play in identifying victims of human trafficking and its prevention were highlighted.

Ms Kennedy said: "The conference reinforced my belief that healthcare professionals have a major role to play in ending this serious crime. Healthcare professionals will often encounter victims of human trafficking, so knowing how to identify them and what to do is crucial. But there is also a responsibility on governments and health services to prevent the billions spent in procurement each year from being tainted by forced labour or child exploitation.

Ms Kennedy said meeting the Pope had re-energised her resolve to do all she can to work with nurses and communities to rid the world of human trafficking. She spoke of the action of an emergency department nurse in London who noticed what she believed to be human trafficking, which led to scores of victims being supported and the conviction of several traffickers who had been operating across Europe.

Endorsing Santa Marta Group efforts, Pope Francis said: "Sadly, modern forms of slavery continue to spread, even in the most developed areas of the world. It is my hope that the fight against human trafficking will take into greater consideration a number of broader realities. This would include the responsible use of technology and social media, as well as the need for a renewed ethical vision of our political, economic and social life, one centred not on profit but on persons."

The INMO has been a long supporter of work in Ireland and by the ICN to prevent human trafficking and to support victims of trafficking, particularly those trapped in the sex trade in Ireland as a result. The union supports the work of partners in this area, and stresses the importance of training and awareness-building so that members, who are often a first point of contact, can support people who find themselves in such vulnerable positions.

See also page 21

ICM surveys European midwives' war efforts

MIDWIVES' associations (MAs) throughout Europe are leading efforts to provide vital health services and other support to Ukrainian refugees, specifically women and children.

In May, the International Confederation of Midwives (ICM) surveyed some member associations on their contributions to relief efforts for the war in Ukraine. Responses from seven European midwives' associations revealed the essential role of grassroots women's groups – such as midwives' associations – in assessing and responding to the needs of women and children during humanitarian emergencies.

Examples of how ICM MAs are providing care to the Ukrainians fleeing war include:

- The Independent Midwives Association of Romania has partnered with a group of mothers to secure housing for Ukrainian women and families entering Romania. They have rented apartments for women who are pregnant or who have small children and children with special needs. They also provide antenatal and postnatal care for mothers and babies, access to abortion, legal support, translation and integration services, and psychological support. They have helped more than 500 families to date
- The Estonian Midwives Association is running a donation campaign to collect hygiene products for facilities housing Ukrainian refugees
- The Federation of Finnish midwives has made donations to humanitarian organisations and local MAs are providing hygiene products to reception centres in Finland
- The Hungary Midwives Association, located close to the Ukrainian border, is providing food, hygiene products and vitamins to families crossing into Hungary, spending most of its annual budget on this vital support
- The Polish Midwives' Association, along with another Polish MA, has provided over 700 emergency birth kits to pregnant women in Ukraine.

ICM chief executive Dr Sally Pairman believes that funding midwives' associations during humanitarian emergencies is one of the most impactful ways to mitigate the adverse effects of war and natural disaster on women, newborns and children. "Midwives work and live in the communities they care for, providing individualised and comprehensive reproductive healthcare, counselling, support services and more. When humanitarian emergencies occur, midwives are on the ground and well-positioned to deliver primary health services, including quality and respectful maternal and newborn care, contraceptive care and pre- and post-abortion care."

global news affecting nursing and midwifery

ICN reports rise in industrial action by nurses globally

THE International Council of Nurses (ICN) says the considerable increase in the number of nurses taking strike action across the world is a direct response to governments' failure to tackle the root causes of our fragile, severely weakened, and in some cases collapsing healthcare systems.

Across the globe the ICN has identified numerous examples of nurses engaged in industrial action over a range of basic issues including safety, security and protection, all of which jeopardise both healthcare staff and patients.

They have observed that one of the fundamental root causes is the global shortage of nurses, which is putting unsustainable pressure on the nurses currently working in healthcare systems that have been disrupted by staff shortages, the Covid-19 pandemic and historical chronic underfunding.

These pre-existing shortages have led to a worrying increase in industrial disputes and strikes – for example a report from Cornell University's ILR Worker Institute shows that half of all strikes in the US in 2021 were of workers in healthcare settings, and on June 18 nurses in Spain held a nationwide demonstration. Among other examples, the ICN has pinpointed nurse actions in Europe, the Americas and Africa.

ICN president Pamela Cipriano said: "Industrial action by nurses is always a last resort but it is not surprising it is happening given the state of the health systems nurses are having to work in, which do not enable them to deliver the high-quality care they expect to. This is because of the pressures they are working under, the lack of value and recognition they receive, historic inequities related to gender, and poor pay and working conditions.

"These past two years have taught the world just how important nursing care is to our health and our social and economic wellbeing, but the lessons learned are not being heeded by the people with the power to make a difference to the state of their health systems, the quality of patient care and the lives of nurses everywhere."

Ahead of a meeting with the president of the United Nations General Assembly, Abdulla Shahid, at the Palais Nations in Geneva, ICN chief executive officer Howard Catton said: "ICN is calling out governments for not tackling the roots of the unrest in our healthcare systems which are fragile, severely weakened and in some cases bordering on collapse. Instead of papering over the cracks they must address the fundamental issues of inequality and gross underfunding which have led to lack of fair pay, shortages and increased risks to patient safety."

Recent action

The ICN has reported nursing colleagues across the globe are taking action as a last resort to obtain a just and equitable working environment which recognises their contribution and safeguards the safety of their patients. Recent industrial action taken by nurses includes:

- Action in Spain demanding urgent improvements to the Spanish healthcare system and the working conditions of the professionals who work in it
- Following an earlier strike in Finland, a second strike was cancelled because of the threat of the new law, the process of which through the Finnish parliament has been suspended. Now, instead of planning further strikes, Finnish nursing unions are scheduling mass resignations, possibly later in the autumn, if an acceptable negotiation solution is not reached before then, to show the strength of their feelings and their determination not to allow the current situation to continue
- The longest strike in Danish history took place last year, lasting 70 days, where nurses have warned for years that salaries and working conditions do not reflect nurses' competencies, tasks and responsibilities. An imposed pay settlement by the government following the action was far short of what was required and now 10% of posts are vacant
- On 7 June, health workers in France held a one-day strike to protest about unmet demands on staff recruitment, better salaries and shortages
- In North Rhine-Westphalia, Germany, nurses at university clinics are protesting against unacceptable working conditions
- In the US, nurses at several hospitals in Oregon, California and Minnesota have been striking to demand better wages and raise nurse staffing levels
- Further action is also reported in Mexico and Uganda.

World news

Nurses and midwives in action around the world

Global
- To save global health, we need vaccine patent waivers now

Australia
- Not all nurses in NSW will be eligible for $3,000 'appreciation' payment
- Hospital emergency department wait times at record highs

Canada
- Ontario healthcare workers sound alarm over 'absolutely horrific' hospital demand
- Hospital launches workplace violence campaign, reporting rising numbers
- Toronto-area nurse says profession crumbling under weight of burnout

New Zealand
- Nurses warn more people will die if health sector's staffing crisis isn't fixed

Paraguay
- Nurses support labour action over lack of medication for cancer patients

Spain
- Union warns 'no nurses for hire' this summer
- 75% of nurses have suffered some aggression

UK
- RCN warns NHS nurse shortages a risk to patient safety
- Improved pay is key to NHS workforce retention, survey suggests

US
- Local nurses plan informational picket during ongoing contract negotiations
- Hospital shootings force systems to review safety measures

Introducing Executive Council 2022/2024

Officers

President

Karen McGowan is a registered advanced nurse practitioner in the ED at Beaumont Hospital, Dublin. She trained as an RGN at Beaumont and completed her BSc in nursing at DCU. She later undertook a postgraduate diploma in emergency nursing and a master's degree at the RCSI. She also holds certificates in drug prescribing and ionising radiation, as well as a certificate in advanced assessment from UCD. This is her second term as president of the INMO.

First-vice president

Mary Tully is a public health nurse working in primary care in Cavan. She is qualified as both a nurse and midwife. She has been an active INMO member for many years, holding key positions in her branch and section and regularly participating at ADC. She previously served on the Executive Council for four consecutive terms and feels that this experience has given her an acute understanding of union structures and how to make them work to ensure maximum participation by all members.

Second-vice president

Caroline Gourley is director of nursing for residential services, CHO Dublin North City and County. Since beginning her career in the 1980s, Ms Gourley has worked in Cherry Orchard Hospital and Bellvilla Community Unit. She holds a diploma in first-line supervisory management, a BSc in nursing management, an MSc in palliative care and an advanced diploma in medical law. She has been an INMO representative at hospital and branch level since 1990 and is chair of the Care of the Older Person Section.

Clinical

Elizabeth Allaugigan is a senior staff nurse at St James's Hospital, Dublin. She has worked as an RGN since 2004, having also practised abroad, including in her native Philippines, where she completed a degree in nursing. Since moving to Ireland, she has completed a diploma in healthcare management, a diploma in reflexology and a master's in public administration. She is currently serving as chair of the International Section.

Margaret Birtley is a PHN working in North Cork. She has worked in both public and private hospitals and in the community as an RGN, theatre staff nurse, practice nurse, community RGN and a PHN. She has a BSc degree, a postgraduate diploma in public health nursing and an MSc in nursing and healthcare quality improvement. Ms Birtley is chair of the Mallow Branch and is passionate about advancing the safety of nurses and midwives in the workplace.

Eilish Corcoran is a CNM2 in OPD in South Infirmary Victoria University Hospital in Cork. She has a degree in nursing and a certificate in emergency nursing. She has worked in ED, cardiology, radiology and OPD, and served on both the board of directors and committee of management of SIVUH. She has been the INMO workplace rep since 1998 and is secretary of the Cork Voluntary/Private Branch.

Mary Dunne is a CNM2 in the ED at University Hospital Waterford (UHW). Having completed her training at UHW, Ms Dunne moved to London before returning home to take up the post she currently holds. In 2012 she became an INMO representative on the ED and hospital committees. She is also chairperson of the Waterford Branch and is involved in the INMO ED Section. She was also part of her local strike committee in 2019.

Elizabeth Egan is a CNM1 in St John of Gods Community Services. She trained as an RNID and later completed a BSc in nursing management at the RCSI. She has carried out training under Genio in enabling excellence and ensuring that those she supports reach their full potential. She has worked in a variety of settings including community, respite, residential and acquired brain injury. Ms Egan has been active as a local rep and a member of the RNID Section.

Ester Fitzgerald is an ICU nurse in CUH. After her general training she went on to complete a higher diploma in critical care in Dublin before returning to CUH to take up her current role. She is chair of the Cork HSE Branch and was secretary of the strike committee in 2019. With an interest in workplace safety she completed a BA in law and a master's in healthcare risk management and quality. She has attended the WRC on the issues affecting members in acute hospital services.

Audrey Horan is a staff midwife at University Maternity Hospital Limerick (UMHL). She qualified as an RGN in 1994 and obtained her certificate in midwifery in 1998 from UMHL. She works on a postnatal ward providing holistic, individualised and family-centred care for mothers and infants. She has been an INMO member since her student days and took part in the 1999 strike. She also served on the strike committee during the 2019 strike.

Aoife Kelly is a staff nurse at University Hospital Galway. She qualified as a registered nurse in 2004 and worked for 12 years on surgical wards both in the UK and in Ireland. She has worked in theatre since 2016. During her time in the UK, Ms Kelly undertook roles as a health and safety and clinical governance representative. She completed a module in mentorship at King's College London. Ms Kelly joined the INMO in 2017 and has been an active member since.

Clinical

Sarah Maher is CNM2 in the ED at Letterkenny University Hospital. She qualified in 2001, having completed her training in LUH, and has worked in the ED as a staff nurse, CMN1 and now CNM2. She has been a member of the Letterkenny Hospital Branch for more than 10 years, where she previously served as education officer, and is currently the health and safety liaison officer. During the 2019 strike she served as secretary on the local strike committee and has been a health and safety rep for the past 15 years.

Lynda Moore is a staff midwife at Cork University Maternity Hospital. She has been a nurse since 1984 and a midwife since 1987. She has also worked providing antenatal education to expectant parents. She previously worked as a midwifery teacher and co-ordinated continuous professional education for nurses and midwives in Cork and Kerry. She feels that greater emphasis needs to be given to nurturing and supporting nurses and midwives in order for them to continue to provide top-class care.

Michael O'Dwyer is a staff nurse at Cashel Residential Older Persons' Services, Tipperary, working in the combined fields of care of the older person, end of life and palliative care. Having been a social worker in London and Belfast, he qualified from Queens University as a nurse in 2007. Mr O'Dwyer was elected as local INMO rep in 2016 and has assisted colleagues with issues around working conditions and staff rights. He has a particular interest in minority rights and gender equality.

Tracey O'Fiaich trained in University Hospital Galway. After working on a surgical ward there, she moved to the UK where she undertook an ENB 100 (ICU). She has worked in Regional Hospital, Mullingar for more than 20 years. She lectured in the Technical University of the Shannon and holds a diploma in general nursing, ENB 100, extra-mural diploma in healthcare management, a BSc in nursing and a master's in nursing. She has been branch secretary and chair of her local 2019 strike committee.

Clinical

Ron Russell is a senior staff nurse in the theatre department, Midland Regional Hospital, Portlaoise. Originally from Australia, he qualified in 2001 and has held positions across several specialties. He has completed a clinical leadership programme and a postgraduate diploma in specialist nursing. He was a branch member of the New South Wales Nurses and Midwives Association and joined the INMO in 2014. He is a member of the Operating Department Nurses Section and the Laois Branch.

Sean Shaughnessy is a staff nurse on the surgical day ward at University Hospital Galway (UHG). He was recently elected chair of the Galway Branch. He was involved in the strike committee at UHG, where he is also health and safety rep for the INMO. He trained and worked in the UK for 11 years and worked in critical care post graduation. He worked up to management level before returning to Galway, where he continues to work. This is his second term on the Executive Council.

Bairbre Webb-O'Maolagáin works as the paediatric liaison clinical nurse specialist in the National Orthopaedic Hospital, Cappagh, Dublin. She previously worked as a clinical nurse in CHI Temple Street for more than 20 years. She has a dual qualification, having originally trained as an RGN in St Vincent's University Hospital. She is vice chair of the Children Nurses Section and is a passionate advocate for improving working conditions and remuneration and achieving a healthy work-life balance.

Administration

Grace Oduwole is ADON at Bellvilla Community Unit, Dublin. She came to Ireland in 2001 after working for 14 years in Nigeria as a nurse/midwife. She has a nursing degree from Trinity College, an MSc in nursing studies, a diploma in leadership and management and a BSc in nursing management from the RCSI. Ms Oduwole is vice chairperson of the International Section. She attended ICN congresses in Barcelona in 2017 and Singapore in 2019. This is her second term on the Executive Council.

Education

Annette Keating registered under the tutors division of the NMBI register in 2001. A midwife teacher for five years in the College of Midwifery, St Finbarr's Hospital, Cork, Ms Keating transferred to UCC in 2006 as a midwifery lecturer and returned to the HSE Centre of Nurse/Midwifery Education as a midwife teacher in 2007. She holds a master's of philosophy from Glasgow Caledonian University for her research into birth and midwives' work. She is secretary of the INMO Nurse/Midwife Education Section.

Paula Barry is practice development co-ordinator at the Coombe Women & Infants University Hospital. She began her career as a general nurse in Cork and worked in a variety of specialties. In 2003 she undertook a higher diploma in midwifery and since then has completed bachelor's and master's degrees in midwifery. In her various roles at the Coombe, she has been instrumental in enhancing the provision of maternity care and maintains a weekly clinic which allows her to keep in touch with practice and support midwifery students.

Student

Ciaran Freeman is a general nursing student in NUI Galway. He has been a member of the INMO since 2018 and is currently chair of the INMO Student Section. Mr Freeman is secretary of the Western Youth Forum and is also INMO representative for his college course. He is also general nursing representative on the Clinical Placement Oversight Group in the Office of the Chief Nurse at the Department of Health. He has recently returned from Poland where he worked with the Order of Malta to assist refugees fleeing the war in Ukraine *(see also page 20)*.

Membership FAQs

In just a sample of the many things that the INMO can assist members with, membership officers **Mary Cradden** and **Stella Carter** address some of the most frequently asked membership-related questions

QUESTION: *I have been working in a hospital but am moving to a community setting in a different part of the country. I pay my INMO membership fees through my salary. Will this continue?*

ANSWER: You must contact the INMO membership department advising them of this as, in most instances, if you are changing work location, you will be moving to a different payroll department. Most hospitals, no matter where they are in the country, have their own payroll department so any change from one work location to another should be advised to the INMO membership department (email: membersupdate@inmo.ie). We will then send you a new salary deduction form to complete so that there will be no gap in payment of your INMO membership fees.

QUESTION: I will be commencing a two-year career break soon. I pay my membership fees through my salary and I am a member of the INMO/Cornmarket income protection scheme, which is also paid through my salary. Please advise what steps I should take to ensure that both my membership and income protection scheme remain active during this period as I do plan to return to work.

ANSWER: It is important that members contact the membership department and Cornmarket directly, prior to taking a career break. The membership department will talk you through what should happen for the duration of your career break in order to keep your membership active. You will also need to contact Cornmarket directly. They will advise you on their procedures, in order to keep your membership of the income protection scheme active.

QUESTION: *I currently work in a private nursing home and pay my INMO membership fees monthly through my personal bank account. I am moving to a HSE hospital in the coming weeks and want to ensure that I keep my monthly fees up to date and that I am paying the correct rate of membership fee in my new role.*

ANSWER: As you are moving from a private nursing home into a new HSE role, your INMO membership fees will increase to the full rate, i.e. currently from €228pa to €299pa. Please ensure that you contact the membership department and they will send you a standing bankers order amendment form so that you can increase your monthly fee to the correct fee for your new place of work. Your current monthly fee will increase from €19pm to €24.92pm. Your bank, as with all financial institutions, will require a minimum of five to 10 working days to process the new payment so it would be important to complete all relevant paperwork prior to taking up your new role.

QUESTION: *I have been on unpaid sick leave for the past four months and have received a reminder for payment from the INMO for the period my membership fees were not paid. I never thought to contact the INMO during my period of unpaid sick leave and I notice that a gap in membership fees has accrued.*

ANSWER: It is important that members contact us prior to taking any period of unpaid leave. Please contact the INMO membership department and they will guide you through the process of what needs to be done from an INMO membership fee perspective during this period of unpaid leave. If you are also a member of the INMO income protection scheme offered by Cornmarket, please also ensure that you contact them directly regarding your period of unpaid leave. As the scheme is linked to INMO membership, it is important that contact is made to ensure your entitlements under the scheme are not impacted.

QUESTION: *Most of my colleagues receive regular updates from the INMO, by email and SMS, but I don't seem to receive any. Could you please investigate on my behalf and ensure that all newsletters and updates are forwarded to me?*

ANSWER: We must not have an active email or SMS on your membership record. Please ensure that you forward all your personal contact details by email to: membersupdate@inmo.ie. It is very important that we have an up-to-date email address for all members as regular notices to members and newsletters are sent by email.

QUESTION: *I will be commencing unpaid maternity leave in the coming weeks. As I pay my INMO membership fees through my salary, I want to ensure that my membership is kept up to date. Could you please advise how I should proceed?*

ANSWER: It is important that members contact us prior to taking any period of unpaid leave, including unpaid maternity leave. Please contact the membership department and they will guide you through the process of what needs to be done during this period of unpaid leave.

Cost of living crisis

Laura Bambrick explains how a change of approach by government could ease the effects of ongoing inflation on workers in Ireland

HIGH prices and the rising cost of living are topics of conversation in every household the length and breadth of the country.

Ireland was already the second most expensive country in the European Union before the ongoing surge in inflation. In 2020, when the inflation rate was below 0%, the price of a sample basket of 2,000 everyday consumer items and services was more than one-third higher here than the EU27 average. Housing costs, which includes utility and energy bills, were higher than anywhere else in the EU at a massive 78% above average. Public transport was 37% more expensive. Average childcare fees for a working couple with two pre-school children were eating up one-fifth of their joint income.

Social wage

Alongside collectively bargained pay increases to offset the effects of soaring inflation, government can bring down the cost of living for workers by improving their 'social wage'. The social wage is a measure of how much better off you are from social spending by government on welfare supports and public services.

New research from the Irish Congress of Trade Unions shows that the value of the social wage for full-time workers in Ireland is exceptionally low by EU standards. Free or very low-cost public services reduce people's out-of-pocket expenses. They act as a virtual income top-up to people's cash income from work or welfare.

But Ireland is unusual among rich EU member states in means testing access to publicly-funded essential services such as housing, healthcare and childcare. Because the maximum income cut-off point is so low, full-time workers rarely qualify. Public services in Ireland are only intended for people on the very lowest incomes unable to meet their basic needs from their own resources. The exception to this rule is free education for all children, free travel for everyone over 66, and free GP visits for those under six and over 70 years old.

In other EU states access to public services is based on need. If, for example, you have a child and a job you need childcare. You are eligible for heavily subsidised public childcare regardless of the size of your pay packet.

In other words, workers in Ireland earning above a very modest wage must pay market prices for essentials, driving up their cost of living, that workers across the EU can freely access.

For example, a single worker in rural Ireland earning not much more than the full-time minimum wage does not qualify for social housing. While only one in seven people in employment hold a Medical Card and a mere one in 28 hold a GP Visit Card. Workers without a medical or GP card have to pay to see a doctor (€52 on average per GP visit nationally), and for other health services and medicines.

Government can ease this unnecessary squeeze on wages by opening up access to public services and thereby increasing the value of workers' 'social wage'.

Low-tax economy

If government is to scale up social spending then it needs to generate more tax revenue. Ireland is a low-tax economy and there is significant space to raise the revenue to pay for more public services without putting tax rates above the EU average and eroding national competitiveness.

Readers will understandably baulk at the suggestion that we are a low-tax economy. We certainly don't feel like a low-tax economy when looking at your pay-slip or at a checkout. The tax-take from employees and consumers in Ireland is above average. Where we under-tax is in relation to property and employers.

Employers in Ireland pay the lowest social insurance contributions in the EU after Cyprus, Lithuania and Malta. The state could have collected €8.3 billion in additional revenue in 2019 had it taxed employers at the average tax level for rich member states. To put this into context, free childcare could be delivered for €2 billion.

Protecting living standards

The pandemic caused unparalleled disruption to our economy and to people's livelihoods. It exposed the weaknesses in our threadbare social safety net in protecting workers' living standards and has sparked wide public support (70%) for government to do more.

Now is the moment for radical change in the role of government in protecting the general population standard of living, including widening access to affordable housing, child and adult care, free healthcare and education, heavily subsidised and sufficient public transport.

Just as the welfare system was built out of the ruins of World War II, one positive legacy of the pandemic can be a more generous social wage for workers and public services for all.

Dr Laura Bambrick is the social policy officer of ICTU

Caring for war refugees: A nurse's diary from Poland

Empathy is a core part of our profession, writes **Ciarán Freeman**, but we can never truly understand the experience of those fleeing war

WHEN Russia invaded Ukraine on February 24, 2022, it sparked the largest refugee crisis that Europe has seen since World War 2, with just short of 8 million Ukrainian people having fled their home country to escape the violence. This crisis has seen a major humanitarian response from many organisations globally. One of these organisations is the Order of Malta, which is active both within Ukraine itself and its neighbouring countries, assisting those countries to help the Ukrainians arriving as refugees.

As a member of the Order of Malta here in Ireland, I was fortunate to travel to Poland on May 14 as part of a team to staff a medical centre for refugees in Kraków. Over three weeks, three Irish teams, totalling more than 30 people, travelled to Poland to assist in their humanitarian response. The members of this team ranged from experienced first aiders to EMTs, nurses and advanced paramedics. I travelled with our second team, with each team spending one week in Kraków.

Poland has led the European response to this crisis by nature of its location, receiving roughly 50% of Ulraine's refugees. Our teams were placed in a medical centre in Kraków Glowny, a huge transport facility that received a large number of trains and buses arriving from various locations. Aside from our medical centre, there were provisions for refugees to ensure that their immediate needs were met while more definitive accommodations were made.

Our centre cared for the needs of refugees spread across two basic sleeping areas, a canteen tent and a secure indoor unit for mothers fleeing with young children. These centres cared not only for those who were fleeing Ukraine, but also those who had fled previously but were now in the process of returning to their homes, each person with their own reasons for doing so.

It quickly became apparent to us that, no matter how much you try, it is nigh impossible to truly put yourself in the shoes of those who are fleeing war. Empathy is a core part of our profession, but it did not take long to realise that we could never immerse ourselves fully in their journey. I recall tending to a woman with cardiac-sounding chest pain, a common presentation here in Ireland. She'd recently fled from Eastern Ukraine, with two of her grandchildren, who were aged around three to five. We treated her condition as we normally would have here in Ireland and as we prepared her for transport to hospital, we asked her if there was anyone who could take care of the children while her health was compromised. Through our translator, we learned that her son, the father of the children, was still fighting in Eastern Ukraine. Their mother had been killed in the fighting, hence the grandmother's decision to take the children to safety in Poland.

It is impossible to genuinely understand the journey of refugees and it only becomes more impossible when that journey is undertaken by a child. We travelled back to Ireland safe in the knowledge that our family, friends and homes would still be there. Nobody who has fled Ukraine can say the same.

This experience reminded us just how fortunate we are to have peace and stability in Ireland. I'll never forget sitting down at 3am on a night shift in Poland, overhearing muffled conversations in Ukrainian as people lay in army camp beds, and listening to the distinctive sound of their children playing with one other, while in the background a constant drone of train station announcements reminded you where these people were, what they were attempting to do and just how uncertain they all must have been about their immediate future. To be there, at such an early stage of the journey of so many people, changes the experience from simply being something you see on the news to something that's so incredibly real and tangible.

Ciarán Freeman:" It is impossible to genuinely understand the journey of refugees."

As I enter my final year of training as a general nurse, this short experience has fundamentally changed my appreciation for the role of a healthcare professional in a humanitarian response and how adaptable our skills are for those who need it. Despite the jarring – and at times surreal – differences between my life and the life of those refugees, it was great to be able to take our skills learned in Ireland to help in a small but real way.

Ciarán Freeman is an emergency medical technician with the Order of Malta Ireland Ambulance Corps and a general nursing student at NUI Galway

Tackling human trafficking

Steve Pitman discusses the importance of recognising the signs of human trafficking and the steps to take if you have concerns

THE 2022 World Day Against Trafficking in Persons theme is 'Use and Abuse of Technology'. It focuses on the role of technology as a tool to both enable and impede human trafficking. The internet, social media and other digital platforms allow criminals to recruit, organise transportation and accommodation, and exploit and control victims across international borders. Technologies also provide an opportunity to monitor and track traffickers, leading to arrest and prosecution.

This article follows Deborah Miranda's article on 'Recognising the signs of human trafficking'[1] published in *WIN* October 2021, highlighting the devastating impact of human trafficking and modern-day slavery.

Human trafficking is a serious crime and it is happening in Ireland. Between 2015 and 2020, 356 potential victims of trafficking were identified by the Irish authorities.[2] Globally, it is estimated that there are 5.4 victims of modern slavery for every 1,000 people.[3] The UN reports that in 2018 approximately 50,000 human trafficking victims were reported in 148 countries.[4] Some 50% of victims were trafficked for sexual exploitation, while 38% were trafficked for forced labour.[4]

Women and girls are the primary targets for trafficking, with one in three victims identified as a child. Human trafficking is a form of slavery. It is a grave violation of human rights and punishable in Ireland with a maximum sentence of life imprisonment and/or an unlimited fine. The primary legislation in Ireland that covers human trafficking is the Criminal Law (Human Trafficking) Act 2008 and the Criminal Law (Human Trafficking) (Amendment) Act 2013. It is important to recognise that human trafficking does not require a person to have crossed an international border for trafficking to occur – it can and does occur within national borders.

Human trafficking is defined by the UN Office of Drugs and Crime as "the recruitment, transportation, transfer, harbouring or receipt of people through force, fraud or deception, with the aim of exploiting them for profit". The Global Estimates of Modern Slavery (GEMS)[3] focuses on forced labour and forced marriage. Forced labour comprises "forced labour in the private economy, forced sexual exploitation of adults and commercial sexual exploitation of children, and state-imposed forced labour". Victims are often locked up while others are hidden in plain sight, working in agriculture, fishing and service industries.[1] At the same time, GEMS estimates that 15.5 million individuals are living in forced marriages.

Survivors of human trafficking often report coming into contact with healthcare professionals while a victim of trafficking,[5] with 80% seeking medical care within the first year of being trafficked.[6]

However, healthcare professionals are not always able to identify signs of human trafficking. Such contacts are missed opportunities to assist and rescue victims of trafficking. Scannell et al reported on a case of a victim of human trafficking where, despite multiple interactions with healthcare professionals the signs of human trafficking were not picked up.[7] They argue that nurses play a key role in identifying signs of human trafficking and highlight the need for further education to improve detection and facilitate treatment and rescue. This is supported by the recent ESRI study[2] that highlighted more training and screening mechanisms were required, as well as a campaign to raise awareness across sectors.

Emergency department and other frontline nurses are in an ideal position to identify victims of human trafficking. Egyud et al introduced an ED education and treatment algorithm to help identify victims of human trafficking and rescue victims through red flags and a silent notification system.[8] Introducing healthcare organisational processes to raise awareness and manage potential human trafficking is vital to ensure victims can be identified and recruited while ensuring their safety.

The ICN provides a guide for nurses on what they need to know about human trafficking. This document 'Human Trafficking. The basics of what nurses need to know' provides information on the types and indicators of human trafficking and a guide on what to do.

The Blue Heart is the symbol of the fight against human trafficking. It 'represents the sadness of those who are trafficked while reminding us of the cold-heartedness of those who buy and sell fellow human beings'. The aim of the Blue Heart campaign is to raise global awareness in the fight against human trafficking and its impact on society. Further information can be found at: **www.unodc.org/blueheart/index.html**

If you suspect someone is a victim of human trafficking, you can contact An Garda Síochána, who are available to help. You can report your concerns by:

- Calling the Garda confidential telephone line 1800 666 111
- Email: blueblindfold@garda.ie
- In an emergency, please call 999/112.

See **www.anyonetrafficked.com** or **www.blueblindfold.ie** for further information.

Human trafficking

- ACT: a person is recruited, transported, transferred, harboured or received
- MEANS: a person is threatened, forced or coerced in some way, through abduction, fraud, deception, the abuse of power or of a position of vulnerability or through the giving or receiving of payments
- EXPLOITATION: a person is exploited (ie. sexual exploitation, labour exploitation, organ removal or exploited into criminal activities or forced begging)

Steve Pitman is INMO head of education and professional development

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Nursing in an unstable world

Nurses are well positioned to advocate for refugees who are among the most vulnerable healthcare service users in Ireland, writes **PJ Boyle**

'WHAT happens globally, impacts locally' is a phrase often used in the context of international development and political studies. Indeed, it has continued to ring true for 2022. For example, it is not surprising that some of the most vulnerable people requiring nursing care in Ireland this year are international protection applicants (IPAs), ie. refugees, asylum seekers, and displaced people seeking safety from war and conflict.

While the world remains gripped in a state of concern for the people of Ukraine, this unjustifiable war has struck a chord and forced us to reflect. Indeed, it is not lost on us as nurses, that the Crimea region, a place of significant association with nursing history and Florence Nightingale, remains the focus of one of Europe's largest humanitarian crises today.

Need to reflect

Often within the comfort of our homes and in the company of loved ones, we witness media reporting of war and conflict. In the current climate we are reminded daily of the political and economic connectedness between nations and regions. This understanding can at times generate an 'unease' within us. For example, the increasing financial cost of fuel and food, travel safety and security. We acknowledge the fragility of human life. We re-familiarise ourselves with the 'fine lines' and structures that co-exist to help maintain our security, safety and happiness. However, it is an unpleasant fact of life that wars and conflicts continue to occur, often lasting decades.

The intergenerational trauma for people innocently caught up in such horror remains lifelong. But what of the people forced to leave or forced to remain in such circumstances? What about our nursing and healthcare colleagues in places of conflict?

Nurses and midwives are no strangers to providing professional care and human compassion to people experiencing difficult periods in their lives. Informed by our knowledge, skill and experience, nurses and midwives continue to play a fundamental leadership role in the strategic planning and provision of emergency development aid and healthcare in global conflict areas.

In Ireland, across the health services there are many nurses working on the frontline with international protection applicants and other migrant groups. In addition, there is an increasing awareness within the Irish voluntary charitable sector working with socially excluded groups for the development of nursing services and inclusion of nursing expertise. A welcome development in recent years is the research evidence and formal education related to inclusion health, migrant health and human rights in nursing and midwifery programmes at undergraduate and postgraduate level across the university sector.

In 2021 (pre-Ukrainian crisis) the United Nations High Commission for Refugees (UNHCR) Global Trend Report identified a population of 92 million people of specific concern to them. Eighty-three million people were forcibly displaced as a consequence of persecution, conflict, violence and human rights violations.

Some 86% of this population are hosted by developing countries, often in poor unstable neighbouring countries. It is now estimated that above 1% of the world's population (one in 97 people), are forcibly displaced within or beyond their own country.

Sadly, children are particularly affected in such crises. UNHCR estimates that one million children were born as refugees between 2018 and 2020. A percentage of these children may spend the remainder of their lives living as refugees. The physical, emotional and psychological impact of such traumatic exposure is borne out in the scars that people carry. Indeed the risks of illness and adverse health outcomes within this population are significant and influenced by many factors, from deprivation, infection, physical and emotional stress to legal and social barriers that exclude and prevent access to healthcare or safe settlement in a host country.

Refugees

Refugees are defined and protected in international law. The 1951 Refugee Convention is a key legal document and defines a refugee as "someone who is

unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion". (**www.unhcr.org**)

For more than 20 years, community public health nursing in HSE CHO9, Dublin has provided a nursing and midwifery refugee health assessment service at the National Refugee Reception Centre in Dublin. Informed by transcultural nursing, trauma-informed care and cultural competence development, newly arrived protection applicants attend voluntarily for health assessment and supports from nursing staff.

In 2021, the health centre provided care to more than 7,000 residents within the International Protection System. Over 1,300 health-screening assessments were completed, while attending to almost 3,000 other health-related problems for clients. Despite the Covid-19 pandemic there was an increase of 33% compared to 2020.

Unsurprisingly the countries of origin of clients attending in 2021 correspond clearly with those countries identified by UNHCR 2021 Global Trend Report. These included people from Afghanistan, Syria, South Sudan, Somalia and Eritrea, countries that continue to be ravaged by conflict and war.

The professional and ethical obligations of nurses to provide humanitarian, ethical and professional care to international protection applicants is clearly outlined in the International Council of Nurses Position Statement on the health of migrants, refugees and displaced persons (MRDPs) (ICN 2018 **www.icn.ch**).

The ICN position makes a number of recommendations for governments, national nursing organisations and individual nurses. In their roles as clinicians, educators, researchers, policy influencers and executives responding to and advocating for the needs of MRDPs is clearly mentioned. In particular, three specific recommendations are of key importance:

- Empower and support MRDPs to navigate the health system of their host country, including being able to identify and access available healthcare
- Provide ethical respectful, culturally sensitive and dignified care to MRDPs and their families that acknowledges the interconnectedness of their physical, psychosocial spiritual, cultural and social needs and challenges
- Advocate for and support dedicated local, national, and international organisations in their efforts to address MRDP rights and socio-economic, health and healthcare needs.

It is extremely worrying that, as we go to press, some 'developed' democratic nations within the European region have proposed policies to exonerate their legal and moral obligations to provide a safe haven to people in need of safety and protection. This xenophobic and racist approach has no place in any society and certainly no place in healthcare and nursing. Nurses and midwives globally are well positioned and informed to stand up and advocate for social justice for all.

Dr PJ Boyle has a doctorate in transcultural healthcare and is a clinical nurse specialist in refugee health with the HSE

'Leave assumptions aside and be open and curious'

***Freda Hughes** spoke to Frances McArdle about her work with asylum seekers*

FRANCES McArdle is assistant director of public health nursing with special responsibility for asylum seekers at Mosney Direct Provision Centre. She has worked there since 2002 having previously worked in Bangladesh and Ethiopia.

Mosney is a family centre, so much of her work involves caring for parents and their children. As a public health nurse she follows the national healthy childhood programme which structures the service around providing core developmental checks for children from birth to age four.

There are approximately 900 residents at the centre with just Ms McArdle and a GP based on site to meet their medical needs. There are up to 50 different nationalities living in the centre with most people fleeing from Syria, Afghanistan, Nigeria, Zimbabwe and South Africa. It is a generally young population with lots of children living there.

"We try to help any resident who needs us – that could be disabled people or people with children who didn't get the healthcare they needed in the country they fled. We listen and assess and sometimes refer them to other services. We try to answer their questions and provide interpreters where necessary."

Ms McArdle works from a family-care and trauma-centred model of care. In doing child health checks, she explained that it gives an opportunity to talk to the mother and ask how she is feeling in a non-threatening way. It might be the first time they have had a chance to talk and many break down.

"Residents can be so alone. You need time to empathise as much as possible. We haven't experienced anything like they have in a lot of cases, but we have to show that we care and want to support them. Sometimes just linking them with psychosocial supports and with ordinary things like schools, family resource centres and voluntary organisations can be of huge benefit," said Ms McArdle.

She explained that flexibility is important in her role. Language and literacy barriers can cause some confusion so it's important to be patient and proactive. She approaches cultural issues with openness and curiosity. She may avail of translated literature and also images to demonstrate where possible but also uses interpreters at times.

"People show great resilience and resourcefulness. Some can fall between the cracks so you need to target the vulnerable. Continuity of staff helps to build trust. It can be challenging and delicate work given the amount of trauma a lot of the residents have suffered. None of them are here for easy reasons. A lot of what we hear can be quite disturbing. Many asylum seekers have experienced trauma and a collection of negative experiences linked to war, conflict, poverty, marginalism, oppression and discrimination. It's important to be kind and compassionate. You might be the first non threatening person they have met for a long time," she said.

It can be difficult for people to leave the centre due to the housing crisis and the cost of living, which make it challenging for people to find a home once they are allowed leave direct provision.

"People make so many assumptions often based on fear and it just creates further division. Be able to listen and be genuinely curious. We live out of assumptions. We don't even know we're doing it, so respect and self awareness are fundamental. We become bigger people if we become curious and people often love you to show an interest."

Cornmarket | 50 years

INMO Income Protection Scheme Claims Process

Tara Cassidy, Salary Protection Account Manager, discusses Cornmarket's role as administrator of the INMO Income Protection Scheme, in guiding members and their families through the claims process and outlines the step-by-step guide should you ever have to claim from the Scheme.

Claims can take around 3 months to process from the date that the claim form is received, until the decision is made by the Insurer. It takes time for the Insurer to gather the medical evidence needed to medically assess a claim, and for Cornmarket to gather the employer information. This can include details of salary, sick leave, half and off pay dates, Temporary Rehabilitation Remuneration and Ill Health Early Retirement Pension. **Therefore, it is vital that you contact us as soon as you become aware that you will need to make a claim, see contact details below.**

1 Contact Cornmarket

Contact Cornmarket and our claims advisor will talk you through the claims process.

2 What you need to send to us

We will send you a handy checklist to make sure you provide us with all of the required information.

It is important that you send us all required documents as soon as possible, to allow sufficient time for the Insurer to assess your claim.

3 Cornmarket will then

1. Acknowledge your Claim Form and the other required documents, before forwarding them to the Insurer to be assessed.
2. Forward your completed Employer Authorisation Form (if applicable) to your employer, along with a request for the required information.
3. Help you as your claim progresses, by guiding you through every stage of the process.

4 The insurer will then

A) Assess all the information they have received from you.

The Insurer may request further information, as necessary. For example, they may require one or more of the following:

- Further medical information from your doctor/specialist
- An Independent Medical Examination to be conducted
- Other appropriate medical evidence to support your claim.

B) Make a decision on your claim.

If your **Short-Term Claim** is admitted, your benefit will be paid into your bank account at the next monthly pay run once all the necessary documents have been gathered and assessed. A Short-Term Claim will only be processed as a Short-Term claim if all the relevant documents requested are returned with the claim form.

If your **Standard Claim** is admitted, the benefit will be paid into your bank account monthly in arrears. In all cases, benefits are subject to income tax, which may include emergency tax.*

For Standard Claims, your benefit will be paid until the earliest of one of the following: You recover, the Insurer determines (based on medical evidence) that you are fit to return to work, you return to work, you resign, you reach the ceasing age of the Scheme or your death; whichever is the earliest.

If your claim is admitted, you will receive a decision letter from the Insurer setting out the benefit details. The insurer can from time to time medically review your claim to determine if you continue to meet the definition of disablement. They do this by requesting medical evidence from your doctors, requesting you to complete a form or requesting you to attend an Independent Medical Examination.

While the majority of claims are admitted, if your claim is declined, this may be because:

- You did not disclose relevant information when you applied for membership of the Scheme **or**
- The medical evidence does not support your claim that you are unfit to carry out your normal occupation.

If your claim is declined, you can make an appeal **within 3 months** of the Insurers decision.

Our Claims Team is easy to talk to and dedicated to assisting members and their representatives every step of the way.

To speak to a member of our team about making a claim or a claim query, call us on **(01) 408 4018** or email **spsclaims@cornmarket.ie**

*You must contact your Inspector of Taxes to make sure that you are receiving your tax entitlements and that you are paying the correct income tax.

Please note: The INMO do not have any role in the day to day management of the Scheme, processing claims or appeals. This is the function of Cornmarket and the Insurer who are responsible for managing the Scheme. It is also a requirement of the Scheme that INMO membership is current and maintained.

18301 INMO IPS Claims Editorial 06-22

Q and A Bulletin Board

With INMO director of industrial relations Albert Murphy

Parental leave – protect your rights

Q. I am currently availing of parental leave. I have a document that confirms with my employer that I am availing of parental leave on a roster of one day per week. My employer has now advised that I have a reduced entitlement to access shifts on which I would earn premium payment. My employer claims that I am now a part-time worker. Can you please clarify if this is the case?

No, this is not the situation, your employer is incorrect. Parental leave is granted on the understanding that all of your terms and conditions of employment are protected. With this in mind, you are not considered to be a part-time worker, rather you are simply availing of a temporary reduction in hours while on parental leave and you must not be regarded as being absent. This means that you retain all your employment rights, other than the right to remuneration and superannuation benefits. Should you have any further difficulties in this area, please be sure get in touch with your INMO industrial relations official who should be able to act on your behalf in this matter.

Annual leave during unpaid maternity leave

Q. I am currently on a period of unpaid maternity leave. Will I lose all my annual leave entitlements during this time?

While on unpaid maternity leave, you are regarded as being in employment and should retain all employment rights such as annual leave. During your 16 weeks of unpaid maternity leave, you can accrue annual leave and you should not lose any annual leave. You also accrue any public holidays that occur during this time. Annual leave that is accrued during unpaid maternity leave can be taken at a time that is agreed between the employee and the employer, and any public holidays that accrue will be added to the end of the period of unpaid maternity leave.

Note while on parental leave, the same rules apply – you accrue your annual leave and any public holidays that may fall during this time. While on either unpaid maternity leave or parental leave you are entitled to continue to receive your increments and your incremental date should not change. However, as this period of time is unpaid, you do not contribute to the HSE superannuation scheme and it is not reckonable for pension purposes.

Part-time work while on carer's leave

I am currently on carer's leave from my place of work. I am unable to work at present but hope to work a few hours per week in the future. Do I have to work at my usual place of work or could I work anywhere?

You are permitted to work outside the home for no more than 18.5 hours a week once your net income does not exceed €332.50 net per week. (This is your take-home pay after deductions such as tax, PRSI and union dues). The Carers Leave Act 2001 does not state where you can work but you would need to inform your employer of your intention to work, and you would also need to inform the Department of Social Protection.

Pregnancy-related sick leave

I have a query in relation to pregnancy-related sick leave. I am currently out on sick leave as a result of my pregnancy. I have been out for a number of weeks so far and have been hospitalised for two consecutive days. What is my entitlement to sick leave?

Because you were hospitalised for two days or more you would be covered under critical illness protocol (CIP). This allows sick leave to be paid at six months full pay and six months half pay. The employer will take into account any previous sick leave. When submitting medical certificates to the employer the consultant or GP must write on the certificate that the sick leave is pregnancy related.

Irish **Nurses** and **Midwives** Organisation
Working Together

NURSE/MIDWIFE REPRESENTATIVE TRAINING

Dates for 2022

The INMO are delighted to announce further training in 2022 for new and existing nurse and midwife representatives. The aim of this training is to provide members with the skills, knowledge, and confidence to represent members in the workplace.

Current arrangements exist for affiliates of the Irish Congress of Trade Unions to receive time off to attend such training for members.

BASIC TRAINING

(for those who have not previously received any training in their role)

- **SEPTEMBER - 20th and 21st (Limerick)**
- **SEPTEMBER - 28th and 29th (Dublin)**
- **OCTOBER - 13th and 14th (Sligo)**
- **OCTOBER - 17th and 18th (Dublin)**
- **OCTOBER - 18th and 19th (Waterford)**
- **NOVEMBER - 3rd and 4th (Galway)**

For further details please contact Kylie on **kylie.mcnicholas@inmo.ie**

Section focus

INMO Professional

Jean Carroll, Section Development Officer

Emergency Department Section has a great turnout for its second annual webinar

MORE than 40 members of the Emergency Department Nurses Section joined a webinar, which was hosted by INMO Professional last month.

INMO president Karen McGowan, who is an advanced nurse practitioner (ANP) in emergency nursing, welcomed everybody and members heard from a variety of speakers, each bringing a unique topic to the event.

Kara McLoughlin, a clinical specialist occupational therapist in care of the older person/FITT (Frail Intervention Therapy Team) in Beaumont Hospital, covered the interesting topic of frailty and geriatric medicine.

Margo Noonan, an ANP in sexual assault forensic examination and the nurse lead in the Sexual Assault Treatment Unit based in the South Infirmary Victoria University Hospital, Cork, also addressed the meeting.

Ms Noonan spoke about how she has used her experiences of working directly with victims of sexual assault to develop and deliver an educational intervention to students (post primary and university/college) about consent and sexual violence, and shared her knowledge and expertise with the group on the day.

Anne O'Keeffe, an ANP in the emergency department of Mercy University Hospital (MUH), Cork, discussed and reflected on the complexity of clinical decision making in emergency nursing today.

Members also heard from Eibhlin Collins, an ANP in inclusion health at MUH, who shared her particular interest in the influence of adverse childhood experiences on addiction and trauma and how it informed care in the healthcare setting.

Within the broad base of inclusion health, Ms Collins explained how she deals both directly and indirectly with patients attending MUH who are homeless or otherwise at risk of exclusion through addiction, being a prisoner, Traveller or Roma, living with a stigmatised illness, refugee/undocumented migrant or identifying as LGBTQ+.

She told the conference that on a day-to-day basis, however, homelessness and addiction are the more common reasons for seeing patients.

She said that inpatient discharge and follow-up issues in the care of people who are homeless were common and could change dramatically at each presentation. Her work involves assessing and individualising patients' support needs while in hospital and referring to, or liaising with, patients' existing services in the community.

Where appropriate, patients are followed up post-discharge to provide advice/signposting to patient and community key workers, and further links with services as required. Diverting to more appropriate services to prevent an emergency department episode can be part of this work, she explained.

The conference also heard from Shona Fitzgerald, who is a CNM2 in the care of the deteriorating patient in MUH. On behalf of the multidisciplinary team, Ms Fitzgerald presented on the introduction of safety huddles, which were brought into the emergency department in 2021. She discussed the challenges presented and results achieved since safety huddles were implemented into practice *(see article on page 45)*.

On behalf of the INMO and the Section, Ms McGowan thanked the organisers for their efforts in planning the event. The Section wishes to express its thanks to pharmaceutical companies Kyowa Kirin and Galen for supporting the event. A draw was carried out at the end of the day and some participants were lucky enough to win One4all vouchers – congratulations to them.

School Nurses Section hears from expert on concussion

THE School Nurses Section was delighted to receive a very informative education evening with Dr Judy Dwyer of Concussion Network Ireland.

Dr Dwyer is student health doctor and the clinical lead in the Student Health Department in University College Cork. She has a special interest in concussion and is a member of Concussion Network Ireland.

The online session was attended by over 40 members and lasted over an hour with interactive questions at the end of the presentation. As managing concussion and head injuries is a huge part of the school nurse's role, this session was important for members. It is paramount that we remain up to date with the ever changing approaches to dealing with concussion in the school environment. The large attendance reflected the importance of this area in our nursing role.

The School Nurses Section will next meet on Saturday, October 8 in the Midlands Hotel, Portlaoise Town Centre. We hope to cover both indemnity and sports injuries. Details will be sent to Section members closer to the event.

IN-PERSON COURSES
September/October 2022

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

NEW!

Phlebotomy

Tuesday, 27 September 2022

Time: 10.00am - 4.00pm

Venue: The Richmond Education and Event Centre, Dublin

This programme provides participants with the skill and theory to perform phlebotomy in a competent and safe manner. It will cover topics such as sites used for phlebotomy, criteria for evaluating a vein, principles of an aseptic technique as well as complications that may arise during and after the procedure.

Fee: €90 INMO members; €145 Non members

NEW!

Healthcare Provider
CPR & AED

Friday, 7 October 2022

Times: 9.00am - 10.30am or 11.00am - 12.30pm
or 1.00pm - 2.30pm

Venue: The Richmond Education and Event Centre, Dublin

The course duration is 1 and 1/2 hours

This course will equip the participants with the necessary theory and skills for the provision of CPR (Cardiopulmonary Resuscitation) and AED (Automated External Defibrillation) use in emergency situations, in line with the latest guidelines recommended by the American Heart Association. The care of the Adult / Child / and Infant will be included.

Fee: €135 INMO members; €175 non members

NEW!

Peripheral Intravenous
Cannulation

Thursday, 13 October 2022

Time: 10.00am - 4.00pm

Venue: The Richmond Education and Event Centre, Dublin

This programme provides guidance to participants in the skill of peripheral intravenous cannulation. Instruction will be provided on the sites used for peripheral intravenous cannulation, identifying criteria for evaluating a vein and the principles of an aseptic technique. The aim is for participants to be able to carry out the procedure in a competent and safe manner.

Fee: €90 INMO members; €145 non members

BOOKING YOUR PLACE IS ESSENTIAL

Tel: **01 6640641/18** or go **to www.inmoprofessional.ie**

INMO Professional

Continuing professional development for nurses and midwives

INMO EDUCATION PROGRAMMES

In the pull-out this month…

Management Skills

Aug 31

This online course outlines the key competencies required for ward managers to be effective in their roles as leaders and managers in healthcare delivery. Clinical managers perform both managerial and leadership functions in order to provide effective healthcare delivery to patients.

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

Become More Assertive

Sep 7

This short online programme is designed to help nurses and midwives develop their skills to be more assertive to help them make decisions with conviction; to deal with difficult situations and people and to influence others positively.

Time: 10am-1pm. Fee: €30 INMO members; €65 non-members

Diabetes CBT and General Wellbeing

Sep 15

This online course is for nurses and midwives who have an interest in the management of a patient with diabetes. The literature would suggest that diabetes, chronic disease management and the self-care that is associated with it brings high incidence rates of depression, anxiety, and negative thoughts. The use of different strategies, Cognitive Behavioural Therapy (CBT) and clinical trials look at the area of wellbeing and theories and models to help clients and healthcare providers try and formulate plans to look at these issues.

Time: 10am-1pm. Fee: €30 INMO members; €65 non-members

Steve Pitman
Head of Education and Professional Development

Plan your development with INMO Professional

DURING June we saw a new wave of Covid-19 cases in Ireland, with more than 24,500 cases (confirmed PCR and registered antigen tests) reported between the June 16 and 22. Confirmed cases in hospital were reported as 629 as at June 22. The cause of the current surge relates to the BA.4 and BA.5 subvariants of Omicron. This virus is spread easily and is on course to become the primary type of Covid in Europe.

This is a clear indication that Covid-19 is still with us, if we needed to be reminded, and that it is having a significant impact on the Irish health service. It is essential that we don't drop our guard and that we remain vigilant and cautious about Covid-19. The government and the HSE need to proactively plan for any potential autumn waves.

12th ICN NP/APN Network Conference

The largest gathering of advanced nurse practitioners and nurse practitioners will take place between August 21-24 2022 in University College Dublin. The event will mark the 12th ICN NP/APN Network Conference and the first in-person conference since 2018. Speakers and participants will take part in lively debates and share their experiences of developing and delivering advanced nursing practice. This is a fantastic opportunity for ANPs to network and learn from other colleagues across the globe. It is anticipated that 450-500 nurses and midwives will attend the three-day event.

Keynote speakers will include Michelle Acorn, chief nurse, nursing and programmes, International Council of Nurses (ICN); Melanie Rodgers, professor of advanced practice and spirituality, UK; Frances Wong, chair professor of advanced nursing practice, School of Nursing, Hong Kong Polytechnic University, Mabel Magowe, University of Botswana and many more. Funding support for attending the conference may be available from your employer or local NMPDU. Further information is available on the conference website **www.npapndublin2022.com**

Training Delivery and Evaluation

The INMO five-day Training Delivery and Evaluation programme takes place in September and October 2022. This hugely popular course leads to QQI level 6 certification and 30 NMBI CEUs. Places on the course are limited to maximise the learning experience of participants. This course is ideal for nurses and midwives working with students in a clinical learning environment and centres for nurse and midwife education.

Webinars and conferences

On Saturday, July 2, the INMO International Nurses Section held a culturefest in the Richmond Education and Event Centre. This celebration of international nurses and midwives included speakers, entertainment and refreshments.

THE RICHMOND
EDUCATION AND EVENT CENTRE

In the autumn, there are a number of webinars and conferences already planned. In September, the INMO Care of the Older Person Section webinar (September 20) and the in-person Telephone Triage Nurse Section Conference take place. In October, we will see the return of in-person Occupational Health Nurse Section and Operating Department Section conferences.

The All-Ireland Annual Midwifery Conference, which is organised by the INMO and the RCM Northern Ireland, will take place in Cavan on November 11. If you are interested in attending or submitting a poster presentation, contact jean.carroll@inmo.ie Further information about these and other events is available at www.inmo.professional.com

Safe nurse staffing and skill mix

In June, the Department of Health and the Chief Nursing Officer published the *Framework for Safe Nurse Staffing and Skill Mix in Adult Emergency Care Settings*. This report includes the recommendations of the Taskforce as part of phase 2 of staffing and skill mix for nursing. The research that underpinned the framework's testing was led by Jonathan Drennan and a team of researchers from University College Cork. The full report is available at **www.gov.ie/en/collection/bebf28-taskforce-publications**

On-site Education

INMO Professional offers an extensive range of on-site programmes facilitated by expert practitioners. If you are interested in booking, you can email: education@inmo.ie or Tel: 016640641/18

Delivering courses and writing for *WIN*

INMO Professional is eager to offer members the opportunity to work with us in delivering education courses. If you are an advanced nurse or midwife practitioner, a clinical nurse/midwife specialist or a nurse/midwife with expertise in clinical or management practice, we would like to hear from you by email: education@inmo.ie or Tel: 01 6640641/18.

INMO Professional is also interested in hearing from members who would like to write professional and clinical articles for *WIN*. Email steve.pitman@inmo.ie

INMO Professional

Education Programmes

Tel: 01 6640641/18
Email: education@inmo.ie

All of the following programmes are category 1 approved by the NMBI and allocated continuous education units
Fee: €30 members; €65 non-members
Time: 10am-1pm

Book three education programmes and get the fourth free
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Keep your CPD up to date • Extensive range of programmes • NMBI category 1 approved • Digital certification provided

Jul 26 **Infection Control Risk Register: Regulation 27; Development and Review**

This three-hour session will outline and provide support in the development of an infection control risk register for your facility. This is a requirement in meeting regulation 27 infection control in residential facilities in Ireland. The session will identify risk description, existing controls, additional controls required and complete a calculated risk rating score based a national framework. The sessions will assist the staff in achieving and maintaining governance compliance in this area for their facility and staff and resident/service user safety.

Aug 26 **Tools for Safe Practice** *(free for INMO members)*

This programme provides safe practice tools to protect the nurse and midwife and patient. This is an awareness session to ensure all staff have an understanding of the process involved regarding patient alerts, clinical incidents and thorough assessment, while remaining focused on patients and individual staff. The programme addresses patient and staff safety and provides five key tools on areas of documentation, clinical incident reporting, safety statements, best practice guidelines regarding assessment and communication practices.

Aug 30 **Infection Control Risk Register: Regulation 27; Development and Review**

This three-hour session will outline and provide support in the development of an infection control risk register for your facility. This is a requirement in meeting regulation 27 infection control in residential facilities in Ireland. The session will identify risk description, existing controls, additional controls required and complete a calculated risk rating score based a national framework. The sessions will assist the staff in achieving and maintaining governance compliance in this area for their facility and staff and resident/service user safety.

Aug 31 **Management Skills**

This programme outlines the key competencies required for ward managers to be effective in their roles as leaders and managers in healthcare delivery. Clinical managers perform managerial and leadership functions in to provide effective healthcare to patients. The course will explore management and leadership functions and how these are applied in practice to promote quality and safety of care.

Sep 1 **Type 1 Diabetes Management for Nurses and Midwives**

This short online programme will provide nurses and midwives with knowledge and skills regarding type 1 diabetes. The literature would suggest that diabetes, chronic disease management and the self-care that is associated with it brings high incidence rates of depression, anxiety and negative thoughts. The use of different strategies, self-management, treatment options, insulin pump therapy and CGM will be looked at to improve patient self-management. The exploration of these strategies and management of type 1 diabetes is a necessary component to help nurses/midwives try and formulate plans to look at issues that clients face.

Sep 5 **Competency-based Interview Skills**

This course will assist participants for a competency-based interview that enables candidates to show how they would demonstrate certain behaviours and skills in the workplace by answering questions about how they have reacted to, dealt with and handled previous workplace situations. It will explore preparation, presentation and performance during the interview and briefly focus on CV preparation.

Sep 7 **'Therapeutic Use of Mindfulness' for Nurses and Midwives**

This online course is for nurses and midwives who work in the area of chronic illness, mental health, maternity care, parent education, palliative care, old age care and who want to support their patients by teaching them mindful breathing and meditation techniques.

Sep 7 **Become More Assertive**

This short online programme is designed to help nurses and midwives develop their skills to be more assertive to help them make decisions with conviction; to deal with difficult situations and people and to influence others positively.

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

Sep 8 **An Introduction to the Management of Chronic Disease in Primary Health Care**

This course provides nurses/midwives who work in primary healthcare with the knowledge and skills to develop and apply the principles of self-management of chronic illnesses. You will discover the most common chronic diseases and learn how to assess clients with ongoing illness and to develop, implement and evaluate planned care and self-management strategies. This is an ideal professional development programme to gain essential skills to better support these patients and provide you with the knowledge and skills in doing so.

Sep 9 **Adult Asthma Getting the Basics Right**

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

Sep 12 **Competency-based Interview Skills**

This course will assist participants for a competency-based interview that enables candidates to show how they would demonstrate certain behaviours and skills in the workplace by answering questions about how they have reacted to, dealt with and handled previous workplace situations. It will explore preparation, presentation and performance during the interview and briefly focus on CV preparation.

Sep 13 **Best practice for Clinical Audit for Nurses and Midwives**

This programme equips nurses and midwives with the necessary skills to plan and implement a clinical audit in their practice and enable them to deliver evidence of improved performance for safer and better care for patients and improved quality service. Participants will be provided with an overview of clinical audit and be informed about each stage in the clinical audit cycle: topic selection, standards development, data collection, data analysis, reporting, implementing changes and re-audit. There will be an emphasis on continuous quality and safety improvement in healthcare.

Sep 13 **Tools for Safe Practice** *(free for INMO members)*

This programme provides safe practice tools to protect the nurse and midwife and patient within current healthcare settings. This is an awareness session to ensure all staff have an understanding of the process involved regarding patient alerts, clinical incidents and thorough assessment, while remaining focused on patients and individual staff. The programme addresses patient safety and staff safety and provides five key tools on areas of documentation, clinical incident reporting, safety statements, best practice guidelines regarding assessment and communication practices in a complex multifaceted healthcare arena.

Sep 14 **Falls Reduction, Assessment and Review**

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

Sep 14 **Wound Management for nurses and midwives**

This short online course will advise participants on wound care management. Topics covered on the day include; wound healing, wound bed preparation and treatment options, and dressing selections.

Sep 15 **Improve your Academic Writing and Research Skills Online**

This course is designed for nurses and midwives who are undertaking third-level academic programmes. This course will assist participants in completing their written assignments. The objective of the course is to help prepare the student for academic study which requires efficient literature searching, research critique and accurate referencing skills.

Sep 15 **Diabetes CBT and general wellbeing**

This online course is for nurses and midwives who have an interest in the management of a patient with diabetes. The literature would suggest that diabetes, chronic disease management and the self-care that is associated with it brings high incidence rates of depression, anxiety, and negative thoughts. The use of different strategies, cognitive behavioural therapy and clinical trials look at the area of wellbeing and theories and models to help clients and healthcare providers try and formulate plans to look at these issues.

Sep 20 **Person-centred Care Planning**

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

When booking online courses please note:
Places must be booked in advance. You will need a reliable computer and internet access. Please ensure a correct email is provided when registering. Certificates for participation will be issued in digital form and sent by email. Do not hesitate to contact us at Tel: 01 6640641/18 or email: education@inmo.ie

Sep 22 **Improve your Academic Writing and Research Skills Online**

This course is designed for nurses and midwives who are undertaking third-level academic programmes. This course will assist participants in completing their written assignments. The objective of the course is to help prepare the student for academic study which requires efficient literature searching, research critique and accurate referencing skills.

Sep 22 **Retirement Planning**

This webinar is to help support you in planning your retirement and will briefly cover the following: superannuation and your entitlements, options for drawing down your AVC at retirement, considering lump sums and AVCs before retirement, protecting your lump sum against inflation, key steps to long-term investing, top tax tips for retirement and a Covid-19 Q&A session.

Sep 23 **Chronic Obstructive Pulmonary Disease (COPD) – Getting the Basics Right**

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

Sep 26 **The Importance of Documentation for Nurses and Midwives – Getting it Right**

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

Sep 27 **Phlebotomy** *(Richmond Education and Event Centre)*

This programme provides participants with the skill and theory to perform phlebotomy in a competent and safe manner. It will cover topics such as sites used for phlebotomy, criteria for evaluating a vein, principles of an aseptic technique as well as complications that may arise during and after the procedure. Guidance will be given on how to reassure the individual in relation to the procedure and on gaining their consent. Fee: €90 INMO member; €145 non member.

Sep 27 **Understanding and Developing Care Plans for Nurses and Midwives**

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

Sep 28 **Medication Management Best Practice: Guidance for Nurses and Midwives**

This education programme supports nurses and midwives in providing safe, evidence-based practice in the area of medication management thus preventing medication errors and near misses. The programme will cover key topics such as: the key principles of medication management, the medication management cycle, management of controlled drugs and medication safety. Participants will have the opportunity to update their knowledge in line with the most up-to-date Nursing and Midwifery Board of Ireland Guidance for Registered Nurses and Midwives Administration (2020) and Health Information and Quality Authority requirements for medication management.

Sep 28 **Leg Ulcer Assessment and Management**

This short online course will advise participants on leg ulcer management. Topics covered on the day include; pathophysiology, assessment and management of leg ulcers. Learning outcomes: have an understanding of the theory and concepts of the different causes of leg ulcerations, gain a deeper understanding of the pathophysiology of leg ulceration, be aware of different non-invasive assessment for leg ulcerations and understand the importance of compression for venous leg ulcerations.

Sep 29 **Introduction to Positive Behaviour Support**

This programme explores the key components of compassion and their application in the care setting. It is an internationally recognised evidence-based approach to supporting individuals with behaviours that challenge. It introduces participants to the model of Positive Behaviour Support and outlines the benefits of its use. It is designed for management and frontline staff to supporting and improving the quality of care of individuals with behaviours that may challenge the services which support them.

Oct 4 **End of Life Care in Residential Care Settings for Older Persons**

This course outlines information specific to the care and support of residents and their families in end of life care. The course aims to recognise signs and symptoms of deterioration, and will assess, monitor and review, physical, psychological, social and spiritual areas of care at end of life for the person. Participants will be able to identify and apply effective interpersonal communication with families of a loved one at end of life during this difficult period. Furthermore the outline of debriefing of staff and bereavement care for residents and relatives is addressed.

Oct 6 **Restrictive Practices in Residential Care Settings for Older People**

The aim of this programme is to identify managerial and leadership competencies for frontline managers and to explore how these are applied in practice. The course will include management theory, effective leadership and teamwork, as well as delegation and clinical supervision.

Oct 6 **Infection Control Risk Register: Regulation 27; Development and Review**

This three-hour session will outline and provide support in the development of an infection control risk register for your facility. This is a requirement in meeting regulation 27 infection control in residential facilities in Ireland. The session will identify risk description, existing controls, additional controls required and complete a calculated risk rating score based a national framework. The sessions will assist the staff in achieving and maintaining governance compliance in this area for their facility and staff and resident/service user safety.

Oct 7 **Healthcare Provider CPR and AED** *(Times: 9am-10.30am, 11am-12.30pm or 1pm-2.30pm)*

This course will equip the participants with the necessary theory and skills for the provision of CPR (Cardiopulmonary Resuscitation) and AED (Automated External Defibrillation) use in emergency situations, in line with the latest guidelines recommended by the American Heart Association. The care of the adult, child and infant will be included. The certificate awarded on completion of the course has a life span of two years. After this time it will then be necessary for nurses and midwives to update their certification.

Oct 7 **Paediatric Asthma – Understanding the Basics**

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

Oct 11 **PEG Feeding – Caring for Adults and Paediatrics who have a PEG Tube in the Hospital/Community Setting**

This course is aimed at nurses caring for adults and paediatrics who have a percutaneous endoscopic gastrostomy (PEG) tube. It will address the clinical indications and requirements for PEG feeding in the home and hospital setting.

INMO
Irish **Nurses** and **Midwives** Organisation
Working Together

TOOLS FOR SAFE PRACTICE

FREE Practical Advice Workshops on the following critical issues;

- **Clinical Risk**
- **Report and Statement Writing**
- **Documentation**
- **Incident Reporting**
- **Fitness to Practise Complaints**

The INMO is providing a nationwide series of 3 hour workshops in your workplace to provide information and guidance to members in a challenging climate.

This workshop is Approved by Nursing and Midwifery Board of Ireland (NMBI) with **3 Continuing Education Units (CEUs)**

3 CEUS

FREE Online Sessions

JULY
Tuesday, 19 July

SEPTEMBER
Tuesday, 13 September
Friday, 16 September

OCTOBER
Friday, 14 October

Time: 10am - 1pm

€65 for non INMO members

NOTE: PLEASE **QUOTE YOUR MEMBERSHIP NUMBER** when booking your place

TO BOOK YOUR PLACE
Email: **deborah.winters@inmo.ie** or Call: **01 6640618**
For further information please contact your Industrial Relations Officer.

SCAN ME

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

5 Day PROGRAMME

Training, Delivery and Evaluation

September / October 2022

NEW BLENDED LEARNING FORMAT

Day 1	Tuesday **20 September**	In-Person
Day 2	Wednesday, **21 September**	In-Person
Day 3	Thursday, **22 September**	In-Person
Day 4	Tuesday, **4 October**	Online
Day 5	Wednesday, **5 October**	Online

This five-day course "Training Delivery and Evaluation" 6N3326 award will equip the nurse/midwife with the knowledge, skills and confidence to plan, deliver and assess learning and evaluate training provision. This course would suit every nurse/midwife working with student nurses in a clinical learning environment and also in centres of nurse education.

A wide range of training methods, including role-play, small group work, case studies, action learning, online training and forums will be used to enhance the learning process. The course aims to foster and share the rich and diverse knowledge and skills of participants whilst providing them with the expertise and confidence to impart their knowledge effectively.

The course is delivered over five days from 9.30am to 5.00pm each day.

This training will lead to QQI level 6 component certificate in Training, Delivery and Evaluation (formally Train the Trainer FETAC 6) and it carries 15 ECTs (European Credit Transfer and Accumulation System). Throughout the programme, trainer support is also available for each nurse/midwife attending the course.

This programme is also category 1 approved by the Nursing and Midwifery Board of Ireland (NMBI) and awarded 30 continuing education units (CEUs).

30 NMBI CEUs Module 6N3326 - QQI Level 6
Category 1 Approved by NMBI

Time: 9.30am - 5.00pm

Venue: online and in-person in The Richmond Education and Event Centre, Dublin a blended learning format.

Fee:

€550
INMO members

€875
Non members

BOOK EARLY

HOW TO BOOK

A non-refundable deposit of €200* must be made to reserve a place. *Payment in full must be made prior to **Wednesday, 31 August 2022.**

FOR MORE INFORMATION

Email: **education@inmo.ie** or call **01 6640641/18**

From the journals

This month the library highlights some Irish and International research from the literature

Children's nursing

- Rosengarten L, Callum J. Continuing professional development: evaluating a masterclass for band 5 children's nurses. Nursing Children & Young People. 2021: 18-24
- Moore C, Clover J, Gibson L. Evaluating parental knowledge of pediatric burns first aid in Ireland and the effectiveness of an educational intervention improving knowledge. Burns. 2022; 48(3):672–82
- White P, Ceannt R, Kennedy E, O'Sullivan MB, Ward M, Collins A. Children are safe in schools: a review of the Irish experience of reopening schools during the COVID-19 pandemic. Public Health. 2021; 195:158–60
- Laserna Jiménez C, López Poyato M, Casado Montañés I, Guix CEM, Fabrellas N. Paediatric nursing clinical competences in primary healthcare: A systematic review. Journal of Advanced Nursing. 2021;77(6):2662–79

Nursing education

- Flanagan C, Lonergan M, Durning J, Frawley T. Role and Function of the Clinical Tutor in Mental Health Nursing in Ireland. Issues in Mental Health Nursing. 2022; 43(6):560–7
- Bartley N, Huntley-Moore S. Supporting the transition from nursing student to newly qualified children's nurse. Nursing Children & Young People. 2022; 34(3):18–25
- Balasa R, Chartrand J, Moreau K, Tousignant K, Eady K. Patients' and parents' perspectives of and experiences with assessing nursing students' paediatric clinical practice. Journal of Clinical Nursing. 2021;30(1/2):217–28
- Bagnasco A, Dasso N, Rossi S, Timmins F, Aleo G, Catania G, et al. A qualitative descriptive inquiry of the influences on nurses' missed care decision-making processes in acute hospital paediatric care. Journal of Nursing Management. 2020; 28(8):1929–39

Long Covid

- Maxwell E. House J. Stuke J. Long Covid 1: assessing the long-term health effects of Covid-19. Nursing Times, 2022: 118: 18-21
- Robinson P. Long Covid and breathlessness: an overview. British Journal of Community Nursing. 2021 Sep; 26(9):438–43
- Palmer SJ. Long Covid and mental health. British Journal of Community Nursing. 2021 Aug; 26(8):406–9

Midwifery

- Dado M, Smith V, Barry P. Women's experiences of water immersion during labour and childbirth in a hospital setting in Ireland: A qualitative study. Midwifery. 2022 May; 108: 103278
- Harty T, Trench M, Keegan O, O'Donoghue K, Nuzum D. The experiences of men following recurrent miscarriage in an Irish tertiary hospital: A qualitative analysis. Health Expectations. 2022;25(3):1048–57
- Cazzini H, Cowman T, Fleming J et al. An exploration of midwives' experiences of the transition to practice in the Republic of Ireland. British Journal of Midwifery. 2022; 30(3):136–43
- Brophy C, Doherty J, Coughlan B, Sheehy L, Folan M, O'Brien L, et al. Improving care for new mothers with postnatal morbidity in Ireland. British Journal of Midwifery. 2022; 30(3):144–51

Leadership

- Evans D. So close to love: compassionate leadership in healthcare. British Journal of Healthcare Management. 2022; 28(4):1–8
- Hanafin S, Cosgrove J, Hanafin P, Lynch C, Brady A-M. Co-worker relationships and their impact on nurses in Irish public healthcare settings. British Journal of Nursing. 2022; 31(7):394–9

Older people

- O'Malley M-P, Shortt O, Carroll C. Representations of the experiences of people with dementia in Irish newspapers. Dementia. 2022 May; 21(4):1343–62
- Lafferty A, Phillips D, Dowling HL, Fahy M, Moloney B, Duffy C, et al. Colliding worlds: Family carers' experiences of balancing work and care in Ireland during the Covid-19 pandemic. Health & Social Care in the Community. 2022 May; 30(3):1133–42

Cost analysis

- Sharma S, Gillespie P, Hobbins A, Dinneen SF. Estimating the cost of type 1 diabetes in Ireland. Diabetic Medicine. 2022 May; 39(5):1–14
- Ferris H, Brent L, Sorensen J. Cost of hospitalisation for hip fracture—findings from the Irish hip fracture database. Osteoporosis International. 2022 May; 33(5):1057–65
- Friel KM, Gillespie P, Coates V, McCauley C, McCann M, O'Kane M, et al. Estimating and examining the costs of inpatient diabetes care in an Irish Public Hospital. Diabetic Medicine. 2022 Apr; 39(4):1–11

Library services

The library offers a literature searching service, which is available to members for a small fee and can be useful if you are having difficulty finding relevant articles or if you do not have enough time to complete your search yourself. The library has other services to support your learning, including document supply, reference desk assistance and searching consultations.

To find out more about the services provided, please contact the library staff by phone or e-mail with your query. Contact: Tel: 01664014 or Email: library@inmo.ie

Online – Introduction to Effective Library Search Skills

Next course date: Thursday, September 22, 2022

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

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

INMO Professional

RCM i-learn

THE ROYAL COLLEGE OF MIDWIVES

Diabetes in pregnancy

Midwives are well positioned to provide education, support and continuity of care to pregnant women who have diabetes

MIDWIVES regularly come in contact with pregnant women with diabetes and play a significant role in influencing care, which can improve the outcomes of current as well as future pregnancies.

The increase in the prevalence of diabetes means that midwives and maternity staff are seeing more women with diabetes at the onset of pregnancy and an increase in gestational diabetes. Women with diabetes are at significantly higher risk of adverse outcomes through pregnancy, birth and postnatally. The foetus or neonate is also potentially compromised as a consequence of the maternal condition.

This updated i-learn module seeks to address this and will provide midwives, support workers and students with a thorough understanding of all aspects of diabetes in pregnancy from preconception counselling to postpartum care. This module will take approximately 1 hour to complete.

Growing concern

Diabetes is a growing concern. With the rising incidence of obesity in the younger people, the incidence of diabetes has also increased. This has resulted in more women of childbearing age attending antenatal clinics with a diagnosis of either pre-existing or gestational diabetes. Management of these women is vital to avoid complications in both the mother and the baby during pregnancy and childbirth. Poor control of diabetes during pregnancy increases the chances for birth defects and other problems for the pregnancy.

Diabetes can also cause serious complications for the woman. Proper health care before and during pregnancy can help prevent birth defects and other health problems. The midwife is often the first point of contact for these women, especially those with gestational diabetes.

Role of the midwife

The National Pregnancy in Diabetes Annual Report states that only one out of eight women were adequately prepared for pregnancy. The role of the midwife is to provide women with adequate information and knowledge to ensure that they are better prepared. The midwife's role is firmly placed to provide care through a continuum which enhances and improves the future health of women and their families.

The midwife is well positioned to provide continuity of care and help establish networks for the woman, thus enabling her to take the responsibility for her own health and care while offering support and guidance for her and her family's future health. Midwives can help ensure that women have an adequate understanding of their diabetes and the importance of glucose monitoring and can adjust their treatment with the help and support from the diabetes team.

Learning outcome

Having completed this module, you should have an understanding of:

- Different types of diabetes and the implications for pregnancy
- How best to prepare for pregnancy when the woman has diabetes
- The management of diabetes during pregnancy and its implications
- Planning and management of safe birth
- Useful advice to maintain the wellbeing of the woman and baby following birth
- Signpost women with epilepsy and other healthcare professionals to local and national epilepsy pathways and support.

RCM i-learn access for INMO midwife members

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

Spotlight on leadership

Servant leadership

THE 10th in a series of articles exploring the topic of leadership – this month, the focus is on servant leadership. What follows is an overview of this leadership approach, its characteristics, benefits and how it is used within healthcare.

Servant leadership is described as "a non-traditional leadership philosophy, embedded in a set of behaviours and practices that place a primary emphasis on the wellbeing of those being served".[1] Popularised by Robert Greenleaf in an essay entitled 'The Servant as Leader', published in 1970, his writing describes "the servant leader is servant first".[2]

This translates to the individual's desire to serve others, followed by a natural aspiration to lead. Servant leaders are at the other end of the spectrum to traditional leaders who focus on gaining control and power. Instead, servant leaders seek to put the needs of others first and attempt to help people perform to the best of their ability.

Many authors have built on Greenleaf's initial work and further developed the definition and its characteristics. The former chief executive of the Greenleaf Center for Servant Leadership, Larry Spears,[3] outlined ten attributes associated with servant leadership. These characteristics are a combination of traits and behaviours that can be learned and developed over time (*see box*).

The benefits associated with servant leadership include encouraging leadership at all levels of the organisation, embracing collaboration and support for workers and creating a positive working environment.

The characteristics associated with this leadership approach and its moral premise have been identified as a good fit for the healthcare setting. Trastek, et al[4] state that because many of the characteristics involve interpersonal relations and contribute to creating strong relationships and trust, servant leadership can lead to improved quality of care and lower care costs. The emphasis on interpersonal skills can improve patient-centred care and help to improve trust between patients and healthcare providers and promote positive change in patients' health behaviour.[4]

Studies have also found that servant leadership can help with change within the context of the healthcare environment and improve employee satisfaction, well-being and organisational performance.[5]

Often seen as a holistic approach to leading, servant leadership is often compared with the values of nursing and midwifery. Its focus on the attributes of listening, empathy, awareness, healing and reflection are essential aspects of nursing and midwifery.[5] The emphasis on serving others can be compared with patient-centred care, and the focus on nurturing collaboration can assist with the workings and development of multidisciplinary teams within a healthcare setting.

In contrast, some are critical of this leadership approach. Trastek et al[4] state that servant leadership will not fit every situation, particularly if urgent matters arise that must be dealt with in a timely manner. It can lead to a lack of clarity and may not be the best solution to conflict.

Servant leadership should be considered a leadership approach as it can bring improvements to a healthcare setting, particularly with respect to patient-centred care and creating positive working environments. Many of the attributes mirror those of nurses and midwives, and its emphasis on leadership at all levels means that it has the potential to deliver high-quality, safe patient care.[6]

Ten attributes of servant leadership

Listening: A deep commitment to listening intently to others is required

Empathy: The most successful servant leaders are those who have become skilled, empathetic listeners

Healing: One of the great strengths of servant leadership is the potential for healing one's self and one's relationship with others

Awareness: General awareness, and especially self-awareness, strengthens the servant-leader

Persuasion: The servant-leader seeks to convince others rather than coerce compliance

Conceptualisation: The leader who wishes to also be a servant-leader must stretch their thinking to encompass broader-based conceptual thinking

Foresight: Is a characteristic that enables the servant leader to understand the lessons from the past, the realities of the present, and the likely consequence of a decision for the future

Stewardship: Servant leadership, like stewardship, assumes first and foremost a commitment to serving the needs of others

Commitment to the growth of people: The servant leader is deeply committed to the growth of each and every individual within their organisation

Building community: Servant leadership suggests that true community can be created among those who work in businesses and other institutions

Contributing to this series

If you are interested in writing or contributing to this series of leadership articles, please get in touch with Steve Pitman by email to: steve.pitman@inmo.ie.

Niamh Adams is head of library services and Steve Pitman is head of education and professional development

Launched in 2021, the Nursing Now Challenge brings forward the Nightingale Challenge mandate, which focuses on developing leadership opportunities for nurses and midwives globally. Visit ***www.nursingnowireland.ie***

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A column by Maureen Flynn

Quality & Safety

Introducing the HSE National Centre for Clinical Audit

CLINICAL audit is an important part of nursing and midwifery practice. In this month's column we share information on a new body, the HSE National Centre for Clinical Audit (NCCA). The NCCA provides a national focus for clinical audit to ensure that those who are conducting local, regional and national audits have access to best practice information and training.

The NCCA is located within the National Quality and Patient Safety Directorate (NQPSD) and was launched in April 2022. The centre was established arising from recommendations in the HSE National Review of Clinical Audit Report.[1] This step confirms the HSE's commitment to developing clinical audit as an essential quality and patient safety tool in Ireland, promoting improved patient outcomes.

"Clinical audit is a clinically-led quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and acting to improve care when standards are not met. The process involves the selection of aspects of the structure, processes and outcomes of care which are then systematically evaluated against explicit criteria. If required, improvements should be implemented at an individual, team or organisation level, and then the care re-evaluated to confirm improvements."[2]

Clinical audit is an integral component of safety in all modern healthcare systems and the NCCA programme will support delivery of a standardised approach. Establishing the HSE NCCA marks an important step in the HSE's continued efforts to improve the quality and safety of healthcare for patients. The work of NQPSD and NCCA is anchored in the HSE Patient Safety Strategy 2019-2024.[3]

NCCA

The centre is primarily responsible for implementing the HSE National Review of Clinical Audit Report recommendations under five key pillars:

- National governance of clinical audit
- Local governance of clinical audit
- Clinical audit training
- Clinical audit education resources
- Legislative changes affecting clinical audit (ie. GDPR and data protection).

This will strengthen the development of an end-to-end process for clinical audit and meet the needs of clinical audit service providers and multidisciplinary teams.

Nomenclature

As there is sometimes inconsistency and confusion in terminology around clinical audit, evaluation and research, the first publication of NCCA was a nomenclature document.[4] This provides a glossary of agreed terms including a standard definition for clinical audit to be adopted across all healthcare services and clinical audit service providers.

Clinical audit training

NCCA supports a clinical audit training pathway – with courses in the fundamentals, advanced and train the trainer in clinical audit (ranging in length).[5] You can start with an e-learning course available any time on HSEland, enrol in virtual training or workshops on the fundamentals or become a trainer in clinical audit *(see panel for details and dates)*.

Get involved

The resources and training courses provided by NCCA are accessible to any nurse or midwife. At your next team, ward or department meeting you might like to talk about your role in clinical audit and explore with your manager how you can develop clinical audit within your practice.

Further information

You can connect with the NCCA team via Email: ncca@hse.ie, Twitter: @hsencca or find out more on the webpage: **www.hse.ie/eng/about/who/nqpsd/ncca/**

Clinical audit training

- The Fundamentals of Clinical Audit e-learning course is live on **www.HSEland.ie**
- The Fundamentals of Clinical Audit virtual training course will take place on September 27 and December 7, 2022
- The Fundamentals of Clinical Audit virtual workshop session will take place on October 14, 2022
- An Advanced Clinical Audit virtual course is available on September 28 and November 7, 2022
- The 'Train the Trainer in Clinical Audit' course will be in-person, classroom based and offered to staff in October and November 2022. Registration/bookings for this course will open later in 2022

Maureen Flynn is the director of nursing ONMSD, QPS Connect lead, HSE National Quality and Patient Safety Directorate

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Acknowledgements

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SCAN ME

Health for peace and peace for health

Róisín O'Connell reports on the 75th World Health Assembly, which was held in Geneva on May 22-28, 2022

LAST month I attended the 75th World Health Assembly which was held in person but virtual attendance was also facilitated. It is the first in-person Health Assembly since the start of the Covid-19 pandemic. This assembly was attended by delegates from over 50 countries across the world.

The World Health Assembly is the decision-making body of the World Health Organization (WHO). It is attended by delegates from all WHO member states and focuses on a specific health agenda prepared by the Executive Board.

The main function of the World Health Assembly is to determine the policies of the organisation, appoint the director-general, supervise financial policies and review/approve the proposed programme budget. This year the WHO member states opted to re-elect Dr Tedros Adhanom Ghebreyesus to serve a second five-year term as director-general of the WHO.

Dr Ghebreyesus discussed the five priorities for the organisation over the next five years:

- Promoting health – addressing the root causes of disease and creating the conditions for good health and wellbeing
- Providing health services – by reorienting health systems towards primary health care as the foundation of universal health coverage
- Protecting health – by strengthening the global systems for health emergency preparedness, response and resilience
- Powering progress – by harnessing science, research, innovation, data and digital technologies
- Performing – by building a stronger WHO that delivers results and is reinforced to play its leading role in global health.

The theme of this year's Health Assembly was 'Health for peace, peace for health'. Over the past number of years, the Covid-19 pandemic and other health emergencies have highlighted the importance of the WHO's role of leadership and co-ordination in response to such events. Strengthening preparedness for and response to health emergencies was a key theme of the Health Assembly.

This year's theme was evident in every aspect of the World Health Assembly. There were many heartfelt presentations from delegates, especially those from Ukraine. It was inspirational to listen to the voices of nurses and midwives from every walk of life speaking about the challenges and struggles they faced in their daily working environment. It was important to remember that each nurse and midwife present at the event was working in completely different circumstances and what may be normal for one area was unimaginable in another. Listening to these nurses and midwives made me proud to be part of such a brave profession.

This year the World Health Assembly was attended by the ICN Nursing Student Steering Group and student delegates from across the globe. I currently hold the position of European representative on this student steering group. Each member of the NSSG tuned into the different committee meetings throughout the week. This was my first time attending the Assembly and I thoroughly enjoyed hearing from delegates from across the globe who voiced their opinions and gave accounts of their experiences relating to the different topics covered.

This year we plan to have a student delegation report which will give you the student perspective of the World Health Assembly. I aim to include this in my next student update. I look forward to attending next year's World Health Assembly in person and getting to contribute further to the Health for Peace movement.

Get involved as a student rep

Now more than ever, it is essential that each class has a student rep linked with the INMO student and new graduate office. If your group does not have an INMO student rep, please discuss this among yourselves and nominate one representative per year, discipline and placement area if you are spread across multiple sites.

It is worth noting that INMO student reps are distinct from student union reps as the INMO is the professional body representing nurses and midwives dealing with matters relating to the workplace. Being a rep does not mean taking on a body of work and solving your class's problems by yourself. A rep is someone who lets me know of any collective issues that their group might have so that I can either address these concerns or bring them to the attention of senior management. This means that your needs and position can be represented at national negotiations.

If you are interested in learning more, please do not hesitate to contact me at roisin.oconnell@inmo.ie.

Prepared to protect:
Safeguarding vulnerable adults

Despite some gains made in recent years, gaps in adult safeguarding legislation and services persist, writes **Amanda Phelan**

ABUSE is defined as "…a single or repeated act or omission, which violates a person's human rights or causes harm or distress to the person."[1] Safeguarding involves proactive actions to prevent or reduce the risk of abuse, promote a rights-based approach, enabling wellbeing and the empowerment of individuals.[1]

There are various forms of abuse that can be perpetrated on the adult; these include physical abuse, sexual abuse, emotional/psychological abuse, financial/material abuse and neglect. Moreover, safeguarding issues may represent a clustering of perpetrations rather than the experience of a single type of abuse.

On a more macro scale, system/organisational abuse, discriminatory abuse or human trafficking can also constitute abuse of adults. Abuse may be perpetrated in any environment – in people's homes, their communities, residential care facilities, hospitals or day care centres. While prevalence studies are rare for abuse within the population of adults at risk, a review of 52 studies demonstrates one in six older people are subject to maltreatment of some form.[2]

In 2021, the HSE reported that between 2016 and 2020, more than 51,000 adult safeguarding concerns were reported, with 66% in the < 65 years age group and 34% ≥ 65 years age group.[3] Self-neglect (also known as senile squalor syndrome, social breakdown syndrome, messy house syndrome or Diogenes syndrome) may also be included in the rubric of adult safeguarding and has a 2.5 times higher mortality rate than those reported to adult protective services in the US.[4]

In 2002, Ireland published its first National Elder Abuse Policy which recommended the introduction of various measures to safeguard older people and included a staff structure to respond to suspected cases reported to the HSE.[5] Many of the policy recommendations remained dormant until poor care practices in a nursing home, Leas Cross, were aired in an RTE *Primetime Investigates* programme in May 2005. A major public and political outcry resulted with the establishment of the HSE elder abuse response service in 2007.

A second undercover broadcast in December 2014, *Inside Bungalow 3*, revealed maltreatment in Áras Attracta, a care facility for people with intellectual disability. This spurred the expansion of safeguarding services to adults who may be at risk, with the HSE introducing a broader adult safeguarding policy.[6]

Despite the advancement of response services, gaps in safeguarding persist. Although the Department of Health has focused on the development of a national policy, this had not yet been realised and other issues persist. For example, mandatory access to some domiciles remains challenging when there is a suspicion of abuse, thus hampering an investigation into concerns.

Although the belated signing of the Assisted Decision-Making Capacity Act occurred in December 2015 (replacing the archaic 1871 Lunacy Regulation Act), its full implementation continues in 2022 and much work needs to be undertaken to fully understand its implications, particularly in the context of a change from a status to a functional approach to decision making capacity.

Other legislation is slow to come to fruition; for instance, there have been revisions of Heads of Bill related to deprivation of liberty (termed liberty protection safeguards in England), yet supporting legislation remains elusive.

It has been recognised that an overarching responsibility for safeguarding adults is a deficit, with inclusive governance for all sectors and environments lacking. Recognising this, continued lobbying has

occurred to introduce adult safeguarding legislation in Ireland, similar to the Care Act 2014 in England and Wales.

In 2017 a private members Bill introduced by Senator Colette Kelleher received all-party support, yet this remains at the third stage of the political process for ratification to legislation. The Bill proposes the establishment of a National Adult Safeguarding Authority to oversee adult safeguarding across sectors.

The potential for national legislation is further explored in a wide-ranging consultation paper on adult safeguarding published by the Law Reform Commission in late 2019,[8] with more recent lobbying for this by Safeguarding Ireland,[7] an organisation that promotes the safeguarding of adults and engages in interdisciplinary and inter-sector collaboration to raise awareness and responses to abuse of adults.

Issues also remain in relation to the public understanding of a rights-based approach based on personhood. Furthermore, formal responses within sectors can be impeded by issues such as a lack of training in the area of safeguarding and data protection issues related to sharing of information. Moreover, fears regarding adult safeguarding continue to surface within reports, such as the Grace and Brandon cases, with concerns also voiced about ageist policy within Covid-19 policy responses and concerns on care quality within the pandemic.

It is within this context that the School of Nursing and Midwifery at Trinity College Dublin established Ireland's first multidisciplinary, intersectoral adult safeguarding programme. The Safeguarding Adults at Risk programme is an MSc level, micro-credential programme that was developed with Safeguarding Ireland to meet the needs of professionals in health and social care, financial institutions, garda, the legal profession and others working with adults at risk.

The programme builds on a human rights-based approach to safeguarding with guest lecturers in practice, education, legislation, policy and regulation nationally and from Canada, the US and the UK. Presentations also include the voice of adults at risk who articulate the lived experience of care service approaches.

The programme is delivered over one semester with two face-to-face days and the remaining classes delivered live or as pre-recorded lectures. For more information, contact Prof Amanda Phelan at email: aphelan1@tcd.ie or visit: **www.tcd.ie/courses/microcredentials/** Applications are currently open.

Amanda Phelan is professor of ageing and community nursing at the School of Nursing and Midwifery at Trinity College Dublin and is a board member of Safeguarding Ireland

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Safety huddle effect

Since introducing a safety huddle in Mercy Hospital's ED, staff feel more supported and patient safety has improved, writes **Shona Fitzgerald**

THE introduction of safety huddles in Mercy University Hospital's emergency department has seen a huge decline in medical emergency calls by 25%. This Cork-based ED is a dynamic, fast paced patient-care environment with many challenges for the multidisciplinary team working there. This environment was made more challenging by the pandemic when isolation cubicles were required in the department and we looked for ways to keep these patients safe behind closed doors.

In September 2021, a team from the ED took part in the S.A.F.E. (situational awareness for everyone) collaborative programme in conjunction with the Royal College of Physicians in Ireland and the Deteriorating Patient Improvement Programme. This programme is a quality improvement and safety initiative aimed at increasing patient safety in hospitals with the use of safety huddles. The initial team that took part in the programme included Dr Darren McLoughlin, emergency medicine consultant; Barbara O' Donnell, CNM3; Anne Healy, clinical facilitator; and myself, Shona Fitzgerald, CNM2 in care of the deteriorating patient.

The aim of the SAFE huddle is to increase situational awareness in identifying patients who are at risk of deterioration. Patients' INEWS scores are documented and updated regularly on the department's white board. Patients scoring > 6 are discussed at the huddle, along with those who are identified as a 'watcher' by a member of the team, ensuring the concerns of staff are escalated appropriately. A patient's condition should be improving within the hospital setting, if the patient is not improving then care is escalated to senior decision makers, and the concerns are acted on.

Initially the ED had one safety huddle at 10am. The huddle takes place at the whiteboard where the multidisciplinary team in attendance identifies themselves. On any given day there is a wide range of staff in attendance, including doctors, nurses, physiotherapists, pharmacists and

Safety huddle: *Pictured at the Mercy Hospital's ED were (l-r): Darren McLoughlin, emergency medicine consultant; Barbara O'Donnell, CNM3; Clara Minihane, CNM1; Shona Fitzgerald, CNM2 care of the deteriorating patient; Abhishek Sharma, registrar; Carol O'Leary,CNM2; Annette O' Regan, clinical facilitator; Martina Hughes, ADON; Anne Healy, clinical facilitator; Bernie McGee, resuscitation CNS; and Samuel Dairiam, registrar*

management. A script containing the following details is followed:

- Patients scoring an INEWS > 6 are identified and discussed using the ISBAR tool (Introduction, Situation, Background, Assessment, Recommendation) and it is decided if further escalation is needed
- 'Watchers' are also identified, these are patients who have potential to deteriorate and who staff express concern for
- Patients on special infusions are identified as a risk, as well as those at risk of sepsis. All these patients are highlighted
- Paediatric patients are included to ensure their care is prioritised
- Patients with mental health issues are identified to ensure their safety and the safety of staff, and to ensure that they are suitably situated within the department
- Concerns regarding equipment and safety in the department can also be raised.

The huddle lasts between five and 10 minutes. The safety huddle has now also been introduced on the nightshift. This takes place at 11pm and includes the night ADON and night medical registrar.

Positive feedback has been received so far on its introduction. Staff report feeling more supported in the ED as they can express their concern to senior members of the team. The department is now using INEWS as a common communication tool. Care is being escalated at an earlier stage.

Staff are willing to engage in the huddle as it promotes a safer environment. Progress is measured using a safety cross. Cases of good escalation and recognition are highlighted daily, these are called 'catch of the day' and can be by any team member. Cases where appropriate escalation did not take place are also looked at to see how these can be improved and what can be learned from the incident.

Since the introduction of the SAFE huddle, the ED has seen a reduction of medical emergency calls by 25% compared to the same period the previous year. This is despite a 31% increase in presentations. The safety huddle has become embedded in the department routine and the number in attendance of the huddle has grown sufficiently. All staff are welcome to attend the huddle and express any concerns they may have.

Before staff were reacting to patients who had deteriorated. Now deterioration is anticipated, resulting in earlier recognition and escalation of care. Staff feel more supported, knowing their concerns are listened to. The ED is becoming a safer environment, where the focus is on improvement in patient care. Steps are now being taken to introduce safety huddles to the other wards in MUH on a phased basis, to ensure high standards of patient safety hospital wide.

Shona Fitzgerald is a CNM2 in care of the deteriorating patient at the Mercy University Hospital, Cork

Living longer: Extending our working lives

Maggie O'Neill and **Áine Ní Léime** discuss the views of long-standing Irish nurses who were interviewed on the subject of extending their working lives in the context of government plans to raise the age of retirement

DUE to many people living longer, healthier lives, governments across Europe are seeking to extend working lives to reduce the cost of pensions. One of the most common policies introduced is to increase state pension age. In Ireland, state pension age is currently 66. It was planned to increase it to 67 by 2021 and to 68 by 2028, but due to widespread opposition the government established a Commission on Pensions, which recommended a more gradual increase to 68 by 2039.[1]

In 2019, we asked nurses in Ireland aged 46 to 65 years about their working lives, including to what age they wanted to work, and for their views on an extended work life. This study forms part of the research project Dynamics of Accumulated Inequalities for Seniors in Employment (DAISIE), investigating the work-life histories and experiences of workers in Ireland, the Czech Republic, Sweden, Switzerland and the UK, and their views on policies designed to extend working life. This article will look at the views of nurses in Ireland on the topic of extending their working lives and the implications of this for their work and home lives. They also shared their policy recommendations.

In total 40 nurses, including 24 women and 16 men, took part in life course interviews in 2019. Further details are available in a policy brief published in 2021.[2] Data were anonymised and pseudonyms are used throughout this article.

These broad, narrative interviews allow consideration of the main elements that come together to shape individual lives and decision-making over time. The participants were working across different services and settings, including acute, community and residential, in roles ranging from staff nurses to assistant directors of nursing.

There are differences between men and women in relation to part-time work and career breaks, significant factors that inform decision-making around extended working life. Of those we interviewed, women were much more likely to work part time now or in the past, or to have taken career breaks, mainly to care for children. This situation often results in lower pensions and the need to work for longer or to pay additional voluntary pension contributions.

International literature demonstrates that for nurses, health, family considerations, job satisfaction and financial factors are important in retirement decision making.[3] In the current study, the participants' responses to questions about their attitudes towards their jobs, experiences of growing older in the workplace, retirement plans and views on extended working life bore out these international findings and highlighted differences between nurses in their ability to work longer based on their employment and pension status, health and stress levels.

Their views were also informed by the experience of working within a health system in Ireland that saw severe cutbacks during a long period of financial austerity in response to the global financial crisis, through which nurses and midwives experienced an increasing workload and higher patient ratios informed by cost-control strategies.[4,5]

Overall, more than half of the nurses held negative or strongly negative views about extending their working lives; almost one-third expressed mixed views about the prospect and one-eighth held positive or strongly positive views.

The reasons behind the negative views on extended working life included many references to the demanding nature of the job. The nurses considered their personal health situation in connection with when they saw themselves retiring.

As Catherine (age 50) stated: "No, I don't think it's right, I don't think it's fair... some of our people at 68 could be minding people who are younger than them... You could be in a nursing home yourself at 68, let's be honest."[2]

Although many of the nurses considered themselves to be in good health generally, half refer to work-related physical or stress-induced conditions. Predominantly, severe stress and burnout were reported, as well as musculoskeletal conditions due to wear and tear or injury.

As Bridget (age 53) described: "I suppose, towards the end of working in the wards... I would have had some problems with my knees... I had a stomach ulcer at that time as well and I probably put it down to a little bit of stress... and trying to juggle everything."

Due to health challenges accumulating over time, many nurses regarded working past current retirement age as unrealistic.

As some nurses stated, reaching their current pension age was already a challenge. Eileen (age 56) highlighted the need for flexible workplace policies if nurses' working life must be extended: "Certainly, when I was up in ICU, I had nothing after the long days or even the short days. Nothing left… There should be a pathway for older people."

These experiences resonated with recognised challenges faced by older nurses in the workplace, however as yet there is a lack of supportive policies.[6]

Almost one-third of the nurses interviewed held mixed views about working longer. They felt that there are some positive aspects, as many people are living longer, healthier lives. However, they also recommended policy changes.

A key consideration, which Anne (51) pointed to, was that some nurses have a financial impetus to continue working, however one's financial situation as well as one's physical ability to keep going can be informed by one's role or clinical area: "It all comes down to your financial situation because it is a difficult job. It's easier to work longer in management."

The gap between retirement age and pension age was another important factor. As Deirdre (54) said, this gap can be troublesome, so some people may need to have the option of working longer: "Even as it stands if I retire at 65 I don't get the State pension until 66. So that year is troublesome I'm sure for some people."

Those with mixed views also referred to accepting the case for extended working life in theory, however they stressed that the ability to continue was health-dependent. Martin (57) said: "I understand why it's being done. I think in reality while people are living longer, are they physically able to continue to work in the roles that they have been working after 65 or 67 or 70... That's not to say that there isn't a role for them, that there isn't a job for them… there's a lot more thinking needs to be done around that."

Martin emphasised the experience that older nurses have to offer, encapsulating a central theme emerging from the interviews: "I think older people have a lot to offer with regard to their knowledge and their experience but physically their bodies are winding down. It's a fact of life."

Five nurses believed that extended working life could be positive or strongly positive, for reasons including welcoming the option to work longer, having a lot to contribute and the social, physical and mental benefits of continuing to work.

"I think I'd be bored… I'd like to be working. That's why I think that whole thing about job sharing for the last few years of your career is a really good idea. Because you've the best of both worlds," said Martina (56).

Those with positive views were also of the opinion that extended working life should be a choice.

The nurses interviewed provided a number of policy recommendations. These include wider availability of the option to reduce hours or job share towards retirement age, options that they note are available in theory but sometimes difficult to obtain in practice.

The pre-retirement pilot initiative, which provides for some eligible nurses (in clinical roles) to work part time for a number of years before retirement and retain full pension rights, was raised as a good example of an enabling policy that should be extended.

Such policies could address issues raised by nurses in Anthony's (59) position: "I think if they were serious about caring for their staff, they would give the likes of me a chance to work maybe three days a week. But if I was to do that now, it would affect my pension… I don't want to be fully off, but I think if they were serious they'd make sure that it didn't affect [us] pension wise."

Following these findings, the researchers recommended that working for longer should be a choice and policies to extend working life should be explored further, to take into account the implications of, for example, caring responsibilities or physically demanding work over the life course.

The researchers welcomed the more gradual increase in state pension age recommended by the Pensions Commission, as well as the plan to align state pensions with retirement age. They stressed that this increase should be accompanied by an exemption for workers in physically demanding jobs, including nurses, who should be facilitated to retire at 65 with a full state pension. While nurses on the older HSE pensions will not be affected by the increase in the state pension age, this issue will be more relevant for older nurses in the future.

The researchers aim to provide insight into older nurses' experiences, to identify the types of support that will be needed to provide for their work-life choices and transitions. This is a pressing issue in a context where there are increasing demands on an older workforce to hold up a healthcare system challenged by the pandemic.

INMO comment

This is a welcome study. In other, male-dominated, public service employment the state allows fast accrual for pension purposes and, as a female-dominated profession with the same or often more gruelling, physical demands and dangers from assault, it is time for the state to treat nursing and midwifery equally in this regard

A qualitative study based on follow-up interviews with the same group of nurses, focused on their experiences of working through the pandemic, found that many older women nurses were now seeking to retire earlier than planned.[7]

In order to retain the essential skills and experience of older nurses, employers and the government must give serious attention to the need for nuanced policies that provide improved infrastructure, increased staffing levels, flexible work options, and pre-retirement schemes.

It is essential to address such issues to develop and maintain the nursing workforce in Ireland.[6] Such actions would contribute to demonstrating in a real and tangible way the appreciation expressed for nurses by the public during the pandemic.

Maggie O'Neill is a postdoctoral researcher and Áine Ní Léime is deputy director at the Irish Centre for Social Gerontology, NUI Galway. *This research was funded under the NORFACE DIAL programme.*

The authors would like to acknowledge the contribution of the men and women who participated in the interviews and generously shared their experiences and views

Some of these findings were initially presented in a policy brief on Extending Working Life Policies in Financial, Healthcare and Transport Services in Ireland by Á Ní Léime, M O'Neill and N Duvvury (2021)

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Integration of care

Nurses and midwives are ideally placed to enable integrated services that focus on population-based healthcare, writes **Clare Lewis**

DURING the pandemic, healthcare has observed unprecedented development and scaling of integration and innovation to ensure that care has continued for the patient, service user and families in the comfort of their own homes. Acute hospital and community nursing and midwifery have paved the way for integration, with pathways developed to deliver services that work across hospital and community and are enabled by technology.[1,2] This places nurses and midwives in an essential role to deliver on integration of care and new, innovative ways of working across the lifespan of care.[2]

Approaches such as video-enabled assessment and clinics to deliver self-management and educational programmes, remote monitoring to support egress from the acute hospital and home monitoring as part of admission avoidance are critical to the design and modernisation of our health and social care services.[3] This includes the use of virtual wards that provide hospital care at home to reduce the need to attend EDs and provide opportunity for early supported discharge.[4]

This article will explore the fundamentals of integrated care and population-based healthcare to demonstrate how nurses and midwives are ideally positioned to continue to drive this. An example of a nurse-led innovation, a community virtual ward (CVW), will be presented, discussing the principles of the model of care to enhance integration and support a shift in care to the community.[4,8,9]

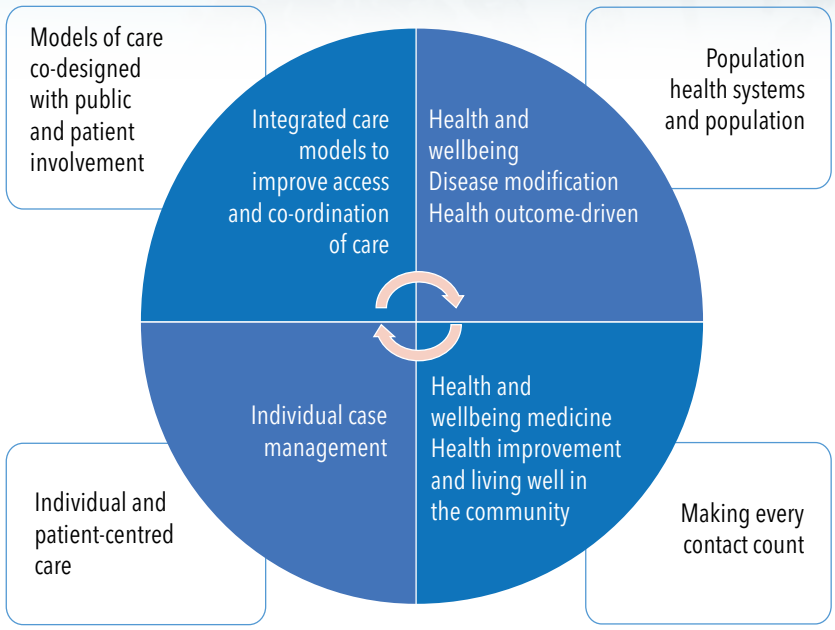
Integrated care and population-based healthcare

Sláintecare has set the direction for integrated care as an essential component to re-orientate the healthcare system towards primary and community care delivered at the lowest complexity.[7] The concept of integrated care is driven by the need to restructure healthcare services and reduce fragmentation to meet population requirements.[10] This represents a departure from hospital-based models of care.[11] Integrated care aims to reduce fragmented healthcare and improve health and wellbeing, with a focus on population-based care.[7] This approach strives to improve access and co-ordination and move away from single disease-driven services to improve health and wellbeing[11] *(see Figure 1)*. Integration of care and population-based healthcare are linked with a recognition that complexity of healthcare is influenced by the wider determinants of health and social care.[13]

Combining integrated care and population healthcare as strategies for intervention has several benefits, such as enabling the redesign of services with a focus on interventions that will have the greatest impact on health outcomes.[13]

There are several international examples of population-based health models that facilitate community-focused integration strategies such as the Embrace model,[14] the Healthy Programmes Model[15,16] and the Kaiser Permanente Model.[17]

Figure 1: Population-based healthcare and integration of care



These models have contributed to care integration and collaboration between general practice, local health and community organisations, in addition to prevention, early intervention and health and wellbeing with fair access to healthcare.

In terms of developing proactive healthcare services in the longer term, interventions that move away from individual management to population management have better outcomes for communities. To enable this we can re-orientate care to the community, encourage cross-collaborative interagency partnerships and adopt strategies to address long-term population needs.[12,19]

Cross-collaborative interagency working and integration

This requires integration of service delivery across multiple system levels, such as employment, housing, transport and access to green spaces.[13] Cross-collaborative working facilitates integration and there are fundamental requirements to

support this. These include:[2,20-23]

- Flexibility in roles that can provide care across areas, specialities and services
- Shared governance with clear clinical governance lines and access to clinical supervision and mentoring to support flexibility and fluidity of roles
- Organisational readiness to enhance leadership; this is essential to enable integration of nursing and midwifery roles to strengthen nursing leadership
- An agreed and defined minimum dataset to capture and measure integration of care and to show outcome and impact.

An example of a model that has enabled integration of nursing care is the CVW, a flexible nurse-led model that works across hospital and community settings.[4,9] The CVW operates in the patient's home and beds are not real beds but virtual beds.[4,9] The model supports both egress from the ED and acute hospital and admission avoidance with direct referral from GPs.[4,9]

This was first tested in Ireland in North Dublin to address the high rate of re-admissions for older persons with complex healthcare needs, and demonstrated a significant reduction in unplanned hospital admissions and ED presentations.[4]

The CVW was adapted and adopted in 2020 by the Office of the Chief Nurse in the Department of Health and the Office of the Nursing and Midwifery Services, HSE. The aim was to test the model to facilitate integration of the nursing workforce with the objective to offer an alternative approach to acute hospital care by providing care closer to home. The target population included patients with chronic respiratory conditions at risk of a hospital admission and was enhanced by the use of technology using remote monitoring and remote monitoring devices.[9,24]

The model was nurse led and supported by advanced nurse practitioners (ANPs) and candidate ANPs (cANPs) in the acute hospital and clinical nurse managers (CNMs), enhanced nurses and RGNs working in the community intervention team (CIT). The majority of ANP care was delivered remotely using video-enabled platforms, extending reach into the home, and through working with CIT with daily virtual meetings to discuss care plans, interventions and responses to inform discharge planning. Objective data provided by remote monitoring devices and patient reported symptoms, as well as direct home visits undertaken by CIT, assisted in informing decision-making.[9] A respiratory consultant based in the acute hospital provided overall clinical governance and was part of virtual ward rounds.

The integration of this model of care required key stakeholder engagement, including nursing leadership from the community healthcare organisation and acute hospital, provided through a local clinical governance group.

To put integrated care into operation it was necessary to establish clarity with respect to roles, responsibilities, out-of-hours support and points of contact for CIT and service users, as well as escalation of care pathways, data collection and key metrics.[9]

To address population health, this nurse-led model was instrumental in identifying psychological, social and financial determinants of care that could impact on interventions and outcomes for patients.

The evidence-based outcomes indicated that the CVW is an exemplar of how care that is informed and delivered using a nursing model has maximised integration and enhanced support for people at home, thus contributing to admission avoidance and providing early intervention with a focus on population healthcare.[4,9,24] This speaks to the principles of Sláintecare and healthcare reform.[7]

Conclusion

Nurses and midwives are ideally positioned to facilitate and enable integrated care and develop roles and services that focus on population-based healthcare. Cross-collaboration engagement of services is key to enabling this. Understanding concepts of integration of care and how population health is part of this is essential to ensure that the fundamentals are in place to support this shift in care.

Dr Clare Lewis has a doctorate in nursing and midwifery from RCSI. She is also a registered advanced nurse practitioner and is general manager of the Office of the National Lead for Integrated Care, HSE

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Delivering with care

It is paramount that midwives provide individualised woman-centred care in partnership with the birthing mother, writes **Lisa Brady**, whose department created a poster to celebrate IDM 2022

THE theme for International Day of the Midwife 2022 was '100 years of progress'. Progress is "the process of improving or developing, or of getting nearer to achieving or completing something".[1] This immediately resonated with me as I reflected on both the Irish maternity services and my own maternity unit and the progress we have made over the past 100 years.

Quality and patient safety within maternity services in Ireland has greatly improved through risk management processes, metrics, audits, governance, key performance indicators (KPIs), open disclosure, quality initiatives and evidenced-based care. Midwives have been instrumental in driving this. Within our unit we welcome and endorse these processes recognising their valuable contribution to the promotion and provision of high-quality care under the support and guidance of our assistant director of midwifery (academic lead) – a post which is unique to our unit.

We, as midwives, have a shared vision, a commitment to providing a high quality, evidenced based, woman-centred service under the realms of exemplary leadership. This vision has guided us in planning and introducing new services and posts and expanding on existing services within our unit to enable us to be responsive to individual needs.

Our unit on Cavan Monaghan Hospital was one of the first two units in the country to offer a midwifery-led service, one that has faced challenges yet continues to operate and provide continuity of holistic midwifery care for normal risk healthy women throughout the antenatal, intrapartum and postnatal period in a woman-centred family-friendly environment. This is a testament to the resilience and commitment of our midwives.

Lisa Brady, a clinical placement co-ordinator at the maternity department of Cavan Monaghan Hospital, is pictured with the poster staff created to celebrate International Day of the Midwife 2022

The introduction of our candidate advanced midwife practitioner in supported care will provide clinical leadership in managing, supervising, improving and enhancing already established midwifery-led services. They will normalise childbirth irrespective of risk category.

We are currently working with the RCSI programme manager on a project 'A little less conversation a little more action guaranteed' with a goal of providing a more person-centred approach to care in:

- Optimising midwifery-led unit (MLU) utilisation
- Implementing 'REAL TIME RIGHT TIME' feedback
- Re-commencing the service user group
- Improving the maternity services web page with access to video education
- Optimising use of the Integrated Patient Management System (IPMS) and supporting the implementation of improved two-way communication with women and their families
- Enhancing the existing parent craft programme with educational videos with the ability to measure participation via SALISO
- Assisting CMS/CMM services to set and achieve goals.

Recent funding from the National Women and Infants Programme and the Department of Health has allowed us to invest in our service with imminent refurbishment of our MLU and labour ward suites planned, alongside additional funding for the lactation department. This will all serve to meet and even exceed women's expectations.

Poster

In celebrating the progress we've made in our unit a poster was created to recognise the key role midwives have and the team work they display in providing a woman-centred high-quality service in partnership with the woman.

Central to the poster is a road signifying the journey a woman takes through our service, with a pregnant woman at the start and a woman holding her baby at the end. This signifies how women are front and centre in all decisions about their care.[2]

Each stone on the path, laid side by side, represents our midwives demonstrating the key role they play. This was portrayed by every midwife placing their fingerprint and initials on the stones.

All the midwives and midwife specialists were included. By working as a team, they have all played a key role in shaping our service even though not every woman avails of every service. Teamwork is essential for providing safe, effective and woman-centred maternity care, with many high profile investigations highlighting the adverse consequences of inadequate teamwork.[3] In working together, we reduce this risk and it was of the utmost importance to capture this.

We chose to use fingerprints due to their individuality. Each individual has a unique set of fingerprints, just as each maternity care experience is unique. Individualised woman-centred care is delivered in partnership with the woman, and this is paramount in delivering our service. The care received during the perinatal period can have a profound impact on the overall experience of pregnancy and birth, which can affect emotional health and wellbeing in the immediate and long-term.[4]

Every woman's journey is guided by the expertise of midwives acting as her advocate in educating and supporting her through pregnancy, labour and the postnatal period.

The poster was illustrated by Fiona Casey who works in our maternity department screening hearing in newborns. Her artistic skills and creative ability expertly portrayed the woman's journey through our service in partnership with the midwife. Space has been left for midwives who were on maternity and other types of leave.

We displayed the poster on the International Day of the Midwife in May and it received positive feedback. We chose that day to also reflect on the work of midwives over the past 100 years and what we have learned from them, how we have built on their experiences, their research and their teaching. As midwives, we will continue to do the same over the next 100 years in further developing a service that continues to ensure women and babies have access to safe, high-quality care in a setting that is most appropriate to their needs, with women and families placed at the centre of all services treated with dignity, respect and compassionate care. [2]

Lisa Brady is a clinical placement co-ordinator at the maternity department of Cavan Monaghan Hospital

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JAKAVI® is indicated for the treatment of disease-related splenomegaly or symptoms in adult patients with primary myelofibrosis (also known as chronic idiopathic myelofibrosis), post polycythaemia vera myelofibrosis or post essential thrombocythaemia myelofibrosis. JAKAVI® is also indicated for adult patients with polycythaemia vera who are resistant to or intolerant of hydroxyurea.[1]

ABBREVIATED PRESCRIBING INFORMATION

Refer to Summary of Product Characteristics (SmPC) before prescribing.

Jakavi (ruxolitinib) 5mg, 10mg, 15mg and 20mg Tablets

PRESENTATION: Tablets containing 5 mg, 10 mg, 15 mg or 20 mg ruxolitinib (as phosphate).

INDICATIONS: Myelofibrosis (MF): Jakavi is indicated for the treatment of disease-related splenomegaly or symptoms in adult patients with primary myelofibrosis (also known as chronic idiopathic myelofibrosis), post polycythaemia vera myelofibrosis or post essential thrombocythaemia myelofibrosis. Polycythaemia vera (PV): Jakavi is indicated for the treatment of adult patients with polycythaemia vera who are resistant to or intolerant of hydroxyurea.

DOSAGE AND ADMINISTRATION: Jakavi treatment should only be initiated by a physician experienced in the administration of anticancer agents. Perform a complete blood cell count, including a white blood cell count differential, before initiating Jakavi therapy. Monitor complete blood cell counts every 2 to 4 weeks until optimal dose is reached. Administration orally, with or without food. *Starting dose:* The recommended starting dose of Jakavi in myelofibrosis (MF) is based on platelet counts. The recommended starting dose of Jakavi for adults in MF is 20 mg twice daily (platelet count of >200,000/mm^3), 15 mg twice daily (platelet count between 100,000/mm^3 and 200,000/mm^3), 10 mg twice daily (platelet count between 75,000/mm^3 and 100,000/mm^3) and 5 mg twice daily (platelet count between 50,000/mm^3 and 75,000/mm^3). Recommended starting dose of Jakavi in PV is 10mg twice daily. If efficacy is considered insufficient and blood counts are adequate, doses may be increased by a maximum of 5 mg twice daily, up to the maximum dose of 25 mg twice daily. The starting dose should not be increased within the first four weeks of treatment and thereafter no more frequently than at 2-week intervals. Discontinue treatment if platelet counts <50,000/mm^3 or absolute neutrophil counts (ANC) <500/ mm^3 (MF and PV patients), in PV patients also interrupt treatment if Hg <8g/dl. Dose reduction should be considered if the platelet count decreases during treatment as outlined in Table 1 (aiming to avoid dose interruptions for thrombocytopenia).

	Dose at time of platelet decline				
	25 mg twice daily	20 mg twice daily	15 mg twice daily	10 mg twice daily	5 mg twice daily
Platelet count	**New dose**				
100,000 to <125,000/mm^3	20 mg twice daily	15 mg twice daily	No change	No change	No change
75,000 to <100,000/mm^3	10 mg twice daily	10 mg twice daily	10 mg twice daily	No change	No change
50,000 to <75,000/mm^3	5 mg twice daily	5 mg twice daily	5 mg twice daily	5 mg twice daily	No change
Less than 50,000/mm^3	Hold	Hold	Hold	Hold	Hold

Table 1 Dosing recommendation for thrombocytopenia.

In PV, additionally dose reduction should be considered if Hg <12 g/dl and recommended if Hg <10 g/dl. Dose should be reduced by approximately 50%, to be administered twice daily when administered with strong CYP3A4 inhibitors or dual inhibitors of CYP2C9 and CYP3A4 enzymes (e.g. fluconazole). Avoid concomitant use with fluconazole doses greater than 200 mg daily. More frequent monitoring (e.g. twice a week) of haematology parameters and of clinical signs and symptoms of ruxolitinib-related adverse drug reactions is recommended. In patient with severe renal impairment (creatinine clearance <30 ml/min), the recommended starting dose based on platelet count for MF patients should be reduced by approximately 50% to be administered twice daily. The recommended starting dose for PV patients with severe renal impairment is 5 mg twice daily. Patients with renal impairment should be carefully monitored with regard to safety and efficacy during Jakavi treatment. For patients with any hepatic impairment, the recommended starting dose based on platelet count should be reduced by approximately 50% to be administered twice daily. Subsequent doses should be adjusted based on careful monitoring of safety and efficacy. No additional dose adjustments are recommended for older people. Safety and efficacy in children aged up to 18 years have not been established. See Section 5.1 of the SmPC for full details.

Treatment should be discontinued after 6 months if there has been no reduction in spleen size or improvement in symptoms since initiation of therapy.

CONTRAINDICATIONS: Hypersensitivity to the active substance or to any of the excipients listed in section 6.1 of the SmPC. Pregnancy and lactation.

PRECAUTIONS AND WARNINGS: Decrease in blood cell count: hematologic adverse drug reactions, including thrombocytopenia, anaemia and neutropenia have been reported with Jakavi treatment. Complete blood count, including a white blood cell count differential, must be performed before initiating therapy with Jakavi. Dose reduction or interruption may be required in patients developing thrombocytopenia, anaemia and neutropenia. Infections: Patients should be assessed for risk of developing serious infections. Monitor patients for signs and symptoms of infections during Jakavi treatment, and initiate appropriate treatment promptly. Treatment with Jakavi should not be started until active serious infections have resolved. Before starting treatment, patients should be assessed for active and inactive ("latent") tuberculosis, as per local recommendations. It is recommended to screen for HBV prior to commencing treatment. Hepatic and severe renal impairment: Due to increased Jakavi exposure, dose reduction is required. Progressive multifocal leukoencephalopathy (PML) has been reported with Jakavi treatment. Physicians should be alert for neuropsychiatric symptoms suggestive of PML. If PML is suspected suspend treatment and until PML is excluded. Lipid monitoring and treatment of dyslipidaemia according to clinical guidelines is recommended. Periodic skin examination is recommended for patients who are at increased risk for skin cancer. Physicians should educate patients about early signs and symptoms of herpes zoster, advising that treatment should be sought as early as possible. See Section 4.4 of the SmPC for full details.

INTERACTIONS: Interaction studies have only been performed in adults. Ruxolitinib is eliminated through metabolism catalysed by CYP3A4 and CYP2C9. Thus, medicinal products inhibiting these enzymes can give rise to increased ruxolitinib exposure. Dose reduction recommended when co-administered with strong CYP3A4 inhibitors or dual inhibitors of CYP2C9 and CYP3A4 enzymes. Avoid concommitant use with fluconazole doses greater than 200 mg daily. See Section 4.2 and 4.5 of the SmPC for full details.

FERTILITY, PREGNANCY AND LACTATION: The potential risk for humans is unknown. As a precautionary measure, the use of Jakavi during pregnancy is contraindicated (see section 4.3 of the SmPC). Women of childbearing potential should use effective contraception during the treatment with Jakavi. Jakavi must not be used during breastfeeding and breastfeeding should therefore be discontinued when treatment is started.

UNDESIRABLE EFFECTS: Very common (≥1/10): Urinary tract infections, Herpes zoster, pneumonia, anaemia, thrombocytopenia, neutropenia, bleeding, bruising, gastrointestinal bleeding, other bleeding, hypercholesterolaemia, hypertriglyceridaemia, weight gain, dizziness, headache, elevated lipase, constipation, raised alanine aminotransferase, raised aspartate aminotransferase, hypertension. Common (≥1/100 to <1/10): Sepsis, pancytopenia, intracranial bleeding, flatulence. Uncommon (≥1/1,000 to <1/100): Tuberculosis, HBV reactivation. Please see Section 4.8 of the SmPC for a full list of adverse drug reactions (ADR) including further information on the frequency category of each ADR for Mylofibrosis and Polycythaemia vera.

PACK SIZE: PVC/PCTFE/Aluminium blister packs containing 14 or 56 tablets or multipacks containing 168 (3 packs of 56) tablets. Not all pack sizes or types may be marketed.

LEGAL CATEGORY: POM

MARKETING AUTHORISATION NUMBER:

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Myeloproliferative neoplasms

Conal Houstoun and **Clodagh Keohane** take a look at the diagnosis and management of MPNs – a group of blood cancers that occur when the body creates too many white blood cells, red blood cells or platelets

MYELOPROLIFERATIVE neoplasms (MPNs) are a group of blood cancers that occur when the body creates too many white blood cells, red blood cells or platelets. The Philadelphia chromosome negative MPNs comprise polycythaemia vera (PV), essential thrombocythaemia (ET) and primary myelofibrosis (MF).[1] They are characterised by overproduction of myeloid cells, accompanied by fibrosis of the marrow in the case of MF. They occur at a rate of approximately one to two per 100,000 per year.[2]

The discovery of the mutations driving MPNs has greatly improved our understanding and management of the conditions. The JAK2 V617F mutation was discovered in 2005. It is present in approximately 95% of patients with PV and 60% of those with ET or MF.[3] Mutations of CALR and MPL genes are present in approximately 30% and 5% of patients with ET or primary myelofibrosis, respectively.[4]

Signs and symptoms

Characteristic features of PV and ET are aquagenic pruritis, where patients develop pruritis after water and erythromelalgia which manifests as pain, redness or paraesthesia in the extremities.[5] Patients can also exhibit symptoms of fatigue, weight loss, fever, night sweats and bone pain. Splenomegaly may be present and may be massive in MF. Patients can develop symptoms of early satiety and nausea from splenomegaly. The MPN 10 form is a scoring tool to assess the symptomatic burden of MPNs and response to treatment.

The main risk associated with MPNs is thrombosis. Most patients present incidentally following a blood count, however the heralding event may be thrombosis which can occur in an unusual site such as portal or hepatic vein thrombosis.[6]

Diagnosis

It is reasonable to consider the possibility of an MPN if a cell line on the full blood count persistently exceeds the normal range. Erythrocytosis with a raised haematocrit would suggest PV, and thrombocytosis would suggest ET. A haematocrit > 0.52 in males and > 0.48 in females should prompt further investigations for PV, and a platelet count > 450 should prompt consideration of ET.[7]

It is important to distinguish between a high cell count due to a primary MPN condition, or one due to a secondary cause. Secondary causes are more common than primary MPNs. Potential secondary causes of erythrocytosis include smoking, chronic lung disease, obstructive sleep apnoea, an erythropoietin-producing tumour or use of medications, such as diuretics or testosterone. Secondary causes of thrombocytosis include infection, inflammation, post-surgery and iron deficiency.[2]

Should blood tests remain persistently elevated with no clear secondary causes, it would be reasonable to refer to a haematologist for assessment. For erythrocytosis, we send a Jak2 mutation, an erythropoietin level and iron levels. Erythropoietin tends to be suppressed in primary polycythaemia, and iron stores are often depleted.[8] Jak2 V617F mutation is nearly always present in primary PV9. If it is negative, further testing can be performed for the Exon 12 mutation, which is present in < 2% of PV.

In cases of a persistent thrombocytosis, we perform sequential molecular testing for the three associated mutations (JAK2, CALR and MPL). As reactive causes of a thrombocytosis are for more common than ET, it is critical to exclude these. An iron profile is sent to ensure these are replete and rule iron deficiency out as a secondary cause, as well as CRP for inflammatory or infective causes. We perform a bone marrow biopsy if an MPN is confirmed, with the main objective being to confirm our diagnosis and determine the degree of marrow fibrosis at initial presentation.

Treatment

The aim of treatment is to reduce thrombotic complications and reduce risk of progression to myelofibrosis and to acute myeloid leukaemia.[10] All patients who are diagnosed with PV or ET should be started on low dose aspirin.[11] Efforts to reduce cardiovascular risk should be made, including controlling hypertension and smoking cessation. The decision on whether to start cytoreductive therapy depends on the risk category of the patient.[12]

Disease risk stratification is traditionally based on age and thrombotic history. In PV, two risk categories are considered: high (age > 65 years or thrombosis history present) and low (absence of both risk factors). In ET, three risk categories are considered: high (age > 60, history of thrombosis or platelets > 1,500), intermediate (age 40-60) and low (age < 40 years and no thrombosis history). Cytoreductive therapy in addition to antiplatelet therapy and cardiovascular risk control is recommended in high-risk patients. The target haematocrit in PV on cytoreductive therapy is < 0.45. The target platelet count in ET is < 400.

The two cytoreductive agents we commonly use as first-line treatment are hydroxycarbamide (HC) and pegylated interferon (peg IFN).[13] HC has traditionally been the front-line cytoreductive therapy for high-risk ET and PV patients. It is generally well tolerated but its teratogenic effects and risk of secondary skin cancers make it less attractive in the younger patient cohort. There are reports of HC increasing the risk of leukaemia with long-term use, but this is unproven in any clinical trials to date.[14]

Standard interferon therapy has been an option to inhibit myeloproliferation in MPNs for a long time but its use was limited due to its side effect burden.[15] The advent of longer acting peg IFN has made the use of interferon more tolerable, with lower discontinuation rates. It is given as a subcutaneous injection once a week. We use peg IFN as first-line for our younger MPN patients, especially females of childbearing age. These treatment options are discussed in more depth in the following case studies.

Conal Houstoun is a specialist registrar in haematology and Clodagh Keohane is a consultant haematologist, both at the Mercy University Hospital, Cork

References on request by email to: Nursing@medmedia.ie (Quote :Houstoun C & Keohane C. WIN2022; 30(6): 53)

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OTEZLA® (apremilast) 10mg, 20mg and 30mg film coated-tablets Brief Prescribing Information. Refer to the Summary of Product Characteristics (SPC) before prescribing. Further information is available upon request. Presentation: 10mg, 20mg and 30mg film coated-tablets. **Indications:** Psoriatic arthritis: OTEZLA, alone or in combination with Disease Modifying Antirheumatic Drugs (DMARDs), is indicated for the treatment of active psoriatic arthritis (PsA) in adult patients who have had an inadequate response or who have been intolerant to a prior DMARD therapy. Psoriasis: OTEZLA is indicated for the treatment of moderate to severe chronic plaque psoriasis in adult patients who failed to respond to or who have a contraindication to, or are intolerant to other systemic therapy including ciclosporine, methotrexate or psoralen and ultraviolet-A light (PUVA). **Dosage and administration:** Treatment with OTEZLA should be initiated by specialists experienced in the diagnosis and treatment of psoriasis or psoriatic arthritis. The recommended dose of OTEZLA is 30mg twice daily taken orally in the AM and PM, approximately 12 hours apart, with no food restrictions. The film-coated tablets should be swallowed whole. An initial dose titration is required per the following schedule: Day 1: 10mg in the AM; Day 2: 10mg in the AM and 10 mg in the PM; Day 3: 10mg in the AM and 20mg in the PM; Day 4: 20mg in the AM and 20mg in the PM; Day 5: 20mg in the AM and 30mg in the PM; Day 6 and thereafter: 30mg twice daily in the AM and PM. No re-titration is required after initial titration. If patients miss a dose, the next dose should be taken as soon as possible. If it is close to the time for their next dose, the missed dose should not be taken and the next dose should be taken at the regular time. Patients with severe renal impairment: The dose of OTEZLA should be reduced to 30mg once daily in patients with severe renal impairment (creatinine clearance of less than 30mL per minute estimated by the Cockcroft-Gault equation). For initial dose titration in this group, it is recommended that OTEZLA is titrated using only the AM doses and the PM doses be skipped. Paediatric population: The safety and efficacy of OTEZLA in children aged 0 to 17 years have not been established. No data is available. **Contraindications:** Hypersensitivity to the active substance(s) or to any of the excipients. OTEZLA is contraindicated in pregnancy. Pregnancy should be excluded before treatment can be initiated. **Special warnings and precautions:** Diarrhoea, nausea and vomiting: Severe diarrhoea, nausea, and vomiting associated with the use of OTEZLA have been reported. Most events occurred within the first few weeks of treatment. In some cases, patients were hospitalized. Patients 65 years of age or older may be at a higher risk of complications. Discontinuation of treatment may be necessary. Psychiatric disorders: OTEZLA is associated with an increased risk of psychiatric disorders such as insomnia and depression. Instances of suicidal ideation and behaviour, including suicide, have been observed in patients with or without history of depression. The risks and benefits of starting or continuing treatment with OTEZLA should be carefully assessed if patients report previous or existing psychiatric symptoms or if concomitant treatment with other medicinal products likely to cause psychiatric events is intended. Patients and caregivers should be instructed to notify the prescriber of any changes in behaviour or mood and of any suicidal ideation. If patients suffered from new or worsening psychiatric symptoms, or suicidal ideation or suicidal attempt is identified, it is recommended to discontinue treatment with OTEZLA. Severe renal impairment: See dosage and administration section. Underweight patients: OTEZLA may cause weight loss. Patients who are underweight at the start of treatment should have their body weight monitored regularly. In the event of unexplained and clinically significant weight loss, these patients should be evaluated by a medical practitioner and discontinuation of treatment should be considered. Lactose content: Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicinal product. **Interactions:** Co-administration of strong cytochrome P450 3A4 (CYP3A4) enzyme inducer, rifampicin, resulted in a reduction of systemic exposure of OTEZLA, which may result in a loss of efficacy of OTEZLA. Therefore, the use of strong CYP3A4 enzyme inducers (e.g. rifampicin, phenobarbital, carbamazepine, phenytoin and St. John's Wort) with OTEZLA is not recommended. In clinical studies, OTEZLA has been administered concomitantly with topical therapy (including corticosteroids, coal tar shampoo and salicylic acid scalp preparations) and UVB phototherapy. OTEZLA can be co-administered with a potent CYP3A4 inhibitor such as ketoconazole, as well as with methotrexate in psoriatic arthritis patients and with oral contraceptives. **Pregnancy, lactation and fertility:** Women of childbearing potential should use an effective method of contraception to prevent pregnancy during treatment. OTEZLA should not be used during breast-feeding. No fertility data is available in humans. **Undesirable effects:** Psychiatric disorders: In clinical studies and post-marketing experience, uncommon cases of suicidal ideation and behaviour, were reported, while completed suicide was reported post-marketing. The most commonly reported adverse reactions with OTEZLA in these indications are gastrointestinal (GI) disorders including diarrhoea (15.7%) and nausea (13.9%). These GI adverse reactions generally occurred within the first 2 weeks of treatment and usually resolved within 4 weeks. Adverse reactions reported in the psoriatic arthritis and/or psoriasis clinical trial programme and post marketing experience include: very common (≥ 1/10) diarrhoea*, nausea*; common (≥1/100 to <1/10) bronchitis, upper respiratory tract infection, nasopharyngitis*, decreased appetite*, insomnia, depression, migraine*, tension headache*, headache*, cough, vomiting*, dyspepsia, frequent bowel movements, upper abdominal pain*, gastroesophageal reflux disease, back pain*, fatigue; uncommon (≥1/1,000 to <1/100) hypersensitivity, suicidal ideation and behaviour, gastrointestinal haemorrhage, rash, urticaria, weight loss; not known (cannot be estimated from the available data) angioedema. *At least one of these adverse reactions was reported as serious. Please consult the SPC for a full description of undesirable events. **Pharmaceutical Precautions:** Do not store above 30°C. **Legal category:** POM. **Presentation and Marketing Authorisation Numbers:** Initiation pack containing 27 film coated tablets (4 x 10mg, 4 x 20mg, 19 x 30mg) - EU/1/14/981/001; 30mg film coated tablets in a pack size of 56 tablets - EU/1/14/981/002. **Marketing Authorisation Holder:** Amgen Europe B.V. Minervum 7061, 4817 ZK Breda, The Netherlands. Further information is available from Amgen Ireland Limited, 21 Northwood Court, Santry, Dublin D09 TX31. OTEZLA is a trademark owned or licensed by Amgen Inc., its subsidiaries, or affiliates. **Date of preparation:** April 2020 (Ref: IE-OTZ-2000019).

Adverse reactions/events should be reported to the Health Products Regulatory Authority (HPRA) using the available methods via www.hpra.ie. Adverse events should also be reported to Amgen Limited on +44 (0)1223 436441.

† Otezla met the primary endpoint of the pivotal trials in psoriasis: PASI-75 response vs placebo at 16 weeks. **ESTEEM 1:** 33.1% (N=562) vs 5.3% (N=282); **ESTEEM 2:** 28.8% (N=274) vs 5.8% (N=137), P<0.0001. OTEZLA met the primary endpoint of the pivotal trials in Psoriatic Arthritis: ACR 20 response vs placebo at 16 weeks. **PALACE 1:** 38% (N=168) vs 19% (N=168), P≤0.001. **PALACE 2:** 32% (N=162) vs 19% (N=159) P≤0.01; **PALACE 3:** 41% (N=167) vs 18% (N=169) P≤0.001.[2]

References: 1. Kavanaugh *et al.* Arthritis Research & Therapy 2019: 21;118. **2.** OTEZLA (apremilast). Summary of Product Characteristics.

Amgen Ireland Ltd., 21 Northwood Court, Santry, Dublin 9

IE-OTZ-0820-00002 | Date of preparation: September 2020

AMGEN®

Psoriasis focus

WIN takes a look at some new findings in psoriasis research recently published in the journals

Covid-19 and psoriasis: biologic treatment and challenges

COVID-19 enters the cells and infects them by binding to angiotensin-converting enzyme 2 (ACE2), a counter regulator of renin angiotensin aldosterone system. In response to infection, T cell activation along with massive production and release of cytokines (cytokine storm), can result in damage to organs, mainly lungs.

In severely affected patients with Covid-19, the levels of many cytokines including interleukin (IL)-17 and tumour necrosis factor-alpha (TNF-α) are increased. Researchers sought to establish if the biologic agents used in treatment of moderate to severe psoriasis that block IL-17 or TNF-α might ameliorate or prevent the cytokine storm that damage the lungs in patients with Covid-19.

Psoriasis is a chronic inflammatory immune mediated skin disease affecting around 2% of world's population. This systemic inflammatory disease is associated with a number of comorbidities such as hyperlipidaemia, increased body mass index (BMI), type 2 diabetes, hypertension and coronary artery disease, and increased mortality. Cytokines such as TNF-α, IL-12, IL-17 and IL-23 are involved in the pathogenesis of the disease and are targets of therapy. Systemic therapies with small molecules (methotrexate, cyclosporin A, and retinoids) and biologic drugs are among the therapies of patients with moderate to severe psoriasis.

Biologic drugs are complex engineered molecules that can target specific inflammatory pathways (TNF signalling and IL-23/Th17 axis) causing psoriasis. Biologic medications for psoriasis generally should be taken continuously; stopping biologic therapy may lead to psoriasis flares. Biologic agents are more specific immune inhibitors than methotrexate or cyclosporine and may not interfere with host defense against viral infection. There is concern that drugs used in treatment of some patients with psoriasis may increase the risk and severity of infection with Covid-19. On the other hand, biologic agents blocking IL-17 or TNF-α might ameliorate the immune response and prevent the cytokine storm damaging lungs in Covid-19. The researchers performed a literature review to identify and analyse the relevant reports in psoriatic patients on the biologics in this period of Covid-19 outbreak to assess whether patients with psoriasis on biologic therapy are more susceptible to SARS-CoV-2 infection and if they are at risk of greater severity of Covid-19.

They searched PubMed for the key term of 'psoriasis biologic and Covid-19'. In spite of limitations in some reports, all papers were included in this review. According to 8,769 medical reports around 0.3% of psoriatic patients had Covid-19 and the rate of hospitalisation was 0.1%. No death due to Covid-19 was reported among 10,509 patients. Reports indicated psoriatic patients on biologics were not more susceptible to Covid-19 and the severe clinical course of disease.

While there was no definitive controlled trial data, the available evidence suggests that patients with psoriasis without Covid-19 can continue the biologic therapy for psoriasis.

DOI 10.1080/09546634.2020.1789051

Patients with psoriasis have a dysbiotic taxonomic and functional gut microbiota

Accumulating evidence supports the findings of an altered gut microbiota in patients with autoimmune disease. However, existing studies on the role of the gut microbiota in patients with psoriasis have demonstrated conflicting results and have mainly been based on 16s rRNA gene sequencing analysis. Researchers aimed to examine whether the gut microbiota of patients with psoriasis was altered in composition and functional potentials compared with healthy controls. A further aim was to investigate relationships to disease severity, and seasonal impact on the gut microbiota.

In a case-control study, 126 faecal samples were collected from a sample of 53 systemically untreated patients with plaque psoriasis; 52 healthy controls matched for age, sex and BMI; and 21 cohabitant partners. A subpopulation of 18 patients with psoriasis and 19 healthy controls continued in a longitudinal study, where four to six faecal samples were collected over nine to 12 months. The gut microbiota was characterised using shotgun metagenomic sequencing analysis.

A significantly lower richness ($p = 0{\cdot}007$) and difference in community composition ($p = 0{\cdot}01$) of metagenomic species was seen in patients with psoriasis compared with healthy controls, and patients with psoriasis had a lower microbial diversity than their partners ($p = 0{\cdot}04$). Additionally, the functional richness was decreased in patients with psoriasis compared with healthy controls ($p = 0{\cdot}01$) and partners ($p = 0{\cdot}05$).

Increased disease severity was correlated with alterations in taxonomy and function, with a slight tendency towards a lower richness of metagenomic species, albeit not significant ($p = 0{\cdot}08$). The seasonal analysis showed no shifts in community composition in healthy controls or in patients with psoriasis.

The findings of a different gut microbiota in composition and functional potentials between patients with psoriasis and healthy controls support a linkage between the gut microbiota and psoriasis. These findings need to be validated in larger studies, and a potential causal relationship between the gut microbiota and psoriasis still needs to be shown.

DOI 10.1111/bjd.21245

Eliminating hepatitis

In advance of World Hepatitis Day 2022, the World Health Assembly has restated its aim to eliminate viral hepatitis by 2030

AT THE recent World Health Assembly, member countries recommitted to eliminate viral hepatitis by 2030. The World Health Assembly is the decision-making body of WHO. It is attended by delegations from all WHO member states and focuses on a specific health agenda prepared by the executive board.

Since the initial historic commitment in 2016, the Sustainable Development Goals 2020 target of reducing the prevalence of hepatitis B in children under five years to under 1% has been met globally and in most WHO regions. In addition, the number of people receiving treatment for hepatitis C has increased 10-fold to more than 10 million.

However, globally more than 350 million people are still living with this life-threatening disease. The gains made have been uneven across the world, with those most impacted often least likely to benefit. Few babies have access to the hepatitis B birth dose vaccine in many low- and middle-income countries, with less than 10% in Africa receiving a timely vaccine.

Additionally, infection and prevention control in healthcare settings needs further improvements and harm reduction remains insufficiently scaled up and accessible. Stigma and discrimination continue to be a barrier to testing and care. Only 10% and 21% of people know that they live with chronic hepatitis B or hepatitis C respectively, even fewer receive treatment, and liver cancer related to hepatitis is on an exponential rise especially in low- and middle-income countries. Furthermore, acute hepatitis A and E continue to impact people's health all over the world.

"Hepatitis is one of the most devastating diseases on earth, but it's also one of the most preventable and treatable, with services that can be delivered easily and cheaply at the primary health care level," said Dr Tedros Adhanom Ghebreyesus, WHO director general.

"Many of the reasons people miss out on those services are the same reasons they miss out on services for other health challenges – accessibility and affordability, because of who they are, where they live or how much they earn. We call on all countries to commit to realising the dream of eliminating viral hepatitis by 2030, as part of a broader commitment to universal health coverage based on strong primary healthcare."

Most recently, in the months leading up to the recent World Hepatitis Summit, some 700 cases of sudden and unexplained hepatitis in young children have come under investigation in 34 countries. Symptoms of this acute hepatitis come on quickly, leading to a high proportion of children developing liver failure with a few requiring liver transplants.

The participants of the summit believe that the new 'Global Health Sector Strategies (GHSS) on HIV, viral hepatitis and sexually transmitted infections, 2022-2030', provides an opportunity to refocus global efforts, accelerate the response and recommit to the elimination of viral hepatitis by 2030.

To make the elimination of hepatitis a reality within evolving health systems, we call on countries, global partners and other stakeholders to act now to achieve the 2025 and 2030 targets by developing and implementing national hepatitis strategies which address the five strategic directions of the GHSS and put people living with viral hepatitis at the heart of the response.

The WHO has asked that multisectoral action, which recognises civil society as an integral partner, is taken to operationalise hepatitis programmes which promote integration, decentralisation and task shifting to improve access.

The organisation has called on governments, global health agencies and donors to honour commitments already made and further commit to prioritise and fund comprehensive hepatitis programmes so that everyone, everywhere, has access to affordable prevention, testing, treatment and care.

Hepatitis CAN'T WAIT!

With a person dying every 30 seconds from a hepatitis related illness – even in the current Covid-19 crisis – we **can't wait** to act on viral hepatitis

People living with viral hepatitis unaware **can't wait** for testing

People living with hepatitis **can't wait** for life saving treatments

Expectant mothers **can't wait** for hepatitis screening and treatment

Newborn babies **can't wait** for birth dose vaccination

People affected by hepatitis **can't wait** to end stigma and discrimination

Community organisations **can't wait** for greater investment

Decision makers **can't wait** and must act now to make hepatitis elimination a reality through political will and funding

World Hepatitis Day

World Hepatitis Day

World Hepatitis Day takes places every year on July 28 to raise awareness of the global burden of viral hepatitis and to influence real change. In 2022 the theme is 'Hepatitis Can't Wait' *(see panel)*.

World Hepatitis Day is a day for the international hepatitis community to unite and make their voices heard. It's a day to celebrate the progress that has been made and to meet the current challenges. It's also an opportunity to raise awareness and encourage political change to jointly facilitate prevention, diagnosis and treatment.

For more information on World Hepatitis Day visit: **www.worldhepatitisday.org/**

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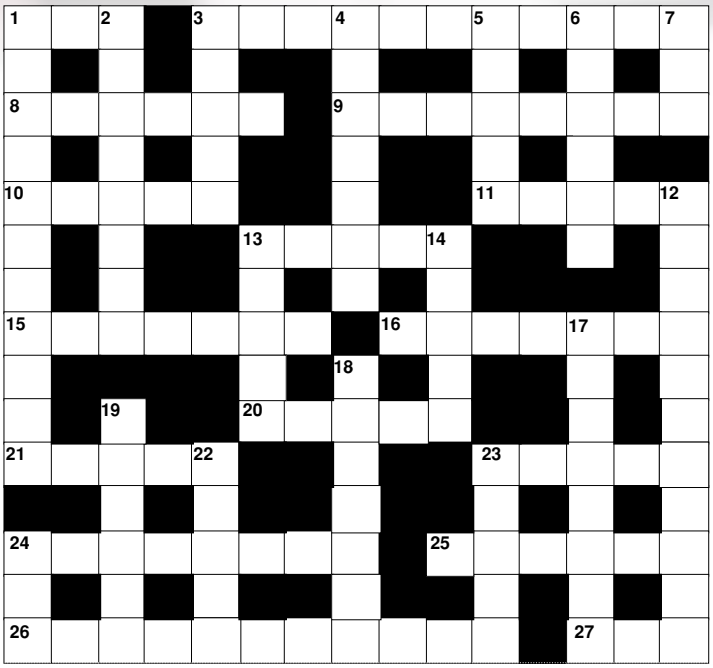
CROSSWORD Competition

Across

1 Medically qualified Disney dwarf? (3)
3 Might one be let murder by this laundry machine? (6-5)
8 Synthetic compound such as heroin or fentanyl (6)
9 Press (8)
10 Spirit in Shakespeare's Tempest, or Disney's Little Mermaid (5)
11 One may glean this ancient Greek was a pioneer of medicine (5)
13 Roman goddess of the hearth (5)
15 Relating to the religion that worships Allah (7)
16 Gift token (7)
20 What's mature looks right in a dress (5)
21 Sheltered port (5)
23 It can be measured in fathoms (5)
24 Drug found in cigarettes (8)
25 Challenge during a match (6)
26 Bulk up, increase one's body mass (3,2,6)
27 Furrow or groove in the ground (3)

Down

1 Make an error in needlework, on seeing the hit postcard being circulated (4,1,6)
2 & 3 Lilac car lit in chaos? It's part of a scientific investigation (8,5)
4 For the reason that (7)
5 Sort out the IT programme's problems – otherwise budge (5)
6 On an annual basis (6)
7 & 17d Flowering plant named for a fireside implement (3,3,5)
12 Hunts merino like this for the goodness of food (11)
13 Competing; contending (5)
14 Oak nut (5)
17 See 7 down
18 Historic site of volcanic destruction in Italy (7)
19 Covet a disorientated bird (6)
22 No imperial weight? That's out of the question! (3,2)
23 Gave out cards (5)
24 A sharp bite (3)



Name:

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You can email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included putting *'Crossword Competition'* in the subject line. Closing date: **August 19, 2022.**
If preferred you can post your entry to: WIN Crossword, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Dublin, A96E096

June crossword solution

Across: 1.Daredevils 6 Scab 10 Large intestine 12 Feasted 15 Freud 17 Argo 18 Oars 19 Rumen 21 Stacked 23 Ashen 24 Waif 25 Oman 26 Femur 28 Glasses 33 Untreated 34 Extol 35 Help 36 Interfered

Down: 1 Dill 2 Rare-earth metal 3 Dregs 4 Voile 5 Lath 7 Chile 8 Breadknife 9 Ashford 13 Text 14 Dancing 16 Royal flush 20 Meat-eater 21 Snorkel 22 Emma 29 Lodge 30 Shelf 31 Stun 32 Fled

The winner of the June crossword is: Regina McDonagh, Ennis, Co Clare

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NEW

INMO Community Intervention Team Networking Group

Members who are working as part of the CIT are interested in establishing a networking group for nurses & midwives.

The initial function of this group is to heighten awareness and increase recognition for this important role .

For those working in CIT and interested in getting involved please contact **Jean.Carroll@inmo.ie**

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Operating Department Nurses Section CONFERENCE

IN-PERSON EVENT
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Saturday
8
OCTOBER

The Operating Department Nurses section are delighted to announce they will be hosting an in-person conference:

on
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in
The Limerick Strand Hotel, Limerick City

Full educational programme will issue in the coming weeks

CONTACT: **Jean Carroll, Section Development Office for further information or www.inmoprofessional.ie/conference**

Necessity is the mother of invention

Public health nurses win top award for innovative 'Wee Catch It' idea

TWO public health nurses at the Department of Public Health Mid-West have received a top award in recognition of their innovative idea to collect urine samples in a cleaner way in order to improve diagnosis and rates of infections.

Bernadette Higgins, assistant director of nursing (ADON) and Anne Murray, CNM2 in health protection, won the National Spark Ignite award and €3,000 seed funding for their 'Wee Catch It' idea, at the recent annual Spark Innovation Programme conference held in Dublin

The Spark Ignite award seeks innovative ideas from the 115,000+ HSE employees aiming to improve patient and healthcare outcomes. Spark Ignite is open to all disciplines and departments within the HSE, enabling staff to develop their ideas through validation of clinical need and to determine the market for their proposed solution, product or service. Successful applicants also receive guidance on how to bring their ideas towards reality.

Collecting a clean, accurate midstream urine in babies, children and adults with incontinence in an efficient and hygienic way is challenging, this can lead to contamination of samples and often results in unnecessary antibiotic prescribing and costly unplanned hospital admissions.

Necessity being the mother of invention, Ms Higgins came up with a solution to improve the 'clean catch' urine samples and targeting antimicrobial stewardship with 'Wee Catch It'.

Public Health Mid-West's CNM2 Anne Murray (left) and ADON Bernadette Higgins pictured with the National Spark Ignite award which they won, alongside €3,000 seed funding for their 'Wee Catch It' innovation idea, at the annual Spark Innovation Programme conference in June

Ms Higgins and Ms Murray had previously won the Regional Spark Ignite award and €3,000 seed funding in early June. 'Wee Catch It' is currently in prototype development phase and the public health nurses will now work towards developing the unique product and software for national and international use.

Bernadette Higgins, ADON, who hails from Longford and lives in Clare, said that she is delighted with the recognition and looks forward to taking the idea to the next stage.

"We are an example of how passionate, creative nurses are in an ideal position to invent and develop ideas as we spend more time with patients. Nurses have a wealth of knowledge of how products work and can make patients and healthcare workers' lives better," said Ms Higgins.

"Nurses have always been unintentional innovators. Improvising, moulding and tweaking what was available to us. They bring true meaning to the phrase 'necessity is the mother of invention' in their efforts to optimise the care they give.

"As a parent, I know the distress of trying to get a urine sample from a baby. As nurses, our patients are the centre of all we do. We want to be able to deliver the best patient experience we can in an effective, efficient, simple, comfortable, safe and cost effective way. 'Wee Catch It' does all this. The idea is that it will improve the process for the healthcare worker, provides education, promotes appropriate and timely treatment, and reduces the risk of harm to the patient and the wider population," said Ms Murray.

Sun shines at Adare Manor for Irish Nurses and Midwives Golf Society tournament as €1,000 donated to Alzheimer charity

On May 27 the Irish Nurses and Midwives Golf Society met and enjoyed a wonderful day of golf at Adare Manor Golf Club, Co Limerick. After two tough years for the professions it was wonderful to hit the fairways together again. Some 105 male and female golfers from all four provinces played on the day. A donation of €1,000 was made to Adare Alzheimer Centre.

Ann Noonan, Golf Society member, said: "The sun shone beautifully and great scores were registered. We, as a committee, were delighted to display our beautiful course to all and got great feedback from the day. Míle buíochas to all our generous sponsors for our beautiful prizes."

The winners of the tournament were Gillian Dawn from Rathdowney Golf Club in first place, Ann Noonan from Adare Manor Golf Club in second place, Breda Edwards from Rathbane Golf Club in third place, with best gross won by Margaret Naughton of Castlebar Golf Club.

The next Golf Society event will take place in Ballinasloe in 2023.

Pictured (l-r) were: Ann Noonan, Marian Noonan, Kathy Keegan, Helen Carroll, Rita Maher, society captain 2022, and Paula Masterson, Adare Manor Golf Club lady's captain 2022

July

Saturday 2
International Nurses Section
Culture Fest. The Richmond Education and Event Centre from 11am. Bookings essential

Monday 18
National Childrens Nurses Section meeting. 11am on Zoom

Monday 18
Nurse Midwife Education Section meeting on Zoom

September

Saturday 3
Midwives Section meeting. 9.30am

Tuesday 6
Retired Section trip to Kilkenny. Depart Heuston Station 10.30am. Meet at Kilkenny Castle 2.30pm. Depart Kilkenny 7.15pm. Optional dinner, bed and breakfast at River Court Hotel. €180 per room. Contact Ann Gee, Tel: 087 1459289

Saturday 10
Special Education Section meeting. 10am via Zoom

Saturday 10
PHN Section meeting. 10.30am via Zoom

Tuesday 13
Retired Section meeting. The Richmond Education and Event Centre from 11am-1pm

Wednesday 14
Operating Department Nurses (ODN) Section meeting. 7pm on Zoom

Tuesday 20
Care of the Older Person (COOP) Section webinar. 11am-1pm

Wednesday 21
Community Intervention Team Networking Group meeting. 11am via Zoom

Wednesday 28
Telephone Triage Section conference. Portlaoise

October

Tuesday 4
COOP Section meeting. 2pm on Zoom

Thursday 6
Occupational Health Nurses Section conference. The Richmond Education and Event Centre. Bookings essential

Saturday 8
ODN Section conference. Limerick Strand Hotel. Bookings essential

Saturday 8
School Nurses Section conference. Midlands Hotel, Portlaoise. 10am

Wednesday 19
Clinical Placement Co-ordinators Section seminar

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

INMO Membership Fees 2022

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

Condolences

- We recently learned of the passing of Christy Lizardo who worked at Bellvilla Community Unit for more than 20 years. Ms Lizardo was a member of the International Section and the Dublin Southwest Branch. We extend our sympathies to her friends, family and colleagues. She will always be remembered for her dedication and friendliness. May she rest in peace.
- We extend our deepest condolences to Rhona Ledwidge on the passing of her beloved sister, Joyce. Our thoughts are with her family at this difficult time. May she rest in peace.

WIN Recruitment & Training

Mailed directly to Irish nurses and midwives every month

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

Saint Joseph's Shankill

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Share your passion in Dementia Care

CLINICAL NURSE MANAGER 2

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- Closing date July 15th 2022

You will make moments matter for people living with dementia.

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INVESTING IN VOLUNTEERS

Please send applications to elaine.byrne@sjog.ie
or for informal enquiries call 01-2823000
Scan the QR code for further information or at www.saintjosephsshankill.ie

A service of Saint John of God Hospital

Practice nurse required

- Full or part time practice nurse
- Hours negotiable
- Dublin 6 area
- Friendly practice
- Experience in immunisations, smear taking and phlebotomy essential.

Enquiries to **rathminesmedicalcentre@gmail.com**

Irish Cancer Society Nurses

The Irish Cancer Society are seeking registered nurses who can provide a minimum of six nights per month and have some palliative experience. Training will be provided.

- Job description on **www.cancer.ie**
- Email CV to **recruitment@irishcancer.ie**
- Informal enquiries to 01-231 0524 or **mferns@irishcancer.ie**

Irish Cancer Society

WIN

Don't forget to mention *WIN* when replying to advertisements

• **Next issue:** September 2022 • **Ad booking deadline:** Monday, August 22, 2022

• **Tel:** 01 271 0218 • **Email:** leon.ellison@medmedia.ie

Recruiting Staff Nurses – Medical, Surgical, ICU

Neuro Cent at Beaumont Hospital, Dublin is the national referral centre of Ireland for patients with neurological and neurosurgical conditions. It is also the location of the national cochlear implantation centre as part of our head and neck service.

Neurosciences is a fascinating and rewarding specialism. We are recruiting registered nurses and are interested in hearing from candidates with acute, community-based or overseas experience.

Join our exciting and supportive teams and we will support your journey through team working, educational opportunities (including postgraduate study), skills development and career pathways.

Contact: Cam Salcedo, Directorate Nurse Manager, Tel: +353 (0) 87 385 9439
Email: camilosalcedo@beaumont.ie

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Staff nurse positions are also available nationwide

Email enquiries to **jobs@bayada.ie**

Irish Nurses Rest Association

A committee of management representing the Guild of Catholic Nurses of Ireland, the INMO, the Association of Irish Nurse Managers and Director of Public Health Nursing exists to administer the funds of the Irish Nurses Rest Association. It's open for applications from nurses in need of convalescence or a holiday for a limited period who are unable to defray expenses they may incur or for the provision of grants to defray other expenses incurred in purchase of a wheelchair/other medical aids.

Please send applications to:
Ms Margaret Philbin, Rotunda Hospital, Dublin 1.
email: mphilbin@rotunda.ie

Read a good book recently? Write a review for *WIN*

Every month we publish a book review written by one of the *WIN* team or by an INMO member. It doesn't have to be nursing/midwifery related, but if you have read something that you found helpful to your practice, please consider writing a review for an upcoming issue of *WIN*.

Submit your review to nursing@medmedia.ie

Word count: 400

Breastfeeding: The best start

Health benefits for infants

Breast milk is the ideal food for newborns and infants. It gives them all the nutrients they need for healthy development. It is safe and contains antibodies that help protect infants from common childhood illnesses such as diarrhoea and pneumonia, the two primary causes of child mortality worldwide. Breast milk is readily available and affordable, which helps to ensure that infants get adequate nutrition.

Long-term benefits for children

Beyond the immediate benefits for children, breastfeeding contributes to a lifetime of good health. Adolescents and adults who were breastfed as babies are less likely to be overweight or obese. They are less likely to develop type 2 diabetes and perform better in intelligence tests.

Benefits for mothers

Breastfeeding also benefits mothers. It reduces risks of breast and ovarian cancer later in life, helps women return to their pre-pregnancy weight faster, and lowers rates of obesity.

Support for mothers is essential

Breastfeeding has to be learned and many women encounter difficulties at the beginning. Nipple pain, and fear that there is not enough milk to sustain the baby are common. Health facilities that support breastfeeding – by making trained breastfeeding counsellors available to new mothers – encourage higher rates of breastfeeding. To provide this support and improve care for mothers and newborns, there are 'baby-friendly' facilities in about 152 countries thanks to the WHO-UNICEF Baby-friendly Hospital initiative.

Work and breastfeeding

Many mothers who return to work abandon breastfeeding partially or completely because they do not have sufficient time, or a place to breastfeed, express and store their milk. Mothers need a safe, clean and private place in or near their workplace to continue breastfeeding. Enabling conditions at work, such as paid maternity leave, part-time work arrangements, on-site crèches, facilities for expressing and storing breast milk, and breastfeeding breaks, can help.

INMO
Irish Nurses and Midwives Organisation
Cumann Altraí agus Ban Cabhrach na hÉireann
Working Together

The Irish Nurses and Midwives Organisation supports breastfeeding
For more information log onto www.breastfeeding.ie

Bliss for babies born premature or sick | IHV Institute of Health Visiting | WaterWipes | Pure Foundation Fund | INMO | Irish Neonatal Health Alliance

WaterWipes® is proud to launch the third annual Pure Foundation Fund, a bursary fund in the United Kingdom and Ireland. For 2022, WaterWipes® is "Honouring our Great Protectors" – healthcare professionals involved in the pregnancy, birth, and postnatal journey. Nominations are now open!

About the Pure Foundation Fund

Healthcare professionals (HCPs) providing maternity, neonatal and postnatal care improve and save the lives of women and babies around the world. For pregnant women that have questions or concerns, HCPs take the time to really listen and understand their concerns, answer all questions great or small and provide comfort every step of the way. For nervous mothers giving birth, HCPs provide a calm presence and kindness to successfully usher them through their delivery. For new mums wondering if their baby is sleeping too much or eating enough, HCPs provide them with guidance and reassurance. When illness strikes or medical conditions arise, HCPs provide care and support during these critical and vulnerable moments. HCPs are the great protectors of our health and our future generations. That is why WaterWipes® wants to celebrate these extraordinary professionals by rewarding two winners, one from the UK and one from Ireland, with prizes.

How to Enter

Healthcare professionals in the United Kingdom and Ireland working in the fields of maternity or neonatology can self-nominate or nominate a colleague that has demonstrated outstanding care.

The deadline for entries is **30th June 2022** and the winners will be contacted via WaterWipes® PR agency, Fleishman Hillard, if they have been nominated.

The winning healthcare professionals will receive:

£10,000 (GBP) or €10,000 (EUROS) for their department to continue to improve the care of parents and babies

A bulk donation of WaterWipes® to the winner's organisation

A WaterWipes® Pure Foundation Fund plaque

A £100 or €100 One4All voucher

For further information about the Pure Foundation Fund or to submit a nomination, please visit:
https://www.waterwipes.com/uk/en/health-care/pure-foundation-fund-2022