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WIN

INMO
Journal of the Irish Nurses and Midwives Organisation

World of Irish Nursing & Midwifery

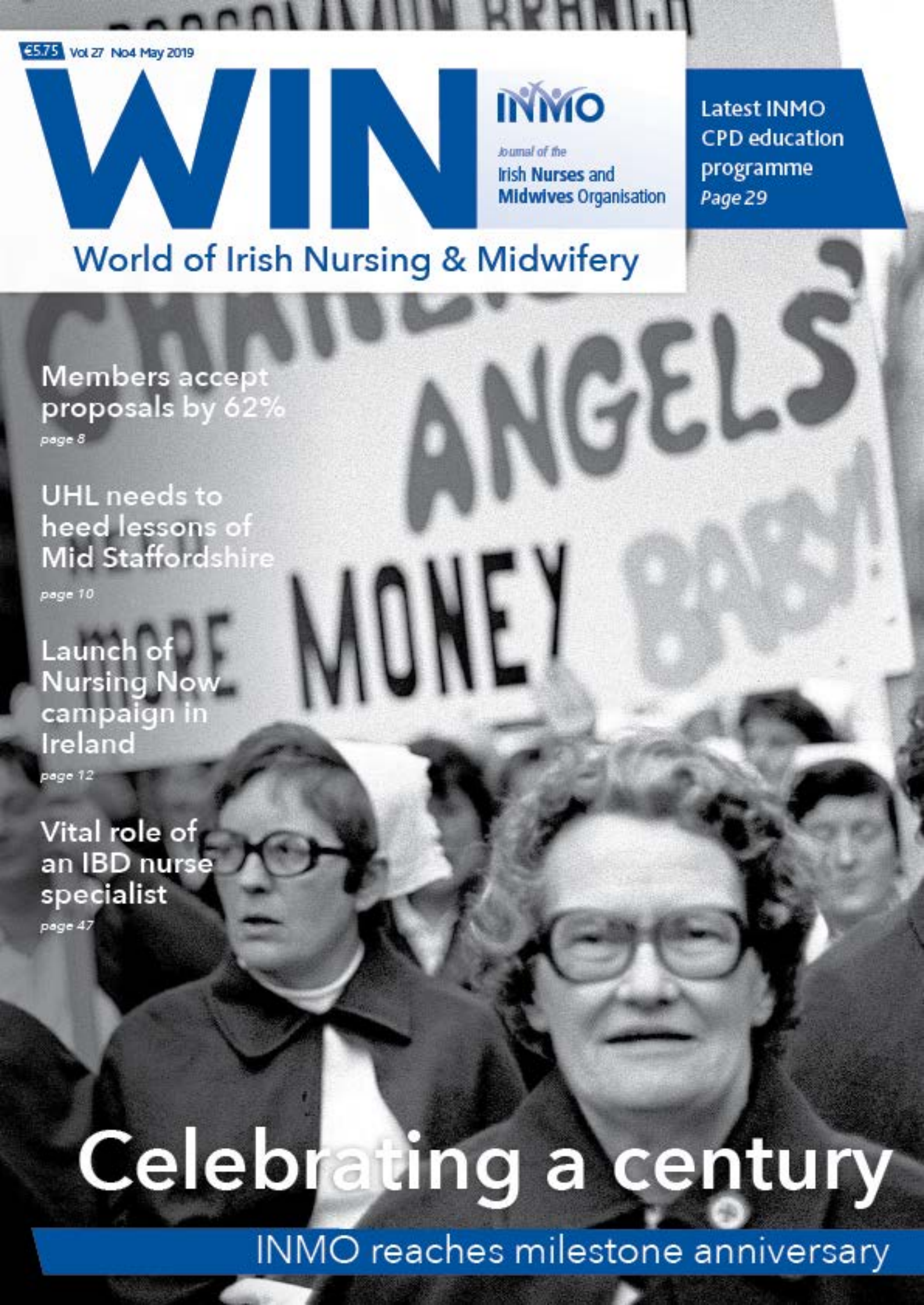
Latest INMO CPD education programme
Page 29

Members accept proposals by 62%
page 8

UHL needs to heed lessons of Mid Staffordshire
page 10

Launch of Nursing Now campaign in Ireland
page 12

Vital role of an IBD nurse specialist
page 47



Celebrating a century

INMO reaches milestone anniversary

Cover image *by Derek Speirs: 'Charlie's Angels' on 'The Big March' in 1980 – as pictured on the cover of 'A Century of Service: A History of the Irish Nurses and Midwives Organisation 1919-2019' by Mark Loughrey (see page 23)*

NEWS & VIEWS

FEATURES

CLINICAL

LIVING

JOBS & TRAINING

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Hard won progress for our professions

AT THE time of going to print, the count of ballots has just been completed. 62% have voted to accept the proposals.

These proposals represent substantial progress for our professions. Tens of thousands of nurses and midwives will see their pay increase, with more to come for management grades. More will get allowances which they were not previously eligible for, all allowances will increase, and there will be additional promotional opportunities for nurses and midwives.

Crucially, we now have funding for the safe staffing framework – a mechanism that allows us to secure appropriate staff numbers based on patient dependency and skill mix. For the first time ever, we will have a scientific method to determine how many nurses are needed and move away from only providing the staffing that budgets allow.

We did not gain this progress because we asked for it. We gained this because YOU fought for it. For three days, INMO members stood proudly on the pickets and in services providing emergency care.

We used our collective unity, organisational discipline and public support. Through our unity, we brought a reluctant government to the negotiating table. Where individually we are often ignored, together we are strong.

We will now focus on implementing the proposals fully and ensuring that the employer lives up to their side of the bargain. These proposals were hard won – we must ensure they become reality without delay. The INMO will use this progress as a base from which to campaign to further improve conditions for our professions and our patients.

Over the past months of this campaign, I've attended meetings with members across the country. One thing was clear: our members' faith in the public sector employers is at an all-time low.

There is rightly a deep anger and frustration at the conditions in which nurses and midwives are forced to work. There is a large gap between the care we are trained to provide, and what we can actually offer in practice.

These proposals will not resolve all our problems – no single solution ever could. But they will make substantial improvements to your working lives and encourage more nurses and midwives to practise in Ireland.

I wish to thank the nurses and midwives on our strike committees, our reps and members for their incredible dedication and hard work over the past months. They have worked long hours, in difficult conditions, under immense pressure, often on top of their day jobs. The manner in which this strike was conducted demonstrated the very best of nursing and midwifery. Patient safety was protected and your workplace committees ran things with precision and skill.

Thanks are also due to our president, elected officers and Executive Council for their tireless work and brave decisions throughout this dispute. I would also like to thank our colleagues in other unions for their solidarity – especially Patricia King in ICTU, who gave us great assistance.

We are also grateful to the Labour Court and the Workplace Relations Commission for their considerable efforts to resolve this dispute. We also owe the public a debt of gratitude. We work hard for them when they need us, but when we went on strike, they were with us all the way. From passing beeps to hot drinks, it was clear that the public stood firmly with nurses and midwives.

As this dispute concludes, I would encourage everyone to remain fully engaged in our union. As professionals with a common interest, we can only move forward together. Striking is the most visible part of union work, but the day-to-day democracy and care for your fellow members is key to improving our workplaces, livelihoods and conditions for patients.

Phil Ní Sheaghdha
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

Centenary delegate conference

AT THE time of print, we are making the final preparations for our centenary delegate conference. The recent ballot results and strikes will no doubt feature heavily in discussions. It will also be a time to reflect on our wider priorities as a movement, as we celebrate our 100th year. The health service and our workplaces have changed dramatically over the past century – and will clearly do so again in the coming one. Sláintecare, in particular, will change the form our health service takes. It is vital that nurses and midwives are at the centre of policy discussions around these changes. But some things do not change; our values remain clear and consistent throughout both centuries. Skilled, dedicated care for our patients is one for all nurses and midwives. Support for colleagues and belief in our collective, unified strength is another for any union member.

Nursing Now launch

NURSING Now is a global campaign to raise the profile and status of nurses. The INMO is the lead organisation of the campaign in Ireland. The campaign aims for recognition of nurses' contribution to healthcare, gender equality, and wider society. Its aims include greater investment in nursing, more nurses in leadership positions, and increasing nurses' input and impact on healthcare. Launching the campaign in the old Richmond Hospital in April, I was proud to see international nursing experts speak alongside nurses from Ireland – including student nurse Roisin O'Connell, intellectual disabilities nurse Ailish Byrne, and Shirley Ingram, an ANP in cardiology. The launch event heard from Elizabeth Adams, president of the European Federation of Nurses, Dame Christine Beasley, Nursing Now board member, and Howard Catton, interim CEO of the International Council of Nurses. This could not be occurring at a more opportune time for this campaign, as Ireland's nurses and midwives clearly need to develop a strong voice in our health service and in the coming reforms.

Centenary planning meetings

THE INMO's centenary is a major milestone. We started celebrations with an event for members in Dublin's Mansion House. Our centenary annual delegate conference in Trim will see further celebrations, including the launch of Mark Loughrey's excellent INMO history book, *A Century of Service*, along with the centenary badges being awarded to the hundreds of delegates at the conference. A final plank of celebrations will be announced at the conference. I would encourage all branches and sections to get in involved – it's not often an organisation has its 100th anniversary.

EFN General Assembly, Brussels

WHILE things have been busy on the home front, the INMO continues to represent members internationally. The European Federation of Nurses (EFN) held its General Assembly in April in Brussels. One of the topics we focused on was the future of the European Nurses Research Foundation, founded in 2016, which is the research arm of the EFN. I represented the INMO on a working group to re-examine its business model and governance. We made recommendations to address previous concerns, which were agreed by the assembly. The EFN also agreed to share information about salary negotiations internationally, to improve practice across Europe. The EFN is in the process of nominating two directors, more details of which can be found on their website, with elections taking place on June 17 and 18. The EFN's presidential elections are scheduled for October 2019 and the sitting president Elizabeth Adams (an INMO member) is eligible to run for a further two-year term. At the Brussels meeting, I expressed our thanks to the EFN for its support to striking INMO members in the recent industrial action, and update our international colleagues on the progress made since.

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

Quote of the month

"The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little."

- Franklin D Roosevelt

Report from the Executive Council

THE Executive Council met on a number of additional occasions this year on earlier dates than scheduled, largely due to the industrial dispute over recruitment and retention. But as they say the show must go on, so the Executive must also deal with the usual day-to-day organisational issues. At the time of going to print, we were engaged in the last stages of planning our centenary annual delegate conference (ADC). The Executive deliberated over the 34 submitted motions – 17 of which were on industrial affairs.

Many of your branches and sections have met to discuss the motions, debate their contents, and select speakers. We will also have elections this year for the Standing Order committee, which is responsible for many of the ADC preparations. All of this preparation took place against the backdrop of balloting across the country, at many hundreds of balloting meetings running from April 8 to May 1. This is a longer time frame than usual to allow as many votes as possible..

I would like to thank all the IROs, staff, Exec members and volunteer reps for their work in seeing this democratic exercise through.

The next planned Executive Council meeting June 10-11.

Get in touch

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

St James's Hospital

INMO members vote by 62% to

Result a direct result of the hard fight by nurses and midwives for patient

INMO members have voted to accept the Labour Court proposals offered to resolve their industrial dispute earlier this year.

The ballot count returned a result of 62% in favour of the proposals, which include measures such as:

- A commitment to safe staffing levels, based on patient dependency
- A new, higher salary scale for staff nurses and midwives
- An independent expert group to look at pay for those in managerial grades
- Increased location and qualification allowances and an expansion of allowances to those working in acute surgical and medical areas and midwives working in maternity services
- Extra promotional opportunities for nurses and midwives, including a commitment that 2% of the nursing/midwifery workforce will be advanced practitioners
- Supports for professional development and education.

INMO nurses and midwives took strike action for three separate days – January 30, February 5 and 7.

Once the final proposals were agreed, voting was held in workplaces across Ireland, running from the April 8 to May 1, with the ballot count taking place in INMO HQ on May 2.

INMO general secretary Phil Ní Sheaghdha said: "INMO members fought hard for patient safety and staffing in a determined, controlled and collective manner. We are extremely proud of the safe, patient-focused strike organised by our strike committees.

"The government has committed to full implementation of these proposals. We are now seeking an immediate meeting with them to ensure this happens without delay.

"I want to thank our president, officers and Executive Council for their tireless work

Temple Street Children's Hospital

Cottage Hospital, Drogheda

Rotunda Hospital

University Hospital Galway

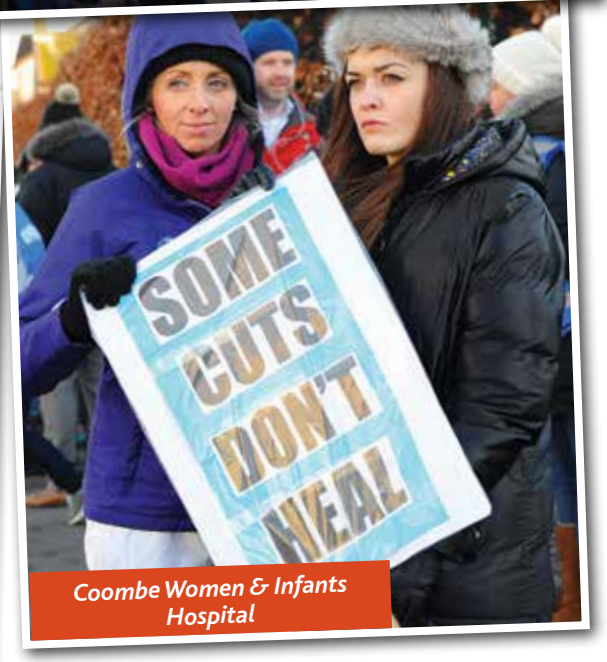
accept Labour Court proposals

safety and safe staffing levels

and brave decisions throughout this dispute. I would also like to thank our colleagues in other unions for their solidarity – especially Patricia King in ICTU, who gave us great assistance. We are also grateful to the Labour Court and the Workplace Relations Commission for their considerable efforts to resolve this dispute. Finally, I would like to thank the public who showed Ireland's nurses and midwives such support during our strike days."

Royal Victoria Eye and Ear Hospital

South Infirmary Victoria University Hospital



Coombe Women & Infants Hospital

University Hospital Limerick needs to heed the lessons of Mid Staffordshire

THE INMO wrote to the Oireachtas Committee on Health recently to outline grave concerns about a combination of issues at University Hospital Limerick.

This followed the INMO highlighting concerns about industrial relations problems in the hospital at the National Joint Council in March and also raising the matters at the Health Service Oversight Body last month.

These problems centre around the failure of hospital management to comply with the Protection of Employees (Information and Consultation) Act 2006 and subsequent health service/trade union agreement around engagement and consultation. The hospital management is disregarding the provisions of this agreement and also the terms of the Public Service Stability Agreement on such matters.

The INMO has also highlighted the significant clinical risk that exists within the hospital as a result of severe overcrowding. In recent weeks the number of patients on trolleys in the hospital reached 81, which is a new record.

This overcrowding ensures that the emergency department is packed full of admitted patients awaiting appropriate inpatient beds. Furthermore, the hospital places additional trolleys on inpatient hospital wards, creating a risk throughout the hospital.

The nationally agreed Escalation Policy requires that when the Full Capacity Protocol is utilised, ie. trolleys placed on a ward, the hospital must prioritise de-escalation immediately. However, the reality in Limerick is that hospital management is now using trolleys on wards as part of its normal bed capacity and the hospital has failed to de-escalate in the past two years. This is putting patients at risk as well as affecting the health, safety and wellbeing of nurses working in those areas.

Tony Fitzpatrick, INMO director of IR: *"The practices at UHL are putting patients at risk as well as affecting the health, safety and wellbeing of nurses working there"*

In addition, as part of the Full Capacity Protocol, day service areas and the medical assessment unit are also being used to accommodate admitted patients while, at the same time, expecting staff to continue to run operating lists. Again, this is creating significant risks and is not appropriate for the safe provision of care.

The clinical director of the hospital astounded members of the INMO recently when he was reported in the media as stating that there was no clinical risk within the department as a result of this overcrowding. The INMO and its members met with public representatives for the area in Dáil Eireann last month to outline the need for action on Limerick University Hospital. An external industrial relations and clinical review of the hospital is needed.

It is the clear view of the nursing staff that University Hospital Limerick is Ireland's Mid Staffordshire waiting to happen, if action is not taken. The INMO is seeking that the lessons from Mid Staffordshire are applied at University Hospital Limerick.

Florence Nightingale's guiding principles stated that the first job of any healthcare professional is to ensure the patients are safe and well cared for. Limerick nurses are speaking out for patients to ensure they are well cared for and insisting the senior managers in the HSE and Department of Health address these concerns. The failure of management to appropriately manage the hospital and comply with national agreements makes it an impossible environment for nursing staff to ensure that patients are safe and well cared for.

Furthermore, it is clear and INMO members have outlined that patients are trying to avoid attending UHL by instead presenting at South Tipperary General Hospital or Galway University Hospital. Practice nurses report that GPs and practice nurses have lengthy debates with patients when they indicate they wish to refer them to the acute facility.

There must now be a review of the standards of governance and performance within University Hospital Limerick. When patients and staff are articulating their concerns about the provision of care within this facility, then the political system as well as health service management must pay attention and take appropriate action.

If they do not then they have not learned the lessons of Mid Staffordshire and patients' lives and the health, safety and wellbeing of staff are at risk.

The Minister for Heath and the director general of the HSE must take action now to address these matters.

– Tony Fitzpatrick, INMO director of industrial relations

Lessons from Mid Staffordshire

THE *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*[1] identified numerous warning signs which could and should have alerted the system to the serious failings in healthcare that took place at the Trust. The report made many recommendations, with the essential aims to:

- Foster a common culture shared by all in the service of putting the patient first
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated
- Provide evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff who have to provide the service
- Ensure openness, transparency and candour throughout the system about matters of concern
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service
- Provide a proper degree of accountability for senior managers and leaders to place all with responsibility for protecting the interests of patients on a level playing field
- Enhance the recruitment, education, training and support of all key contributors to the provision of healthcare, in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do.

Launching the Nursing Now Ireland campaign in the Richmond Education and Event Centre last month were (l-r): Ailish Byrne, intellectual disabilities nurse with Muiriosa Foundation; Phil Ní Sheaghdha, INMO general secretary; Shirley Ingram, advanced nurse practitioner, Tallaght Hospital; Steve Pitman, INMO head of education and professional development; Elizabeth Adams, president, European Federation of Nurses Associations; Dave Hughes, INMO deputy general secretary; Dame Christine Beasley, trustee of the Burdett Trust for Nursing; Martina Harkin-Kelly, INMO president; Howard Catton, CEO, International Council of Nurses; Edward Mathews, INMO director of professional and regulatory services; and Roisin O'Connell, student nurse at Waterford Institute of Technology

Nursing Now launched in Ireland

Global campaign calls for greater government investment in nursing

NURSING NOW, a global campaign to improve health by raising the status of nursing, was launched in Ireland last month.

The worldwide campaign aims for the recognition of nurses' contribution to healthcare, gender equality, wider society and improved economies. Its aims include:

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

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

The launch of the Nursing Now Ireland campaign took place at the Richmond Education and Events Centre on April 25, 2019. The audience heard how the health challenges of the 21st century cannot be overcome without strengthening nursing. Speakers outlined how it is time to give nurses more recognition, investment and influence.

Nurses are at the heart of most health teams, playing a crucial role in health promotion, disease prevention and treatment. As the health professionals who are closest to the community, they have a particular role in developing new models of community-based care and supporting local efforts to promote health and prevent disease.

The INMO is leading the campaign in Ireland in partnership with University College Cork and Dublin City University. The patron for Nursing Now Ireland is Sr Stanislaus Kennedy, a visionary who has pioneered, campaigned, explored and developed a range of inspiring social innovations to benefit thousands of people who have experienced exclusion in its many forms.

Nursing Now is a three-year global campaign organised in collaboration with the International Council of Nurses (ICN) and the World Health Organization (WHO). Nursing Now is run by a campaign board comprising nurses and non-nurses from 16 countries. The campaign is a programme of the Burdett Trust for Nursing, with the Duchess of Cambridge as the international patron.

Nursing Now is based on the findings of the WHO's *Triple Impact* report, which concluded that as well as improving health globally, empowering nurses would contribute to improved gender equality – as the vast majority of nurses are women – and build stronger economies.

Pictured above (top): INMO president Martina Harkin-Kelly and director of professional and regulatory services Edward Mathews cut the cake to launch Nursing Now Ireland campaign. (lower pic, l-r): Fiona Hannon, student nurse, UCC; Neal Donohue, INMO student and new graduate officer; Sarah Collins, student nurse, UCC; and Roisin O'Connell, student nurse, WIT

Nursing Now calls on governments to invest in improving nurses' working conditions, training and leadership skills to enhance health, empower women and strengthen local economies.

Opening the launch of the campaign in Ireland INMO president Martina Harkin-Kelly said: "Patients and health staff can tell you – nurses are consistently undervalued. Nursing Now aims to change that, demonstrating the incredible work that nurses do worldwide. Not only are we the lynchpin of health services, nurses are a driving force in ensuring healthy lives and promoting wellbeing around the world."

Welcoming the guests and global speakers to the event, INMO director of professional and regulatory services Edward Mathews said: "Nursing and

Also at the launch were (l-r): Christine McDermott, ANP neonatology, Rotunda Hospital; Karen Brennan, ANP emergency department, South Tipperary General Hospital; and Daniela Lehwaldt, assistant professor and international liaison, School of Nursing and Human Sciences, Dublin City University

Ibukan Oyedele, staff nurse, Cherry Orchard Hospital, at the Nursing Now Ireland launch

Howard Catton, CEO, International Council of Nurses

nurses in leadership are changing the face of healthcare delivery in Ireland and worldwide. Innovative and effective developments in nurse-led and delivered healthcare are improving health outcomes and delivering more economic healthcare. Fundamentally, nurses are improving lives, our society and economies and we can do more when nurses are empowered to do their job."

Global speakers at the launch included: Howard Catton, ICN CEO; Elizabeth Adams, president of the European Federation of Nurses Associations (EFN); and Dame Christine Beasley, Nursing Now board member and trustee of the Burdett Trust for Nursing.

There were also three presentations to showcase the work and contribution of nurses from:

- Ailish Byrne, senior staff nurse (RNID) with the Muiriosa Foundation, who spoke about the role of nurses in caring for people with intellectual disabilities
- Shirley Ingram, advanced nurse practitioner at Tallaght Hospital, who provided an outline of her role as a specialist in chest pain and assessment
- Roisin O'Connell, student nurse (intern) at Waterford Institute of Technology, who outlined her experience as student nurse and her expectations and hopes as a nurse.

Running until the end of 2020, the bicentenary of Florence Nightingale's birth and the WHO Year of the Nurse, the Nursing Now campaign aims to improve perceptions of nurses, enhance their influence and maximise their contributions to ensuring that everyone everywhere has access to health and healthcare.

For further information **visit www.inmo.ie** or **www.nursingnow.org** or follow the campaign on social media.

Trolley crisis plumbs new depths

Worst-ever April for overcrowding in Irish hospitals – INMO

MORE than 10,000 admitted patients were made to wait without beds in Irish hospitals last month – the highest ever figure for April, according to the INMO trolley/ward watch *(see Table 1)*.

The monthly analysis revealed that a total of 10,229 admitted patients, including 106 children, were left without beds on trolley or chairs, representing an 8% increase on April 2018 and a 125% increase on April 2006 – the year INMO trolley/ward watch analysis began.

University Hospital Limerick once again recorded the highest trolley figures in the country with 1,206 patients waiting on trolleys or chairs *(see also page 10 and 16)*.

The other hospitals hardest hit in April were:

- Cork University Hospital, 826
- University Hospital Galway, 683
- South Tipperary General Hospital, 623
- Tallaght University Hospital, 566.

INMO general secretary Phil Ní Sheaghdha said: "This is the second month in 2019 where more than 10,000 patients have been forced to wait without a bed. The crisis is without question worsening.

"Overcrowding hits two main groups directly: those who depend on public health services and those who work in them, providing the safest care that they can in these conditions.

"We started the trolley count over a decade ago because of unacceptable overcrowding. The problem has more than doubled since then."

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

Hospital	Apr 2006	Apr 2007	Apr 2008	Apr 2009	Apr 2010	Apr 2011	Apr 2012	Apr 2013	Apr 2014	Apr. 2015	Apr 2016	Apr 2017	Apr 2018	Apr 2019
Beaumont Hospital	283	350	758	784	812	534	624	753	546	646	732	134	178	452
Connolly Hospital, Blanchardstown	133	135	298	313	163	352	338	716	318	517	245	156	346	237
Mater Hospital	306	415	590	421	496	233	321	387	148	413	356	437	415	524
Naas General Hospital	272	100	225	382	194	377	109	158	190	269	307	246	390	432
St Colmcille's Hospital	121	62	35	278	148	157	170	124	n/a	n/a	n/a	n/a	n/a	n/a
St James's Hospital	215	53	210	200	71	138	71	297	89	385	80	238	258	277
St Vincent's University Hospital	337	431	559	498	440	462	426	450	162	355	443	192	391	328
Tallaght Hospital	425	247	722	1,011	628	476	196	434	261	309	372	327	451	566
National Children's Hospital, Tallaght	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	5	4
Our Lady's Children's Hospital, Crumlin	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	39	48
Temple Street Children's University Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	54	51
Eastern total	**2,092**	**1,793**	**3,397**	**3,887**	**2,952**	**2,729**	**2,255**	**3,319**	**1,714**	**2,894**	**2,535**	**1,730**	**2,527**	**2,919**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	19	27	108	61	129	59
Cavan General Hospital	324	165	307	159	186	448	295	222	24	11	68	19	84	199
Cork University Hospital	344	285	551	297	523	484	543	440	380	289	277	658	890	826
Letterkenny General Hospital	226	25	55	48	33	32	55	137	343	299	41	320	254	420
Louth County Hospital	15	4	46	n/a	4	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo University Hospital	171	5	148	44	83	48	198	230	176	198	157	89	94	272
Mercy University Hospital, Cork	132	112	110	104	134	159	116	258	182	188	281	228	312	251
Midland Regional Hospital, Mullingar	4	17	17	46	104	214	283	440	371	468	367	256	378	208
Midland Regional Hospital, Portlaoise	8	29	52	49	6	112	11	105	200	166	313	244	223	197
Midland Regional Hospital, Tullamore	n/a	6	4	n/a	53	167	89	171	256	172	466	326	459	313
Mid Western Regional Hospital, Ennis	42	169	44	15	18	49	23	51	n/a	17	22	20	3	13
Monaghan General Hospital	9	52	16	19	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nenagh General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	2	8	13	n/a	59
Our Lady of Lourdes Hospital, Drogheda	147	200	221	305	163	498	566	360	486	602	517	296	135	129
Our Lady's Hospital, Navan	19	34	101	171	46	137	57	81	35	82	50	156	108	61
Portiuncula Hospital	39	27	48	20	132	65	92	106	43	112	18	73	135	179
Roscommon County Hospital	66	65	87	34	72	87	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sligo University Hospital	114	23	85	46	161	139	254	166	170	323	408	140	388	446
South Tipperary General Hospital	77	21	145	45	58	39	161	176	173	229	561	493	571	623
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	n/a	57	24	155	293	269	273	319	576	411
University Hospital Galway	208	158	399	311	264	455	390	512	377	470	587	410	576	683
University Hospital Kerry	97	31	116	10	25	97	33	88	55	120	92	143	174	238
University Hospital Limerick	162	102	171	280	186	222	274	801	557	544	620	649	1,028	1,206
University Hospital Waterford	n/a	n/a	41	76	101	111	80	203	301	172	317	393	314	386
Wexford General Hospital	259	3	162	191	51	287	55	264	106	206	59	163	75	131
Country total	**2,463**	**1,533**	**2,926**	**2,270**	**2,403**	**3,907**	**3,599**	**4,966**	**4,547**	**4,966**	**5,610**	**5,469**	**6,906**	**7,310**
NATIONAL TOTAL	**4,555**	**3,326**	**6,323**	**6,157**	**5,355**	**6,636**	**5,854**	**8,285**	**6,261**	**7,860**	**8,145**	**7,199**	**9,433**	**10,229**
Of which were under 16	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**107**	**106**

Percentage increase/decrease:
2018 compared to 2019: 8%
2017 compared to 2019: 42%
2016 compared to 2019: 26%
2015 compared to 2019: 30%
2014 compared to 2019: 63%
2013 compared to 2019: 23%
2012 compared to 2019: 75%
2011 compared to 2019: 54%
2010 compared to 2019: 91%
2009 compared to 2019: 66%
2008 compared to 2019: 62%
2007 compared to 2019: 208%
2006 compared to 2019: 125%

Limerick sees 81 on trolleys – highest ever daily count

THE INMO recorded 81 patients waiting for a bed at University Hospital Limerick on Wednesday, April 4, 2019 – the highest-ever daily figure recorded in an Irish hospital, according to INMO trolley/ward watch.

This record number took place just days after UHL management closed a 17-bed ward at the hospital, which the INMO said contributed to the problem.

Five days after the ward was closed, there were 52 patients waiting in UHL's emergency department and a further 29 on trolleys on hospital wards.

INMO reps met with TDs from Limerick and the Mid-West to raise the overcrowding and understaffing problems at UHL on April 9, 2019.

INMO IRO Mary Fogarty: *"Worst-ever figure came less than a week after a 17-bed ward was shut by management in UHL"*

INMO IRO in Limerick, Mary Fogarty said: "Staff and patients were under intolerable pressure in Limerick on the day. This is the worst-ever figure we've recorded in an Irish hospital.

"This comes less than a week after a 17-bed ward in UHL was shut. The beds that have been closed in UHL need to be reopened immediately.

"We are calling on the Minister for Health to intervene and deal with the chronic overcrowding in the hospital as an urgent matter of patient and staff safety."

The INMO has launched an online petition, calling for the closed ward to be reopened and for bed capacity and staffing at the hospital to be increased, see: **my.uplift.ie/petitions/reopen-the-closed-beds-in-university-hospital-limerick**

Lobbying Limerick TDs on UHL overcrowding: *The INMO met with TDs from Limerick and the Mid-West in Dáil Eireann last month to outline the need for urgent action on Limerick University Hospital. Pictured were (l-r): Tom Neville, TD, Fine Gael; Mary Fogarty, INMO IRO; Siobhan Thornton, INMO rep UHL; Claire Burke, INMO rep, UHL; Willie O'Dea, TD, Fianna Fáil; Tony Fitzpatrick, INMO director of industrial relations; Ann Noonan, INMO Executive Council member who is a staff nurse at UHL; Maurice Quinlivan, TD, Sinn Féin; and Niall Collins, TD, Fianna Fáil*

Parental leave reinstated for member

AN INMO member who had been denied continuation of her parental leave on successful appointment to a promotional position, has been successful in having it reinstated.

After a protracted negotiation period, a revised but acceptable reinstatement of the parental leave was negotiated by the INMO and granted to the Kerry-based member last month.

Members who experience issues such as this in the workplace are urged to contact their local IRO.

From this November, all new parents in employment in Ireland will be able to avail of a new national parental leave scheme, which offers two weeks' leave and benefit to spend with their new babies during their first year.

Ultimately, parents will be able to benefit from seven weeks' leave each under the scheme as it develops incrementally over the next three years.

– Mary Power, INMO IRO

World news

Nurses and midwives in action around the world

Australia
- ANMF Tasmania formerly rejects latest state government wage offer

Bahamas
- Nurses and government at an impasse

Canada
- Minister of Health agrees with nurses on overtime
- Mandatory overtime: 27-year-old nurse gives her account of burnout
- Striking public health nurses rallying for new employer mandate

Kenya
- No pay increase for nurses as talks end

Northern Ireland
- Northern Ireland nurse crisis branded 'public safety issue'

Portugal
- Government approves specialist nurses. Union suspends strike for three days

Spain
- Nurses at General Hospital denounce risk of infection in ICU
- Chuvi suspends non-priority surgeries due to a lack of available nurses

UK
- RCN president tells of confronting bullies as student nurse
- Nurses should be prepared to take industrial action to defend safe staffing levels

US
- US nurse shortages and the fight for better staffing ratios
- Legislation improving hospital patient safety passes Senate Health Committee
- Can community paramedicine provide relief to crowded emergency rooms?

WIN Vol 27 No 4 May 2019

This year marks 100 years of the INMO's good service to the professions of nursing and midwifery , writes **Dave Hughes**

100 years of progress

THE INMO, this year, celebrates a centenary as the premier organisation representing nurses and midwives in the Republic of Ireland.

Professional regulation and registration in Ireland were first legislated for midwives in 1918 and for nurses in 1919. In that same year a group of 20 nurses combined to sow the seeds for what has grown into the 40,000 strong Irish Nurses and Midwives Organisation today.

Originally a branch of the Irish Women Workers' Union, it quickly grew and developed into the Irish Nurses Union. The first secretary of the union was Marie Mortished. Today the INMO is also led by a registered nurse – Phil Ní Sheaghdha, general secretary.

The Organisation has always represented both nurses and midwives but the advent of direct entry to the midwifery profession led to the changing of the name to encompass midwives, with the INO becoming the INMO in 2008. Prior to that midwives were nurses in the first instance and, following further study and practice, became midwives.

The history of the Organisation demonstrates that the professions have only progressed when nurses and midwives combined to put pressure on governments to recognise their value to society. The INMO has developed far beyond the original objectives of simply dealing with conditions of employment for nurses and midwives. As far back as the 1930s it lobbied for post registration education. After three years of pressure on government it was granted permission to provide the first week-long post-registration educational course for nurses and midwives in 1938. That first programme, run by the then Irish Nurses Union, was held in the old Richmond Hospital, which the INMO now owns and from which the Professional Development Centre provides a full range of post registration education.

Patient advocacy has always been seen as a key function of the nurse and midwife. The INMO is a leading voice for patient advocacy in this country and daily, for almost two decades, has highlighted the scourge of long waits for patients in emergency departments for access to a hospital bed. Highlighting the problems of the health service and the difficulty for patients including mothers and their children has not always been popular, but the Organisation and its members have never flinched from making the case for the most vulnerable in our society.

In 2018 the INMO formed a partnership with the Royal College of Midwifery (RCM), strengthening the links between midwives in Northern Ireland and the Republic and delivering access for INMO midwives to the educational, library and eLearning resources of the RCM.

When the original 20 nurses gathered in 1919, the world was in turmoil following the First World War. Ireland was increasingly revolutionary since the 1916 uprising. Nurses and midwives working in English hospitals at the time were paid substantially higher than in the voluntary hospitals in Ireland. Many married nurses and midwives saw their husbands go to war and faced the economic necessity of getting a better salary for their labour. The spirit of trade unionism and combining to improve their lot has been demonstrated in national campaigns, but only twice in its 100-year history has the Organisation had to resort to a full national strike of nurses and midwives. In 1980, when Charles Haughey was Minister for Health, nurses and midwives took part in what became known as The Big March, protesting at the low level of their incomes. The Minister for Health settled with the nurses, and the media promptly dubbed the professions 'Charlie's Angels'.

Wage pressures again in the 1990s saw a campaign running from 1994 which culminated in a national nursing and midwifery strike in 1999. The outcome of that strike heralded the implementation of the report of the Commission on Nursing, which had been established to avoid an earlier threatened strike in 1996. The Commission's report with 200 recommendations became the blueprint for nursing and midwifery into the 21st century.

Nursing and midwifery were severely impacted by the economic recession which almost broke the country in 2008. It left in its wake austerity measures which saw the number of nursing and midwifery posts reduced by 5,000. An embargo on recruitment up to the end of 2013 ensured that most graduating nurses and midwives emigrated for work and out of economic necessity. This resulted in 20,000 nurses, midwives and newly qualified graduates leaving the country.

That decrease in numbers, combined with the growing demand for health services and the inability of the Irish public health service to recruit and retain nurses and midwives, brought the INMO to the second national strike in its 100-year history in 2019. The action involved three days over two weeks and a public rally which garnered massive support. Ultimately that pressure brought the government to the negotiating table. The Labour Court intervened and recommended a set of proposals which the Organisation is optimistic will, if accepted by members, turn the tide in terms of the ability of the Irish public health service to recruit and retain sufficient numbers of nurses and midwives to provide safe care for the population.

The INMO represents most nurses and midwives in the Irish public and private health sectors. It is the internationally recognised organisation for Irish nurses and midwives and holds the presidency of both the International Council of Nurses and the European Federation of Nurses in 2019.

The Organisation, by providing a comprehensive education and professional development centre as well as workplace representation and legally qualified defence, aims to cater for the needs of nurses and midwives from their commencement as students for the rest of their days.

Irish nurses and midwives are the backbone of the health service and the INMO provides a voice for them, not only in their own interests, but also in the interests of their patients. 2019 marks a century of good service to the professions.

Dave Hughes is deputy general secretary of the INMO

INMO celebrates two pioneering International Section members

Bolatito Aderemi (left) arrived in Ireland in 2002 and joined the INMO in 2004 – recruited by Phil Ní Sheaghdha; and Lina Ducao (right) is a former nursing college dean, chapter president of the Philippine Nurses Association, advisor of College Red Cross Youth and College Brotherhood of Nurses

IN LIGHT of the 100th anniversary, the INMO International Section would like to honour two pioneering members, Bolatito Aderemi and Lina Ducao, for their contribution to the health service and the nursing profession in Ireland.

Ms Aderemi has been instrumental in recruiting many international members since joining the INMO in 2004, and Ms Ducao is a former dean of the College of Nursing in the Philippines who served as advisor to two past chairpersons of the Section.

Bolatito Aderemi

Bolatito Aderemi arrived in Ireland in 2002, recruited from Nigeria by the South Western Health Board, to work as a senior staff nurse. She was a pioneering member of the International Section and recruited many international nurses and midwives working in Ireland to join the INMO.

Through her hard work and passion for the Organisation, the International Section was firmly established.

As well as her role as section officer, Ms Aderemi is also an INMO workplace rep and was treasurer of the Dublin South West Branch for a number of years. She has faced many challenges but takes her role seriously and actively encourages international nurses and midwives to join the INMO.

She has visited many hospitals and nursing homes across Ireland with general secretary Phil Ní Sheaghdha, meeting and supporting her colleagues.

She likens her role as local rep to being "the eyes and ears of the wider membership" as she keeps INMO management informed of members' needs.

We would like to honour Ms Aderemi for her contribution to the growth and development of the Section.

Lina Ducao

In March 2000, following a discussion with an Irish missionary priest serving as chaplain at a hospital in the Philippines about the shortage of nurses in Ireland, Ms Ducao submitted documentation to the NMBI (then An Bord Altranais) to assess the educational qualification and related learning experiences of Filipino registered nurses. The process of getting an NMBI decision letter and travel visa was quicker at that time.

Employers from a group of Irish nursing homes and hospitals travelled to the Philippines to interview hundreds of nurses. They offered jobs to many of them and facilitated their access to travel visas and clinical adaptation programmes in Irish hospitals.

The first wave of migration of Filipino nurses to Ireland started in May 2000, an influx which helped to address staff shortages in the hospitals and nursing homes.

Ms Ducao was also asked about qualifications for healthcare assistants and submitted qualifications and course descriptions for midwives, health aides and graduate nurses (without Philippines Nursing Licensure Examination). Many of these qualified to work as HCAs and were offered jobs in Ireland.

Ms Ducao is now a clinical nurse manager at a nursing home in Kildare where she has worked for almost 20 years. She was planning to retire this year but due to staff shortages and her love of nursing, she has decided to continue to practise and care for the elderly.

Retired Section visits JFK homestead

*Around 25 members of the INMO Retired Nurses and Midwives Section enjoyed a four-night break in Dungarvan recently. They visited different places of interest each day, including Mount Mellery, Lismore, the Dunbroady famine ship in New Ross and the homestead of John F Kennedy (pictured above). They also visited a scenic part of the Gaeltacht in Youghal. The trip was part of a busy social committee calendar for 2019, which also includes a day trip to Athlone on Tuesday, May 21 and a visit to Airfield Estate in Dundrum on Thursday, June 20. Details of how to get involved are available on the INMO website – **www.inmo.ie***

Date change: ODN Section

THE Operating Department Nurses Section conference will now take place on Saturday, November 30, 2019 in the Richmond Education and Event Centre. The price of attendance is €85 for members and €120 for non-members. The first 50 people to book will be entered into a draw to win a free place at next year's conference, so please book your place early. To make your booking online, please visit **www.inmoprofessional.ie**

INMO leading and influencing European policy agenda

It is crucial that the EFN is strengthened and empowered to influence the EU political agenda, writes **Elizabeth Adams**

The INMO and Ireland were represented at the 109th general assembly of the European Federation of Nurses Associations (EFN) in Brussels on April 11-12 by INMO president Martina Harkin-Kelly and myself Elizabeth Adams. There were more than 100 representatives from 28 member countries across Europe. The EFN, of which the INMO has been a member since its inception, represents more than three million nurses across 36 European countries.

European projects

The INMO is central to a number of significant projects and policy developments due to its membership of the EFN. Issues concerning health, patient care, mobility of healthcare professionals, education, terms and conditions, working environments, technology and health funding continue to be central to the EU debate. These debates result in legislation that all member states are obliged to implement.

It is imperative that the EFN is strengthened and empowered to influence the EU political agenda, particularly in the current economic climate. Member associations share information regarding the effects of the economic crisis on healthcare. This exchange of information is essential to the strategic policy and lobbying activities of the EFN in portraying the difficulties facing nurses in providing a safe and quality service as well as highlighting the inequalities of citizens in regard to nursing services in the EU.

At the general assembly, EFN members had the opportunity to analyse the key political topics that are driving the EU agenda and discuss the nursing contribution, in addition to their impact on the nursing profession and the citizens of Europe. They had the opportunity to liaise and share views with Agata Walaszczyk-Terrasse (EC DG GROW) on nursing skills. They also had a chance to speak with Jeroen Jutte (EC DG Employment) on the EU country reports 2019 and EU semester, which are seen as key tools to implement the European Pillar of Social Rights.

Agata Walaszczyk-Terrasse presented on the EC study on Annex V of Directive 2013/55/EU (including on article 31, a set of eight competencies that set out the minimum educational requirements for nurses responsible for general care).

EFN members also discussed their contribution to three European projects that the EFN is involved in:

- *QualMent* – The 'Quality Mentorship for Developing Competent Nursing Students' project is coordinated by the College of Nursing in Celje, Slovenia. The project objective is to address the lack of clinical mentors in nursing education and develop clinical mentors' competence with mentor education for national and international nursing students. The duration of this project is 28 months
- *InteropEHRate* – The 'Interoperable Electronic Health Record at user edge' project is coordinated by Engineering Ingegneria Informatica. The project objective is to realise an open, standardised and unique European extended EHR and provide European citizens with a complete view of their health history, shareable with health operators and researchers. This project commenced in January 2019 and is planned to take 42 months
- *Smart4Health* – The Citizen-centred EU-EHR exchange for personalised health project is coordinated by UNINOVA – Instituto de Desenvolvimento de Novas Tecnologias (Portugal). The objective of the project is to develop, test and validate a platform prototype for the Smart4Health citizen-centred health record with integrated ability for data donorship to the scientific community, enabling citizens to manage, collect, access and share their own health data. The duration of the project is 50 months from January 2019.

Elizabeth Adams and Martina Harkin-Kelly pictured at the EFN general assembly in Brussels

Policy to practice

The EFN general assembly believes that nurses working to their full scope of practice and evolving advanced roles are crucial in empowering patients and implementing meaningful value-based healthcare systems.

The close relationship of nurses with patients is fundamental to ensuring that what is developed in policy is delivered appropriately in practice. Therefore, the EU and national governments need to concretely engage the nursing leaders in the co-design of the health and social care systems in the EU.

EFN members are committed to and fully engaged with making a difference to the current EU policy agenda. They are working relentlessly to ensure that the contribution of three million nurses is valued and the potential of the nursing profession is maximised to positively benefit patients and health systems.

Elizabeth Adams is president of the European Federation of Nurses and former INMO director of education

Celebrating our professions

As May marks International Day of the Midwife and International Nurses Day, it is timely to celebrate members of both professions

International Day of the Midwife – May 5

IN celebrating the International Day of the Midwife (IDM) on May 5, the International Confederation of Midwives (ICM) is highlighting the many ways in which midwives defend, protect and stand up for the rights of women and girls. Its theme for this year's event, 'Midwives: Defenders of Women's Rights', reflects this intention and champions the second of the Confederation's three strategic directions up to 2020: quality, equity and leadership.

Women's rights are under fire globally. Despite attempts by world governments to dismantle the rights and dignity of women and girls, there is so much to celebrate on May 5, including:

- The midwives who stand up for the rights of women to receive respectful maternity care
- The midwives who offer contraception despite their government's refusal to allow women access to it
- The midwives who support pregnant women suffering from domestic abuse
- The midwives who say no to performing female genital mutilation.

Nearly 350,000 women and over three million infants around the world die every year due to preventable complications arising from pregnancy and childbirth. The World Health Organization (WHO) has identified midwives as the key to reducing the incidence of such complications, and the ICM is encouraging everyone in the healthcare professions to recognise the role that midwives play in reducing maternal and neonatal morbidity, and to motivate policymakers to implement adequate midwifery resources worldwide.

ICM president Franka Cadée said: "IDM is not only about midwives being defenders. It is also an opportunity to highlight the right for a midwife to practise in a safe and enabling environment. We have heard of horrific incidences in Mexico and Nigeria where midwives have been kidnapped and killed on their way to work. These are just the cases that have captured the attention of global media. More common in many workplaces is the abuse and bullying of midwives by colleagues and the abuse of those who stand up against such behaviour. There are many more stories of abuse that go unheard and unaddressed. Midwives should be free from harm going to work, at work and in their homes. We want to thank and celebrate you, the midwives who have continued to fight, protect and defend women, girls and midwives' rights, no matter the circumstance and consequence."

Further information can be found in the IDM advocacy pack, downloadable from **www.internationalmidwives.org**

International Nurses Day – May 12

Ahead of International Nurses Day, the International Council of Nurses (ICN) has released a resource and evidence toolkit entitled: *Nurses: A Voice to Lead Health for All*.

Nurses worldwide will mark International Nurses Day (IND) on May 12 and this year's celebration provides three important messages for nurses and policymakers:

- Nurses save lives and improve, protect and promote health and wellbeing
- Nurses are an access point to 24/7, birth to death, emergency and ongoing care
- Nurses are the foundation of high quality, affordable and accessible care.

The toolkit contains a number of case studies that highlight the important role nurses play in ensuring that everybody has proper, unfettered access to the care they need.

ICN president Annette Kennedy with Dr Tedros Adhanom Ghebreyesus, WHO Director-General , launching the toolkit for International Nurses Day

Speaking in Geneva at a meeting with WHO director general Dr Tedros Adhanom Ghebreyesus, ICN president Annette Kennedy said: "Nurses all over the world every day are advocating for health for all in the most challenging circumstances with limited resources to deliver healthcare to those most in need. ICN believes that the time is ripe for nurses to assert their leadership. As the largest health profession across the world, working in all areas where healthcare is provided, nursing has vast potential and value if appropriately harnessed to finally achieve the vision of health for all."

Dr Ghebreyesus said: "Nurses and midwives are the backbone of every health system. They account for more than half of the global health workforce and are vital for realising the vision of universal health coverage. But to achieve UHC and the Sustainable Development Goals by 2030, the world will need nine million more nurses and midwives. WHO is proud to support ICN and the Nursing Now campaign to ensure we fill this critical gap."

The ICN International Nurses Day resources can be accessed on the IND website: **www.icnvoicetolead.com**

100 years of the INMO

Mark Loughrey, author of a new book looking at the past 100 years of the INMO, explains his passion for the project

"THE belief that we have come from somewhere is closely linked with the belief that we are going somewhere."

This is the opening quote from *A Century of Service*, a new book documenting the history of the INMO which is being launched this month to commemorate the Organisation's centenary. The book's author, Mark Loughrey, explains the quote's significance: "I stayed late in the library in UCD one evening; I was cramming for an assessment. It was near midnight and everyone else had gone home. Then I came across that sentence in a book. It clicked with me at once. Like a child at school, I ran my finger under the words and read it again. In the context of the task at hand it meant that the battles the INMO fights today are a continuation of the battles that it fought yesterday. So I set about writing a book about the INMO's past that resonated with, and had lessons for, the present. Why? Because we can learn a lot from these past battles and from the experiences of those who fought them".

Mark Loughrey is a registered general nurse. He lives in the countryside near Macroom in Cork and divides his time working as an intensive care nurse and as a research nurse at UCC. In 2011 he was awarded a PhD scholarship, by the INMO, to study nursing and midwifery history. He completed his PhD on the history of the INMO in 2015 and has now produced a book on the same subject.

"I was very fortunate to be awarded a PhD scholarship by the INMO. I learned a great deal about 'doing' history while at UCD. I met some great people and made good friends. The scholarship was like a gift to me so, now, it is good to be able to give something back to the INMO in the form of the book.

"I wrote it between shifts in ICU. I was adamant that the INMO be placed front and centre in the unfolding story. You see, I was tired of reading histories of nursing and midwifery that failed to mention trade unionism. I do not know whether the authors of those histories omitted trade unions by accident or by design, but I felt it was important to rectify this. The INMO is an integral part of nursing and midwifery's past in Ireland, the professions would look and feel much different today were it not for the Organisation and I felt that it was time that its significant role was recognised.

"My priority was to recount the INMO's history as though I was telling a tale. It is easy to cobble together a hodgepodge of random events from the past but that is not really what history is about. History is about weaving a meaningful story from past events. It is about recounting the events of the past in a way that explains how one event might have influenced the next. In essence, it is about trying to explain how we got to where we are.

"I was able to gather much information about the INMO's past from the Organisation's own archive. Many insights also came my way from the INMO's journals. I was also very fortunate that a number of key players, eye-witnesses to major events in the INMO's past, sat down with me and let me record their accounts: what they did, what they saw, how they felt. Some were telling their stories for the very first time, others were settling old scores, more were setting the record straight, a few were getting things off their chest; but all were speaking to the passion and poignancy that characterise nursing, midwifery and trade unionism more generally. The book would not have been the same without those people and their stories. Nor would the book be the same were it not for the hundreds of images that are scattered among the pages. If you look closely at these images you will see that they tell a story in their own right".

The book is comprehensive. It begins with a close look at the heady backdrop that gave birth to the INMO in 1919. It moves on to detail the Organisation's relatively conservative middle years and finishes with the INMO we know today.

"One of my missions was to shed light on the founding women – the early movers and shakers in the Organisation. Those 20 nurses and midwives who established, in the INMO, what was the first trade union for hospital nurses in the world. Unfortunately, they never got to see the fruits of their labour. More unfortunately still, they were mysterious and elusive. We did not know their names. We did not have pictures of them. Partly thanks to the kindness of their grandchildren we can now, for the first time, put names and faces to the Organisation's founders. Now, for all of posterity, these names and faces can rightfully claim 'we were here'. I think that we owe them that. Indeed, I think we owe them much more".

A Century of Service, A History of the Irish Nurses and Midwives Organisation: 1919-2019 by Mark Loughrey is published by Irish Academic Press and is out now. *See* **iap.ie**

Statement writing and defending your practice

Before completing an incident form or writing a statement, stop, think, ask questions and seek advice from the INMO, writes **Edward Mathews**

NURSES and midwives are often called on to provide a written account of their practice, or to write about an event which occurred during their practice.

Recording practice in the normal way is unremarkable, however, each time that you are called on to provide a formal account of something that has occurred, outside the normal recording of practice, this is a significant event and one that deserves special attention.

Where you are called on to provide an account of your practice, for example by providing a statement on or an account of an event, or to complete an incident/occurrence form, there is the potential for the information that you provide to be used in the processes and procedures of your employment, and outside of your employment, such as in fitness to practise proceedings.

Regrettably, all too often nurses and midwives, who are working under severe pressure, commit an incomplete version of events to paper, and this version of events follows them through all the processes following the event in their workplace.

It is important to remember that where for example a Fitness to Practise Committee is looking at the practice of a nurse or midwife, they often pay particular attention to the first account of events provided and regard that as the most accurate account, given the proximity of when it was written to the events in question.

In the INMO's experience, nurses and midwives often write incomplete accounts, or summary accounts of what occurred, and it can be mistaken that what they have written at a particular period of time amounted to the totality of their recollection.

As registered professionals who are accountable for their practice to the Nursing and Midwifery Board of Ireland (NMBI), and as registered professionals carrying substantial responsibilities, it is important that nurses and midwives recognise the importance of providing an appropriate and complete account of their practice, when called on to either complete an incident form or to provide a statement.

Incident forms

Reflecting on the completion of incident forms, these are a common occurrence in the workplace, and they often follow issues of concern or note during your practice. When completing these forms there is often an opportunity to provide a narrative account as to what has occurred. The space available is often brief, and the time available is often even less. In that regard, if you are completing an incident form, and if there are particular issues of concern, it is important to include these in the narrative of account. However, at each occasion where you are completing an incident form, unless you are absolutely satisfied that you have included all relevant detail as to what occurred, we strongly recommend that you include the following sentence at the end of the narrative account: "*This is a summary of events and does not include all details.*"

Statement

Time: Having submitted an incident form, or indeed in circumstances where you have never submitted an incident form, you may be called on to provide a statement or account of events by your employer. It is a reasonable and lawful request by your employer that you would provide a statement, however, you are not obliged to provide a statement on demand. Everyone who is asked to provide a statement is entitled to time to consider the contents of that statement, and to seek advice on the contents. Therefore, notwithstanding anything that is said to you by a manager, you are not under an obligation to provide a statement on demand, and you are entitled to insist that you be provided time to allow you consider the contents of your statement and to allow you to seek advice.

Context: On any occasion where you are asked to provide an account of your practice, it is important that you are aware of the context in which this request is made. Is the request being made as part of a systems analysis dealing with risk management? Is it an issue relating to the dignity at work policy? Are you responding to a grievance? Are you responding to a patient complaint? In all circumstances, always ask the context in which the information is being sought.

Nature of issue/complaint: In addition, if you are responding to any complaint or expression of concern in relation to your practice, then you are entitled to know the nature of the concerns that you are responding to. If a person has made a written complaint against you, you are entitled to have a copy of that written complaint prior to completing your statement of response. Even in circumstances where a written complaint has not been made, if a verbal complaint has been made to a manager, you are entitled to a written account of the complaint made to the manager prior to completing your statement of response.

Records: Additionally, prior to completing any statement which refers to your practice, you are entitled to have access to all relevant records relating to your practice. For example, it you are asked to give an account of your care of an individual patient, it is essential that you have access to, and consider, the records of care which you completed, and indeed the records of others which may be relevant to your care, so that you can use these in formulating your response.

Advice: It is important once you have all the relevant information, and once you have gathered your thoughts and committed them to writing, that you seek advice prior to the submission of a statement or account of events.

Every occasion where a registered professional has been asked to provide a formal account of their behaviour outside the normal recording of clinical practice is a notable event. Notable events can have unexpected consequences. It is not unusual that a set of circumstances which are initially thought to be quite benign and capable of being managed locally, can in turn give rise to a formal investigation. There can be investigations outside the employment such as by the Gardaí, and it is not uncommon for such processes to lead to complaints to the NMBI under its fitness to practise regime.

Therefore, given the notable event of being asked to provide a formal account of one's behaviour, it is inadvisable to provide that account without seeking professional advice from the INMO. Your INMO official can advise you in relation to the tone, content and format of a statement, and can often identify gaps or issues which could injure your best interests if the document was submitted in an unedited format. The role of an INMO official is not to tell your story; they are there to ensure that when you are telling your story, that you do so in a way that best defends your best interests.

Aside from the general advice above, a number of points which you should bear in mind when preparing your statement are outlined in the *Table*.

Writing a statement: Important points to bear in mind

- Always ensure that you have copies of all the relevant documentation available to you, including a record of any complaint if this is relevant, and including all care records
- When writing a statement, it should be as factual as possible. Unless specifically called for, and unless you are qualified to provide them, refrain from providing opinions in your statement
- In almost all circumstances, a statement should proceed in a chronological order, and should be a structured account of events from the commencement to the conclusion of the sequence of events
- It is important to be as accurate as possible and to include detailed information, such as the day, date, the time, where something occurred, the context in which it occurred, an explanation of the effect of events, and any particularly notable occurrences during the sequence of events. It is quite common for nurses and midwives to be cross examined during a fitness to practise inquiry in relation to a previous statement, where they have omitted important detail, therefore this is an opportunity for you to tell your story as close to the events as possible, and you must tell the full story
- If there are others who have witnessed the event, these should be identified in the statement
- When writing the statement use professional language, avoid undue emotion, and present yourself in your written word as you would want people to view you and that is as a professional
- Where you are dealing with clinical issues, then clinical detail is extremely important, use professional and appropriate language to refer to clinical matters, and ensure that you give a full account of your reasoning for your actions in a clinical context
- If the subject matter of the statement is of an embarrassing nature, then the embarrassment must be set aside, and you must provide the full detail. Notwithstanding any level of embarrassment, you will injure your best interests if you do not provide a full account of events in your statement
- In the event that you do not recall something having occurred, then you should state that you do not recall it. However, language is important, and it is essential that you understand the distinction between saying that you cannot remember something occurring, or when something did not occur. If you say that something did not occur, that is a definite statement, if you state that you cannot recall, then it may or may not have occurred. It is okay to say that you do not recall, as long as that is what you actually mean
- In writing the statement, shorter sentences are better. Longer sentences lead to contradiction and unintended qualification, and consequently you should use short, clear and definite statements
- Again, always prepare a draft statement, always seek advice from the INMO, and never submit a statement without adequate information, adequate time and adequate advice on your response

Conclusion

Incident forms and statements of events are often the first formal account of what has occurred in the workplace, apart from what you have recorded in a patient's notes. In that context these documents are extremely valuable in defending your best interests in the future, however, if improperly prepared, they can also injure your best interests. Incident forms which are submitted in the context of risk management, and statements which are submitted in the context of workplace procedures, often weave their way into multiple forums, including internal inquiries, commissions of inquiry, coroner's courts, dignity at work investigations, Garda investigations and fitness to practise inquiries.

Therefore, in summary, where you are completing an incident form and are not sure that you have provided a full account of events, then ensure that you state in the incident form that it is not a full account of events. Additionally, where you are submitting a statement always stop, think, ask questions and seek advice before submitting any written account of your practice.

Edward Mathews is INMO director of regulation and social policy

Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Query from member

I will be 65 in May and, as per my contract, this is the age at which I will retire. I entered the public service before April 2004. Do I have to retire at 65 or have I an option to stay on?

Reply

The Public Service Superannuation (Age of Retirement) Bill was signed into law on December 26, 2018.

This Bill allows for relevant public servants who reach the age of 65 on or after December 26, 2018 to continue working up until the age of 70 if they so choose.

The compulsory age of 65 has been abolished. Any public servant covered by this legislation will continue to be a member of the relevant pension scheme and any additional years' service from 65 to 70 are reckonable for pension purposes, subject to the statutory maximum of 40 years' service.

Query from member

My employer advised that the salary scale for appointment as candidate advanced nurse practitioner in the public health service is paid at the grade of CNM2. I spoke to a colleague and she advised that the salary for this appointment is CNM3. Can you advise if this is correct?

Reply

As a result of pay anomalies with a small number of employees following implementation of Circular 10/2017, the HSE and the unions reached agreement under the auspices of the WRC. All candidate ANP/AMPs undergoing the candidature process on or after May 1, 2017 will be paid the CNM3 rate with effect from that date. The terms will be no less favourable than those recruited under Circular 10/2017, which relates specifically to candidate ANPs/AMPs. The provisions of the Circular 10/71 (which governs promotional posts in general) will apply, with normal progression. Hence, candidate ANP/AMPs should be paid at CNM3 level.

Know your rights and entitlements

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

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

INMO

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• Pay and pensions • Public holidays • Career breaks
• Injury at work • Agency workers • Incremental credit

Introducing Executive Council members

Marie O'Brien

CNM1, Mid-Western Regional Hospital, Ennis

IN secondary school Marie was involved with a voluntary group that brought disabled children on holidays. This gave her a love of caring for others. Later Marie trained at University Hospital Limerick and did her midwifery training at St Munchin's College, Limerick. She went on to work in orthopaedics in Cork before moving to Mid-Western Regional Hospital, Ennis in 1985.

Marie became active with the INMO as a student. When she started working in Ennis she was only temporary like many of her colleagues, meaning they could be called in at any time and sent home once their work was done, often not getting paid for a full shift.

About this experience, Marie said: "Temporary nurses had no rights whatsoever so I initially became a rep with the INMO to highlight our plight. However, overcrowding was also off the scale back then. There were beds up the corridors and in wards all over our hospital. We were concerned about health and safety. Eventually we managed to get rid of the policy of moving extra beds up the wards, but there were very few staff on night duty. We sought an external review and as a result we got a third nurse on night duty. This made a huge difference. I was also involved in campaigning to have interns paid which was ultimately successful."

Marie believes every nurse and midwife should join a union for indemnity and an opportunity for professional development.

About the proposed new deal, Marie said: "My aim is to see the nursing profession valued and paid accordingly. The proposed deal could see this happen. If it is implemented, and we get those terms that have been negotiated for us, we could see a fully funded workforce with safe staffing for nurses and midwives. This would allow us to provide optimum care for patients while working in a safe environment."

Ann Noonan

Staff nurse, surgical day theatre, University Hospital Limerick

ANN worked as an attendant in a geriatric hospital in secondary school. There were no nurses in her family but watching the nurses at work attracted her to the profession. Ann began training at University Hospital Limerick in 1984, aged 17. She briefly worked in the Mater Private and went back to Limerick in 1988 to complete her midwifery training.

When Ann started working as a theatre nurse in 1995 there were many issues with on-call and rostering. Significant changes were taking place and Ann felt that nurses should have a voice in negotiations. She became the theatre rep in 1995/96 and progressed to getting involved with her branch.

Ann likes having the information necessary to organise herself and her fellow workers, stating: "The health service is changing dramatically, and nurses and midwives must have a voice in that. Unfortunately, the litigious nature of life nowadays means that you need the insurance of being a member of a union. There are also great educational opportunities through the union. There is power in a collective. It gives us a greater voice to campaign for our rights and for safe care for our patients."

Staff nurses are the biggest collective in the health service and, for Ann, it is important that they are represented. Working in the most overcrowded hospital in the country, Ann feels she is the voice on the Executive Council for the staff nurse but also for UHL, where safe staffing is a major issue. "It is really important for nurses and midwives to be aware of industrial relations mechanisms when it comes to campaigning for safe staffing. The issues encountered on the ground by nurses and midwives working in our overcrowded acute hospitals are huge and varied. Our voice needs to be heard."

Sean O'Shaughnessy

Surgical day ward
University Hospital Galway

SEAN's interest in nursing started at a young age as he lived with all of his four grandparents. There was a caring environment at home and, although he never fully understood what attracted him to nursing, he feels this had an impact. His career guidance teacher was surprised by his choice and he found it difficult to get started here so he went to England to study. He spent 11 years working there before returning to Ireland in 2006.

Speaking about his job, Sean said: "The attraction is that you get to talk to people, help them out, learn about them. It's that interaction and the human touch. You learn from your patients and they learn from you. It keeps the job interesting."

Sean became active with the INMO to learn what his rights and entitlements were. He realised that with union support, he could deliver information to colleagues and update them on their rights. He became a workplace rep and progressed from there.

For Sean, the main reason for being in a union is to keep abreast of ongoing changes in the health service. As a member of the Executive Council, his priority is to break down barriers within nursing and midwifery. His method is to identify what the barriers are, find solutions to them and teach members how to overcome the problem.

"As an Executive member you are representing your colleagues. The most important thing is that we are there for the members on the ground. There are more and more requirements for service to be provided, but we are expected to do more with less and less. Often information that is disseminated down from the employer to the employee is not 100% by the policy/agreement."

Interview skills for internship students

INMO student and new graduate officer, **Neal Donohue**, offers advice to internship students preparing for job interviews

OVER the coming weeks many internship students will be attending job interviews. Having invested four years of time, money and hard work into your careers, many of you will be anxious about upcoming interviews, but remember: you have prepared for this and you are ready. An interview is not an exam and it is definitely not an interrogation. Employers do not simply look for the person with the most knowledge when it comes to offering a job. They want to get a sense of who you are as a person and are looking for insight into how you would fit with their organisation.

It is important to note that social media and online activity provides a public reflection of who you are. This is a good time to review your social media accounts and remove any links between you and any compromising posts or material. Each workplace has a social media policy and the NMBI has also issued guidelines, which can be viewed at: **https://bit.ly/2WEmjgu**

You really only need to know three things in preparation for an interview: the employer, the job and yourself.

Know the employer

Show an interest in the organisation. Know its mission, vision and values. Are staff working on anything innovative? What are the main challenges it faces? Do your research and you will not fail to impress. You will find a lot of information online, especially if the organisation uses social media. It also helps if you know who is on the interview panel in advance. Some people may have a particular area of interest and you can prepare for the questions they may ask.

Know the job

Although you are an intern the job you are interviewing for is staff nurse/midwife. Avoid responding with the phrase "I am only an intern…" While there are aspects of the job that you may not be able to do yet, it is best to highlight your desire to learn, rather than highlight your lack of knowledge or experience.

The interviews will be competency-based, which ensures they are fair and standardised. Most employers will look for a certain set of characteristics or behaviours, like how you handle crisis situations, why you chose nursing/midwifery, and how you work as part of a team.

The main competencies employers look for include:

- Applied skills/knowledge (eg. aspects of nursing/midwifery practice such as post-op care, infection control, risk assessing, safeguarding)
- Personal and professional development (do you have plans to study further?)
- Communication (eg. How would you deal with a disruptive patient? How do you know if a patient has understood your instruction?)
- Organisational skills (eg. How do you prioritise care at the beginning of a shift)
- Change management (eg. Have you been involved in any change of practice in the workplace?).

When you are answering these questions, use a story from personal experience if possible. This will help you get the information across in a way that is interesting and helps to show your interest and passion. Never lie in an interview; it is better to admit that you don't know something rather than pretend you do and get caught out. In nursing and midwifery, we are always learning. It is acceptable to not know everything so long as you are willing to learn. Dishonesty, however, is completely unacceptable when you are working with vulnerable people.

Know yourself

You may be asked questions like: 'Why did you chose to become a nurse/midwife?', 'What are your strengths/weaknesses?' or 'How do you handle pressure?'

Such questions can be daunting, so it is important to prepare well in advance. This is an opportunity to show how you stand out from the rest of the applicants, so don't be afraid to tell your story.

It is important to also be aware of your communication style. Take your time with each answer, breathe and gather your thoughts. Practising some answers will help with your articulation. Doing mock interviews or recording yourself are great ways to become aware of your behaviour. Your non-verbal communication is just as important as your verbal communication so take the time to prepare for this. If you are anxious, practice breathing exercises, avoid fidgeting and try not to overuse words such as 'like', 'ah' and 'um' while you are gathering your thoughts.

Don't panic

Don't worry about the little things. Plan what you will wear, think about your travel time and parking etc. These things should not be an issue once you have prepared. Take care of yourself, get plenty of sleep the night before, eat a good meal and drink plenty of fluids. Without these basic needs being met you will struggle to concentrate.

Resources

Some colleges have career guidance services and offer resources such as CV preparation, mock interviews and sample interview questions. The INMO also offers a course on CV preparation and interview skills. For information on INMO courses go to **www.inmo.ie/Education**

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

This information was put together with the help of Dublin Youth Forum members. Thank you to Catherine O'Connor, Jenny Rea, Roisin Callaghan and Susan Williams for taking the time out to support your colleagues

Quality & Safety

A column by Maureen Flynn

More information on using 'good information practices'

ADVANCES in information technology have given rise to the everyday adoption and use of new types of information, new apps and new devices. All of these change the ways nurses and midwives perform their everyday work. Everyone in healthcare deals with information each and every day while doing their job.

Information comes in many different forms and formats, both paper and electronic. Regulations like the General Data Protection Regulations (GDPR) make healthcare organisations and the nurses and midwives acting on their behalf, responsible for securely protecting the personal healthcare information entrusted to them. So what does this mean?

Good information practices

Sometimes it is difficult, while doing complicated everyday tasks, to figure out how to best handle this information especially with GDPR, etc, to consider. Everyone wants to avoid the headlines below happening again.

- X-ray report found in Penneys
- Cancer patient's chart left on roof of car
- Child's mental health records accidentally faxed to Bank of Ireland.

Good information practices are central in providing quality nursing and midwifery care. The HSE provides an online training course, via HSELanD, which aims to help refresh our thinking in relation to everyday information and related problems.

Online training

This 'Good information practices' online training only takes 20 minutes to complete and can be completed over multiple sessions if necessary. There is a short assessment at the end of the training. When all five questions are answered correctly (multiple attempts are allowed... just in case) a certificate of completion is awarded and can be printed off for your professional development plan (PDP).

The good information practices online training will help with areas like GDPR compliance, internet and email security and data quality. All of the following topics are covered during the training:

- Types of information
- Correct information handling
- Storing and transferring information
- Restricting access to information
- Identity security and sharing
- Maintaining internet and email security
- Improving data collection, quality and reporting.

Reporting data breaches

How will this training help?

Completing the short online programme we help you identify your responsibilities in relation to gathering, handling and disposal of restricted and confidential information. Common everyday work situations and practises involving information are worked through, with short multiple choice exercises, to help you put your knowledge into practice in a safe environment.

In busy clinical settings it can be difficult to recognise unsafe or bad practices which may have crept in over months or years, without any bad intent. Good information practices training encourages us to take a step back and look at our own everyday work, how information is routinely handled and how this can be improved for the benefit of everyone.

Many of us can be unsure of when, how and who to ask for advice if we come across an information related question or problem – what would you do if you lost some patient files or your HSE computer was stolen? The good information practices training helps us to identify the steps to be taken in these types of situations.

Opportunity to get involved

At your next PDP discussion, ward/team/clinic meeting you might take the opportunity to talk about how information is managed and consider if the online training would be valuable for you and your team members to complete. Find more information on the HSE website at: https://bit.ly/2GgChVy

Steps to access the online training

1. Log on to **HSELanD.ie**
2. Click on course catalogues
3. Search for 'good information practices'
4. Click to take the training.

You receive a certificate of completion when you pass the short test including 0.5 continuing professional development points from the Nursing and Midwifery Board of Ireland (NMBI).

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

Acknowledgement: Particular thanks to Helen Lambert, HSE Office of the Chief Information Officer (OCIO) for sharing this information and assistance in preparing this column. For further information please contact Helen by email to: helen.lambert@hse.ie

Warning signs

The application of clinical governance to the Home Service Support provision in Ireland is flawed and an imminent risk to patient safety, warns **Rachel Eustace**

PATIENT safety is the biggest challenge in healthcare today.[1] In the US, one study found that medical errors are the third-leading cause of deaths in hospital.[2] Sláintecare has placed safe, quality, patient care at the core of health reform.[3] Clinical governance is seen as a key element in improving patient safety. It is defined as clear lines of accountability: knowing who has what roles and responsibilities.[4]

My own background is in public health nursing in Dublin North and I am interested in how clinical governance applies to my daily practice, specifically the provision of Home Service Support (HSS). This was formally known as Home Help or the Home Care Package and is funded by the HSE in the community setting. Applications for this service and caseload management of clients in receipt of it form part of my daily practice. However, I had not considered its impact on patient safety or thought about who has true clinical governance over service delivery?

In 2017 the Department of Health undertook a public consultation called *Improving Home Care Services in Ireland: Have Your Say!* In this, PHNs were identified as the professionals the general public would most likely contact for information about HSS. Therefore, it is essential that PHNs are knowledgeable about the delivery and structure of this service.

On January 1, 2018 the HSE's new *National Guidelines and Procedures for the Standardised Implementation of the Home Support Service* came into effect. This policy has streamlined the provision and delivery of this service nationwide. The service funding is now more transparent, and the application process is standardised nationwide.

An examination of the HSS patient information booklet says that help and support with everyday tasks and personal care will be provided by HSE staff or external providers on behalf of the HSE. The staff providing the hands-on care are healthcare assistants (HCAs).

These carers have different titles in different areas, their role is poorly defined and they are not regulated. Their levels of training and qualification vary enormously. In the UK, 40% of HCAs were found to have no relevant qualification and were not being supervised sufficiently or consistently to ensure patient safety.[7] In addition, research in the community setting reported that HCAs are increasingly working alone without adequate supervision and support.[8] My experience is that there has been a huge increase in HSS provision in my geographical area. I would question how well the HCAs delivering the services are being supported or supervised.

The NMBI in its Scope of Practice Framework[9] describes delegation as "when the nurse who has authority for the delivery of healthcare transfers responsibility for the role to another person" ie. the HCA. When this happens, the registered nurse is accountable for ensuring that the HCA is competent to perform the caring role that they are delegating. In the case of the HSS delivery, the HSE states in its 2014 *Home Help Services Roles and Responsibilities* policy that the PHN service retains clinical governance of this service on behalf of the HSE. No attempt has been made to revise this document in line with increasing and changing service delivery.

INMO stance on 2014 policy

Interestingly, this 2014 policy is being disputed by the INMO. The union argues that the governance structure outlined in this policy is unsafe and unworkable. Members are advised not to accept responsibility for the governance of the HSS as outlined in the policy. INMO director of industrial relations Tony Fitzpatrick is involved in ongoing negotiations with the HSE to reach consensus as to how to provide a more constructive form of clinical governance for this service.

This document needs to be carefully considered by all PHNs. It states that PHNs have oversight and responsibility for all clinical aspects of care delivered by home helps (and presumably HCAs) on behalf of the HSE. This is regardless of whether the care is delivered by HSE employees or private care agencies contracted by the HSE. PHNs are responsible for ensuring that home helps are competent and certified. They also should delegate, orientate, supervise and monitor the care delivered by home helps.

The NMBI (2015) states that organisations should put structures in place to support the delegation of care by nurses to HCAs. My view is that the HSE has failed to adequately do this and that is why the INMO is disputing this clinical governance document. Currently there is a state of limbo as to who has true clinical governance over this service.

Recent HSE figures show that 1,553 PHNs are employed in the Republic of Ireland.[10] The National Service Plan states that over 53,000 people will receive a total of 17.9 million hours of home care support.[11] This means that on average each PHN has governance over 11,526 hours of care provision funded by the HSE. The practicality of every PHN having true clinical governance over 11,526 hours of HSS, in addition to our other roles, is unlikely. In

my opinion, true clinical governance of this service is not happening.

When promoting the implementation of clinical governance to improve patient safety there is a need for clarity. Staff members need to know and understand their personal, team role and responsibilities at all times. The HSS delivery is under the control of the Social Care Division of the HSE and the PHNs work in the Primary Care Division.

My impression is that PHNs have no defined authority in this process and therefore cannot affect any meaningful change. This is an example of a confused unsafe picture that is a risk to patient safety.

As an individual PHN on the ground, it is not clear what my roles and responsibilities in relation to the clinical governance of this service provision are. In my opinion the new HSS Guidelines (September 2018) necessitate the review and updating of Clinical Governance as set out in the HSE's *Home Help Service Roles and Responsibilities* document.[12]

Imminent risk

The current clinical governance structure states that PHNs retain clinical responsibility for all care delivered via the HSS. This is regardless of whether the HCA works directly for the HSE or a private agency. This type of governance is inappropriate and not fit for purpose as, how can you be responsible for clinical care delivered by an external agency over whom you have no authority?

Safety is an organisational issue and not just an individual practitioner one. The outcome of the 2014 HSE *Home Help Service Roles and Responsibilities* document will be to blame the person nearest the incident,[13] in this case the PHN, when poor standards of care delivery come to light.

In my opinion the application of clinical governance to the HSS provision in Ireland is flawed and an imminent risk to patient safety.

Rachel Eustace is a qualified public health nurse working in Malahide, Dublin North. She is currently undertaking a Masters in Leadership in the Royal College of Surgeons.

References

1. World Health Organisation. Patient Safety Making health care safer. Geneva, Switzerland: WHO; 2017 [Available from: https://www.who.int/patientsafety/publications/patient-safety-making-health-care-safer/en/.

2. World Health Organisation. 10 facts on patient safety Geneva, Switzerland.: WHO; 2018 [Available from: http://www.who.int/features/factfiles/patient_safety/en/.

3. Government of Ireland. Slaintecare Implementation Strategy. Stationery Office, Dublin 2: Government of Ireland; 2018

4. Health Service Executive. Quality and Patient Safety, Clinical Governance Leaflet. Dublin 8: HSE; 2012

5. Department of Health. Improving Home Care Services in Ireland: Have Your Say! Dublin 2: DoH; 2017

6. Health Service Executive. National Guidelines & Procedures for the Standardised Implementation of the Home Support Service (HSS Guidelines) September 2018 Kells Co Meath Ireland.: HSE; 2018 [Available from: https://www.hse.ie/eng/services/list/4/olderpeople/national-guidelines-and-procedures-for-the-standardised-implementation-of-the-home-support-service-hss-guidelines.pdf.

7. Cavendish C. The Cavendish review: an independent review into health care assistants and support workers in the NHS and social care settings. London: Department of Health.; 2013

8. Glackin P. The Evolving Role of the Health Care Assistant and its Implications for Regulation in the Republic of Ireland-A Case Study Approach. Northumbria University, UK.; 2016

9. Nursing and Midwifery Board of Ireland. Scope of Nursing Midwifery Practice Framework. Dublin: NMBI; 2015

10. Health Service Executive. Health Service Employment Report: November 2018. Dublin 8: HSE; 2018 [Available from: https://www.hse.ie/eng/staff/resources/our-workforce/health-service-employment-report-nov-2018-.pdf

11. Health Service Executive. National Service Plan 2019. Dublin 8: HSE; 2019

12. Health Service Executive. Home Help Service Roles & Responsibilities Dublin 8: HSE; 2014 [Available from: https://www.hse.ie/eng/services/list/4/olderpeople/hse-clinical-governance-for-home-help-service-roles-and-responsibilities-august-2014.pdf

13. Warrick DD. The urgent need for skilled transformational leaders: Integrating transformational leadership and organization development. J Leadership, Accountability, and Ethics. 2011;8(5):11-26

Nurses are well positioned to positively affect the health and care of homeless people, writes **Jessica Kenny**

Caring for the homeless

HOMELESSNESS marginalises people in many ways, but its negative effects are particularly acute in the context of access to healthcare. In Ireland the median age of death of a homeless man is 43 years and lower for a woman at 41 years.[1] This is almost half the life expectancy of the general population.

Homeless people have significantly higher morbidity and mortality rates than those of the general population. Studies have shown that homeless people account for a disproportionate number of attendances in emergency departments and are at a higher risk of re-attendance due to social, health, housing and addiction issues.[2] Additionally, the presence of a mental illness, alcohol and drug addiction leads to a significantly higher attendance rate than those without these factors.

Homeless people do not usually have a registered address and are documented as 'NFA' (no fixed abode). This leads to significant administrative difficulties communicating through the normal hospital procedure, such as posting outpatient appointments. It is not surprising, therefore, that there is a high 'did not attend' rate among this cohort.

As healthcare workers, we need to be more imaginative when caring for homeless people who are on the margins of our healthcare system. National reports stress the 'inappropriate usage' of EDs by homeless people for refuge and shelter and urge that this situation be addressed. However, this also presents healthcare workers with a unique opportunity to engage.

Homeless people are often discharged into inappropriate accommodation with poor aftercare or respite services available to them. This can result in repeat attendances, usually with similar complaints. This is neither cost-effective nor efficient and it is detrimental to their health and wellbeing.

Dublin in particular is seeing increasing numbers of homeless patients in adult and children's hospitals. The inclusion of community and primary care services in the care plans of homeless patients being discharged is essential.

The area of 'inclusion health' has made significant advances in the past few years with the introduction of new hospital posts that have proven to be very effective. In Dublin, the Mater Misericordiae University Hospital and St James's Hospital are piloting projects aimed at improving the health of those traditionally on the margins of healthcare. This was in response to an identified need for a co-ordinated approach in caring for homeless people. It is based on the HSE National Office for Social Inclusion's aim of reducing inequalities in health.

A lot of this is done through increased co-ordination of care and services between the community and the hospitals. People who are homeless often have negative experiences with authority and healthcare services. The reasons for this are complex but must be recognised and acknowledged.

The introduction of inclusion health nurse posts has allowed a single point of contact for the community services which is invaluable. Where possible, staff (clinical and non-clinical) working with homeless people in the community are encouraged to participate and are included in care plans. It is community services and homeless agencies that we rely on to implement patient care plans on discharge. Direct access to a specialised nurse in the hospital who is also familiar with the real health and social issues that people are facing on discharge has been shown to be very effective.

Safe discharges are promoted and prioritised throughout the Irish healthcare system. However, this is an area in which, at times, we are failing for the homeless. This can come down to lack of access to medication on discharge and not communicating discharge information/appointments to the relevant people. This has improved with the introduction of the inclusion health posts in the hospitals. The hospital staff and community services also now meet regularly to look at complex cases and how best to manage the health needs of this cohort and try to plan for safe discharges.

Providing nursing services to homeless and marginalised people, while extremely challenging, is also very rewarding. When trust is gained, co-operation often follows, and it is extraordinary how rapid progress can be made. Having a holistic multidisciplinary and multisectoral approach is valuable and allows maximum assistance to be given. Such considerations are essential when designing a care plan since healthcare is often not the priority for homeless people, given the chaotic nature of their lives.

Continued and persistent engagement allows a nurse to really know the patients and their needs and a high level of trust can be developed. Since nursing traditionally plays a large part in the co-ordination of care in the hospital and primary care setting this puts us in a critical position to positively affect the health and care of homeless people. Given the stark mortality and morbidity rates among those who are homeless, healthcare workers have a vital role to play in breaking down the barriers that are present for this patient group.

Jessica Kenny is an ANP candidate at the Mater University Hospital, Dublin

References
1.Ivers JH, Zgaga L, O'Donoghue-Hynes B, Heary A, Gallway B, Barry J. Five-year standardised mortality ratios in a cohort of homeless people in Dublin. BMJ Open 2019
2. O'Reilly F, Barror S, Hannigan A, Scriver S, Ruane, L, MacFarlane A, O'Carroll A. Homelessness: An Unhealthy State. Health status, risk behaviours and service utilisation among homeless people in two Irish cities. Dublin: The Partnership for Health Equity (2015)

Informed consent

Hazel A Smith discusses the process of obtaining informed consent and assent in children's clinical research

RESEARCH is seen as a core value by the Nursing and Midwifery Board of Ireland (NMBI). Principle 3 of the Code of Professional Conduct and Ethics states: "Nurses and midwives value research. Research is central to the nursing and midwifery professions. Research informs standards of care and ensures that both professions provide the highest quality and most cost-effective services to society."[1]

Patients, family members and staff deserve the opportunity to benefit from and participate in research. Children, regardless of age, are no exception to this standard of care. As children are a unique and vulnerable population there are additional ethical and legal steps that must be adhered to when undertaking paediatric research.[2] Informed consent and assent are one of the most important elements of research.

The aim of this article is to discuss, in brief, informed consent and assent for nurses and midwives undertaking their own research in child health. In this article a child's legal guardian(s) will be referred to as parent(s).

Legal definitions of informed consent and assent in research come from legislation involving clinical trials. The European Union Clinical Trials Directive (2001/20/EC) defines informed consent as a: "decision, which must be written, dated and signed, to take part in a clinical trial, taken freely after being duly informed of its nature, significance, implications and risks and appropriately documented, by any person capable of giving consent or, where the person is not capable of giving consent, by his or her legal representative."[3]

This definition is transposed into Irish law (SI No190/2004 – European Communities [Clinical Trials on Medicinal Products For Human Use] Regulations, 2004).

Under part four of SI No 190/2004 child assent is defined as providing "information according to his or her [child's] capacity of understanding, from staff with experience with minors, regarding the trial, its risks and its benefits. The explicit wish of a minor who is capable of forming an opinion and assessing the information…to refuse participation in, or to be withdrawn from, the clinical trial at any time is considered by the investigator."[4]

Informed consent and assent is an ongoing process and is much more than a paper exercise. It starts as early as recruitment and continues throughout the child's participation in the research study. The process of informed consent and assent must adhere to the study protocol that was approved by the ethics committee and be fully documented in the child's medical records. Nurses and midwives can take consent for observational (non-interventional) studies once it has been approved by the ethics committee.

In Ireland, children under 18 years of age require the consent of their parent(s) to participate in observational studies.[5] Parents who are under 18 years of age themselves may still consent for their child. Currently, only one parent is required to sign the consent form but it is preferable to have the signatures of all parents.

When approaching parents and their children to participate in research studies it is important that the environment is appropriate. Waiting rooms are usually not suitable as it is a busy environment, parents and children can be distracted waiting to hear their name being called and other parents and children can hear the conversation. Parents and children must be given information sheets about the study, have the opportunity to ask questions and time (where possible) to think about participating in the study.

The language used, both oral and written, should be as non-technical as possible so that both the parent and, where possible, the child can understand what is involved with taking part in the study. The language used cannot be coercive or influential (eg. 'we need you to take part'). It is also important to remember that Ireland's adult literacy levels are below the European average[6] and that some parents and children may have learning disabilities or difficulties with sight and/or hearing.

There is no universal agreement on what age you should start to seek a child's assent.[7] Each information sheet and assent form, given to a child, must be suitable for their stage of development. Study information sheets and their accompanying assent forms are usually broken up into different age groups, eg. four to six years, seven to 12 years and 13 to 17 years.

It is important to note that if the child changes age group during the course of the study then you will need to seek their assent again based on their new age grouping. For example, if you recruit a child when they are five years old to participate in a longitudinal study and they are still participating in the study when they turn seven years old you will need to gain their assent again. This is important because as children grow their understanding of the research and what it involves develops and it is important that they are re-approached to participate based on their greater understanding of the study. For observational studies, when a child turns 18 they can consent for themselves.

Hazel A Smith is a research co-ordinator for haematology/oncology at Our Lady's Children's Hospital, Crumlin

References:

1. Nursing & Midwifery Board of Ireland (2014). Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives. Dublin: NMBI

2. Nursing & Midwifery Board of Ireland (2015). Ethical Conduct In Research Professional guidance. Dublin: NMBI.

3. Directive 2001/20/EC of the European Parliament and of the Council of 4 April 2001 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the application of good clinical practice in the conduct of clinical trials with medicinal products for human use. Off. J. 2001;(34) EC No L 121

4. Irish Statute Book (2004) SI No. 190/2004 - European Communities (Clinical Trials on Medicinal Products For Human Use) Regulations, 2004 Retrieved from http://www.irishstatutebook.ie/eli/2004/si/190/made/en/ accessed in March 2019

5. Health Service Executive (2017). National Consent Policy 2017 Retrieved from https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/consent/national-consent-policy-august-2017.pdf in March 2019

6. Organisation for Economic Co-operation and Development (2016). Compare your County: Adult Skills Retrieved from https://www.compareyourcountry.org/adult-skills?cr=oecd&lg=en&page=0&charts=c1465293239548+c1465293241698+c1466427128067&template=6 accessed in March 2019

7. Lepola P et al (2016). Informed consent for paediatric clinical trials in Europe Archives of Disease in Childhood 101:1017-1025

Supporting role

The role of a specialist nurse is key in the ongoing care and support of patients with IBD, writes **Angela Mullen**

INFLAMMATORY bowel disease (IBD) comprises two main conditions: ulcerative colitis and Crohn's disease. These are acute and chronic inflammatory conditions affecting the gastrointestinal tract, of uncertain aetiology. They are non-gender specific and can occur at any age.

There are approximately 40,000 people living with IBD in Ireland. Both diseases cause ulceration of the digestive tract. Crohn's disease can affect all areas from the mouth to the rectum. Ulcerative colitis is restricted to the large intestine.

IBD is an unpredictable disease, with currently no known cause or cure. Management of the condition is through medication and lifestyle changes. The disease affects the ability of the digestive system to function properly. The most common symptoms include: persistent diarrhoea, vomiting, abdominal pain, cramping, bleeding, severe weight loss, chronic fatigue and malabsorption of essential nutrients.

Onset triggers are well known: medications, ie. non-steroidal anti-inflammatory drugs (NSAIDs), some antibiotics, stress and anxiety. At the time of a flare of their disease, patients need lots of support from their IBD healthcare team, in which the IBD nurse specialist plays a significant role. However, in times of remission or with symptoms under control, patients can experience extreme fatigue and still require support to maintain a good quality of life.

As the IBD nurse specialist in the Mater University Hospital and with over 20 years' GI experience, my role forms the main conduit for communication and support between the patient and the multidisciplinary team. The role involves providing constant patient support. Regular weekly outpatient clinics are the main mechanism of keeping in touch with patients and those requiring support and assistance in the management of their condition.

In addition, I provide a telephone and email support service, giving advice and recommendations to facilitate patients in self-managing their symptoms. As a result we reduce unnecessary hospital visits and admissions. This advice and support is seen as a life-line for some patients, who in an acute phase are frightened to leave the security of their homes, for fear of having an 'accident'. Talking to a nurse, who is a familiar face/voice, can be very reassuring for them during such difficult situations.

In addition, the provision of rapid access to GI specialist clinics can often save valuable time and resources within the healthcare sector – for example attending an already overcrowded emergency department – by providing appropriate patient-centred care.

Education and self-management is key in attempting to manage and control this unpredictable and unsociable disease. As patients become more aware of their disease and its triggers, they can move forward and maintain regular and normal daily activities without fear or anxiety of their condition. Patients with IBD should be capable of carrying out and maintaining a normal existence, eg. attendance at work, travel, sports, school and college.

As part of education and self-management, my role also involves the encouragement of patients to ensure adherence to the accurate and most effective use of their medication. We have very effective medical treatments in oral, rectal, intravenous (IV) and subcutaneous (SC) preparations, which if used correctly are hugely beneficial in the long term and avoid the repeated over use of short-term treatments, such as steroids.

As with any chronic illness, taking medication when patients are feeling well is often an issue, therefore continued education and advice are necessary to ensure long-term usage for continued management of the condition. This is a significant part of the role of the IBD nurse.

These medications are expensive and all are covered on the drugs payment scheme, currently at a cost of €124 monthly. However, as a chronic illness, IBD is not automatically covered under the medical card scheme or long term illness scheme. If IV therapy is required then an additional cost of €80 up to a maximum of €800 per annum government duty is a further cost to non-medical cards holders.

As with any chronic relapsing condition that may begin in early life and require individuals to access healthcare repeatedly over many years, IBD is multifactorial. Keeping patients well and out of hospital, encouraging them to maintain a normal lifestyle and stay healthy is my mantra.

Currently, in Ireland, there are 23 IBD nurse specialists working in various centres, supporting an estimated 40,000 patients, with headcount numbers well outside recommended international standards. In the UK, for example the guidelines are to have one full-time clinical nurse specialist per 666 patients *(Crohn's and Colitis UK Report 2017)*.

The Irish Society for Colitis and Crohn's Disease – **www.iscc.ie** – launched a 'double up campaign' in November 2017 to increase headcount and highlight the lack of IBD nurses available to maintain an acceptable standard and provision of care throughout the country. The current role of the IBD nurse specialist in Ireland is very valuable for patients and their ongoing care and support.

Angela Mullen is an IBD nurse specialist at the Mater University Hospital, Dublin

Major deficits in diabetes services

Despite the pressure on hospitals and lack of staff, there still appear to be barriers to referring people with uncomplicated type 2 diabetes to primary care

SERIOUS shortcomings in the delivery of diabetes services by Irish hospitals have been highlighted in a recently published survey, which has suggested that there seems to be a reluctance to refer patients with uncomplicated type 2 diabetes back to primary care.

The National Model of Integrated Care recommends that those with uncomplicated type 2 diabetes should be treated in primary care. These patients should be discharged into primary care if they are participating in this model of care.

Findings from this survey suggest that many hospitals are still accepting referrals for people with uncomplicated type 2 diabetes and the majority of hospitals are not routinely discharging people requiring uncomplicated management with a medical card or GP visit card into primary care.

According to the report, although many hospitals have agreed to the model in principle, there was a perception that GPs were reluctant to take these patients. There were also concerns about the level of diabetes services patients would currently receive in primary care.

Concerns

The recently published National Survey of Diabetes Care in Acute Hospitals[1] prepared on behalf of the National Clinical Programme for Diabetes in 2017, included all 31 public hospitals currently providing diabetes care in Ireland. It drew attention to several areas of concern.

The survey highlights understaffing and lack of service availability across Ireland. The current national whole-time equivalent of consultant endocrinologists is estimated to be 72% lower than recommended minimum levels. Major staffing deficits were also identified across other disciplines, with a national deficit of 95% in psychologists, of 74% in dietitians, 32% in podiatrists and 19% in specialist diabetes nursing staff.

Staffing levels

The report says that in order to achieve an integrated diabetes model of care, adequate staffing levels need to be in place to allow for hospital multidisciplinary teams to manage people with complex diabetes, while supporting general practice to deliver a greater amount of routine diabetes care to people with uncomplicated type 2 diabetes.

In terms of getting an overview of the problem, the report said that setting up a national diabetes register is complicated by the fact that current hospital patient registers and management systems differ and some cannot even generate a list of diabetes patients.

In addition, a clinical information system that can track individuals as well as patient populations has been described as a necessity when managing chronic illnesses such as diabetes. Only 17 of the 31 diabetes services reported they could generate a list of diabetes patients. Only four of the 31 diabetes services could provide 'actual' figures for the number of patients attending in 2016.

Recommendations

In relation to type 1 diabetes, the national model recommends that people with type 1 diabetes should be managed in secondary care and seen two to three times per year. Complicated type 2 diabetes should be seen at least once a year in secondary care.

However, recommendations are not being met by many hospitals, with over half reporting a recall time of more than seven months for adults with uncomplicated type 1 diabetes and almost a quarter of hospitals reporting a recall time of more than 13 months for people with type 2 diabetes who are on insulin.

Despite the importance of structured patient education for people with type 1 or type 2 diabetes, only 409 adults with type 1 diabetes attended such a programme in 2016, with only 158 having attended a programme which meets international standards. Hospitals not delivering structured education for type 1 patients identified lack of dietetic support to deliver education as a major issue.

On foot care, not all hospitals are meeting recommendations made in the updated draft Model of Care for the Diabetic Foot. All nine 'Model 4' hospitals reported having a multidisciplinary foot team but not all had access to all the specialties recommended as part of a team. Of the remaining 22 hospital services, findings suggest that over one-third do not have the recommended established foot protection team in place.

In addition, it is recommended that obesity surgery should be included as a treatment option for certain people with type 2 diabetes. The findings suggest that the numbers referred for bariatric services are small, with an estimated 61-64 patients being referred in the 12 months prior to the survey.

Staffing levels, access to structured diabetes education that meets international standards, better clinical information systems to track diabetes populations, improvements in diabetes foot care and improved access to bariatric services are priority areas that need to be addressed, the report concludes.

– Geraldine Meagan

Reference
1. O'Donnell M, Smyth N, Dinneen SF on behalf of the National Clinical Programme for Diabetes. National Survey of Diabetes Care Delivery in Acute Hospitals. As accessed on: https://www.hse.ie/eng/about/who/cspd/ncps/diabetes/resources/national-survey-of-diabetes-care-delivery-in-acute-hospitals-2018.pdf

Childhood atopic eczema

David Buckley outlines a stepwise approach to managing atopic eczema – from emollients to effective application of topical steroids

ATOPIC eczema is a common, chronic, hereditary skin condition that affects up to one in five children.[1] It can be associated with other atopic diseases such as asthma, allergic rhinitis or allergic conjunctivitis in the patient or in other family members. The basic underlying problem in atopic eczema is a skin barrier defect resulting in porous skin that allows irritants, allergens and infectious agents to enter the skin, causing inflammation and itch. There is also increased transepidermal water loss leading to dry skin.

Atopic eczema causes itchy skin which is sometimes intense and intolerable. If there is little or no itch, then the child probably does not have atopic eczema. The resulting scratching can lead to more skin damage that results in further skin barrier dysfunction. While the majority of children with atopic eczema have mild to moderate disease that clears as they get older, a small percentage of children with atopic eczema (10%) can have severe disease that causes misery for the child and also for parents and extended family. These children may continue to have atopic eczema into adult life.

There are no characteristic histological features or blood tests to confirm the diagnosis of atopic eczema. However, there are agreed strict criteria to enable an accurate diagnosis to be made *(see Table 1)*. Differential diagnosis of a child with an itchy rash includes scabies, seborrhoeic dermatitis, psoriasis, tinea infection, dermatitis herpetiformis, pityriasis rosea, discoid eczema and contact dermatitis.

Management of atopic eczema

The management of atopic eczema can be divided in to six main areas: emollients, eliminating irritants, topical treatments, dealing with infections, systemic treatments and dealing with allergens.

Emollients

Using emollients is the most effective and cheapest way to restore the defective skin barrier.[2] The best emollient is the greasiest one the patient can tolerate. Because they remain on the skin for a number of hours, they only need to be applied two or three times per day. Greasy moisturisers should be rubbed downwards (like you stroke a cat) especially on hairy skin, as rubbing them up and down can result in them blocking hair follicles which can cause folliculitis.

Emollients are steroid sparing but sufficient quantities (eg 500-1,000g/month) should be applied, depending on how much skin is involved and the size of the child.[2,3] It is important to warn parents that paraffin-based emollients can be slippery, especially in the bath or on tiles, and are flammable, especially if they impregnate cotton clothing. If the parent wants to try a non-paraffin-based emollient, pure virgin coconut oil can be tried, which can be inexpensive in supermarkets' grocery section.

A recent study showed that daily application of moisturisers during the first 32 weeks of life reduces the risk of atopic eczema by 32% in infants at risk of atopic eczema due to a family history.[3]

Eliminating irritants

Soaps, shampoo, conditioners, shower gels and bath additives often contain detergents that break down oil, which is the last thing a child with atopic eczema needs as they already have too little oil in their skin. Therefore, it is important to use products that are free from soap, perfume and preservatives. Other irritants that need to be avoided are perfumes, bubble baths, talcs and deodorants.

Topical treatments to control the itch

Targeted therapies such as topical steroids or topical calcineurin inhibitors (TCIs) can be effective at easing itch *(see Figure 1)*.

Table 1: Diagnostic criteria for atopic eczema

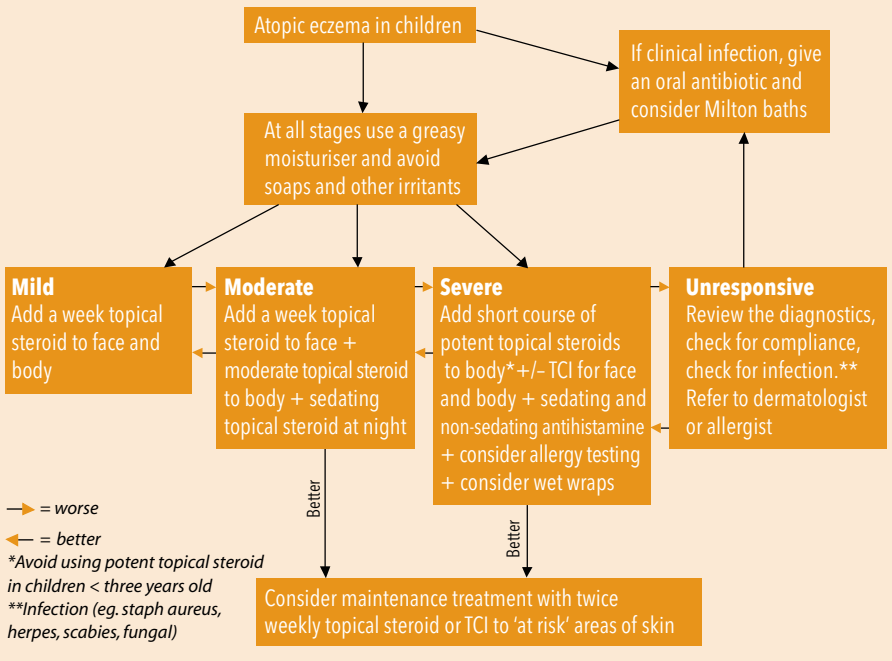
Must have:

- An itchy skin condition (or report of scratching or rubbing in a child)

***plus* three of the following:**

- History of itchiness in skin creases such as folds of the elbows, behind the knees, front of ankles or around neck (or cheeks in children under four years)
- History of asthma or hayfever (or history of atopic disease in a first degree relative in children under four years)
- General dry skin in the past year
- Visible flexural eczema (or eczema affecting the cheeks or forehead and outer limbs in children under four years)
- Onset in the first two years of life (not always diagnostic in children under four years)

Figure 1: Stepwise approach to atopic eczema



Topical steroids are divided into four main categories:

- Mild (1% hydrocortisone ointment for the face) – suitable for children of all ages
- Moderate topical steroid (Eumovate) ointment for the body – suitable for children of all ages
- Potent topical steroids – should be avoided in children under the age of three and should only be used for a maximum of two weeks in children with severe atopic eczema aged three to 12 years
- Super potent topical steroids – should never be used in children.

Ointments are safer than creams as they can act as an emollient and contain fewer preservatives.

There is a lot of fear around using topical steroids in children and some parents are steroid phobic. However, when used correctly under medical supervision, topical steroids are extremely safe and effective. It is important to know which strength steroid to apply to which part of the body and what is the correct amount to use. Words like 'use sparingly' are unclear and unhelpful and can be alarming to worried parents. It is far more useful to give a parent a particular size tube of topical steroids and tell them how often to apply it (usually once at night to affected areas), which area of the body to apply it to (face, flexures or the body) and give them some indication as to how long that particular size and strength tube should last *(see Table 2)*.

TCIs include tacrolimus ointment which is as potent as a potent topical steroid but has none of the potential steroid side effects such as skin thinning or suppressing of the adrenals. Because it is expensive and slow to work, tacrolimus ointment is usually reserved for the more severe resistant cases of atopic eczema. The 0.03% strength may be used in children from the age of two to 16 years. Adults can use the more potent 0.1% strength. It should be applied twice a day to affected areas for up to three weeks and then twice a week to prevent relapse. It can be used on any part of the body including the face, flexures and genitalia. One difficulty with tacrolimus ointment is it can cause a transient irritation and apparent worsening of the rash in the first week of use in up to 50% of patients. It is impossible to predict who will react. Around 10% of children cannot tolerate tacrolimus ointment, even after the first week of application.

Systemic treatments to control the itch

If the itch is keeping the child awake at night, a sedating antihistamine, such as promethazine hydrochloride can be useful to prevent itch and promote sleep. However, it is not licensed for children under two years of age. The new generation, non-sedating oral antihistamines may be helpful for severe atopic eczema and can be given in the morning. Oral steroids are rarely necessary in managing atopic eczema in primary care as topical steroids are safer and more effective in the majority of cases.[4]

Dealing with infections

Atopic eczema is usually dry and itchy. If it is wet, sticky, weepy or sore, this usually implies that the skin has become infected *(see Image 1)*. Topical steroids and TCIs do not work if there is infection present. The most common organism to cause clinical infection is *Staph aureus,* which is usually sensitive to fucidic acid cream and/or flucloxacillin or clarithromycin orally.

If the child is prone to recurrent skin infections, it might be worth bathing them in a Milton bath (1ml of Milton per litre of water; soak for a maximum of five minutes and then rinse off with shower head).[5] Children with atopic eczema are also prone to viral infections such as *molloscum contagiosum* and herpes simplex virus. Herpes simplex can present as a fever or worsening eczema and multiple vesicles or punched out small ulcers in one area of the body *(eczema herpeticum)*. This usually requires hospital admission for systemic anti-viral treatment.

Dealing with allergens

Allergy testing should only be considered for children with moderate or severe atopic eczema not responding to standard therapies. While many parents may suspect food allergies, non-food allergies such as animal dander, pollen and house dust mite might also aggravate atopic eczema.

Allergy tests such as skin prick tests, blood tests for IgE and RAST and skin-patch tests may identify underlying offending allergens. However, these tests are difficult to carry out on small children and are not 100% sensitive or specific.

Table 2: Diagnostic criteria for atopic eczema

Potency	Adult	12 years	Three years	Infant < 12 months old
Mild	No max	No max	200g***	100g***
Moderate	200g	100g	60g	30g
Potent*	90g	30g	15g (for acute use only)	Avoid
Very potent	30-60g	Avoid	Avoid	Avoid

** Adapted from: Position paper on diagnosis and treatment of atopic eczema. EADV (2005)19, 286-295*
*** Four times this amount can be prescribed if using Betnovate RD*
**** This is for demonstration purposes only. In practice it would be impractical to use this much mild topical steroid in a child. They probably a need moderate potent topical steroid rather than a large quantity of mildly potent one*

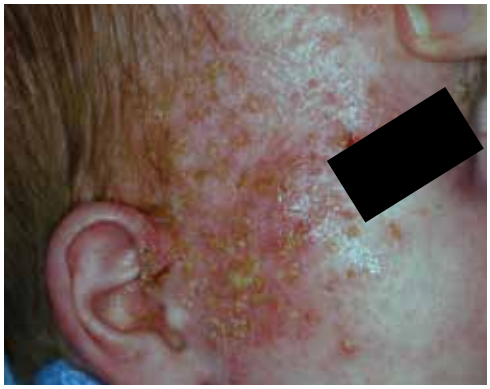


Image 1: Infected atopic eczema (staph aureus)

The most commonly implicated foods that can cause an allergic reaction resulting in atopic eczema in some children include dairy produce, soya, eggs, peanut and wheat.[6,7,8] It is reasonable to try a dairy-free diet in children with severe atopic eczema – the best substitute is an extensively hydrolysed formula. Hydrolysed formulas are better than soya-based dairy substitutes or goat's milk as children who are allergic to cow's milk are often also allergic to soya. Exclusion diets should be limited to six weeks. The restricted food should then be gradually re-introduced. If the itch and rash clear up on stopping the food and recur once the food is re-introduced, this is a reasonably accurate test of food allergy. Eggs, wheat, peanuts or soya can also be eliminated for six weeks if there is sufficient suspicion that the child is allergic to one of these foods. If the child is to be left on a restricted diet, a dietitian should be involved. Children often grow out of food allergies so restriction should be reviewed annually.

Severe cases of atopic eczema in children may need to be referred to a skin or allergy specialist as some may need specific allergen immunotherapy[9] or systemic treatments such as methotrexate, cyclosporin or some of the newly developed biological agents.

David Buckley is a GP at the Kerry Skin Clinic, Tralee

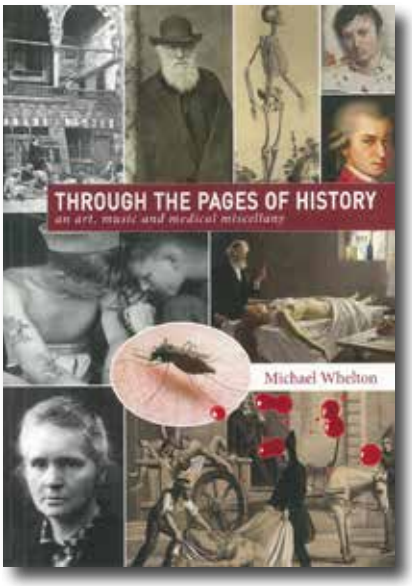
References available on request. Email nursing@medmedia.ie (Quote Buckley D. WIN 2019: 27(4):51-52

A well written miscellany

DID Richard III really have a hump? How did Stalin die? Who really invented penicillin? These and other questions are explored and answered in *Through the Pages of History*, by retired medical consultant Michael Whelton. This is a selection of lively and entertaining essays which uncover some interesting medical perspectives on figures and events from history.

As regards the aforementioned monsters and their medical conditions, Richard III wasn't actually a hunchback but suffered from scoliosis. Stalin died following a stroke having suffered a number of TIAs previously. Both of them had impressive tyrant CVs, killing enemies real and imaginary (mostly imaginary in Stalin's case) with gay abandon. Stalin's evil was on a greater scale than that of Richard III, whose bloodthirsty behaviour was probably pretty standard for medieval times.

Stalin at the time of his death in 1953 was propagating 'The Doctors' Plot', which saw many medics tortured. Had he not died, many doctors would have been executed. Good times – and not too long ago either.



Michael Whelton also reveals an Irish connection here. Stalin suffered from Cheyne-Stokes breathing, first described by two Irish physicians.

Incidentally, who was the first American to hear of Stalin's death? Johnny Cash (yes that Johnny Cash), who was working as an army Morse code operator in Germany at the time. This isn't in the book, but it's useful to know.

The book has a particularly interesting chapter on the invention of penicillin. Alexander Fleming essentially discovered penicillin by accident in 1928. However, he failed to refine it and develop it as a medicine and eventually abandoned work on it. Later, three other scientists – Florey, Chain and Heatley – had more success, leading to penicillin's eventual mass production from the 1940s. While he did play a major role in the discovery of the 'wonder drug', Fleming had little or nothing to do with its successful development.

This and many other medico-historical stories are told in a very engaging style by Dr Whelton. The book could have done with slightly better proofreading, however, for example, it was Henry VI, not Henry I, who was briefly restored to the English throne during the Wars of the Roses.

– Niall Hunter

Through the Pages of History – an Art, Music and Medical Miscellany. Published by The Manuscript Publisher RRP €12.99 ISBN: 978-1-911442-16-5

CROSSWORD Competition

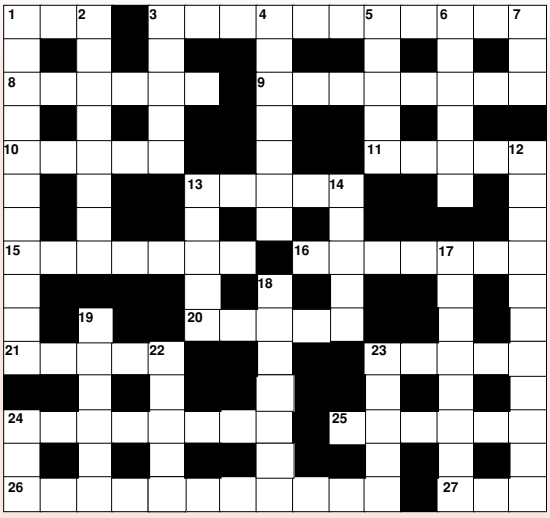
WIN a €50 gift voucher

Across

1 Pub (3)
3 The chief culprits or organisers of troublemaking (11)
8 Vegetable paste in Cork's river (6)
9 Wealthy (8)
10 Chelmsford is in this English county (5)
11 Perhaps the safe contains a hot bundle (5)
13&15 Snack contained in white barrels (5,7)
16 Make more rigid (7)
20 Strong winds (5)
21 Whatever floats your boat, Noah! (5)
23 Aviator (5)
24 Noticed (8)
25 Somewhere in La Paz, a leafy shrub may be seen (6)
26 Charity a cad upset – not a sign of a good heart that! (11)
27 But, however (3)

Down

1 Invulnerable to gunshots (6-5)
2 Formally enrol (8)
3 Rex, I'm about to get a remodelling of some music (5)
4 Divert the Lagan, or find a breakfast food (7)
5 Shafts upon which wheels spin (5)
6 The number of players on a soccer team (6)
7 Part of a tennis match (3)
12 Do they raise their glasses in Paris to this snack? (6,5)
13 Manually get the water out of a wet garment (5)
14 Detests, abhors (5)
17 Cheating, as in a drama called "Dangerous Tackles"? (4,4)
18 Thin, narrow (7)
19 Beautifully written (probably in verse) (6)
22 Dukedom (5)
23 Italian food with toppings on a base (5)
24 Morse code symbol (3)



April crossword solution

Across: 1 Banishment 6 Spam 10 Papal 11 Caesarian 12 Brioche 15 Teems 17 Came 18 Hits 19 Nicer 21 Forages 23 Wiser 24 Snap 25 Emir 26 Heart 28 Satanic 33 Fall apart 34 Cecil 35 Town 36 Beer garden

Down: 1 Baps 2 Nephritis 3 Salvo 4 Micah 5 Need 7 Poise 8 Manuscript 9 Hastens 13. Ciao 14 Eclairs 16 Chew the fat 20 Convinced 21 Fretsaw 22. East 27 Allow 29 Aster 30 Accra 31 Gate 32 Clan

The winner of the April crossword is: Sinéad Burke, Leixlip, Co Kildare

You can now email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included.
Closing date: Monday, June 24, 2019
If preferred you can post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin, A96E096

Name:
Address:

MONEY MATTERS

AVCs for SPSPS employees

Ivan Ahern discusses how the Single Public Service Pension Scheme could affect you at retirement

IF YOU started working in the public sector after January 1, 2013, then you are most likely in the Single Public Service Pension Scheme (SPSPS). Your pension entitlements would differ substantially compared to nurses or midwives who joined the public sector before 2013.

Given this, it is important to prepare financially for your retirement. An additional voluntary contributions (AVC) plan could make a big difference to your lifestyle and finances in retirement.

How the SPSPS will affect you at retirement

- You will receive a significantly reduced pension in comparison to your colleagues who are members of earlier pension schemes
- If you choose to retire early, for example at age 60, you will have to wait up to eight years before receiving the State Pension (which is increasing to age 67 in 2021 and to 68 in 2028)
- When you stop working, you will face a cut in annual income of almost 80%, meaning you may need to seek further employment in order to maintain your lifestyle.

See panel on the right for an example.

What to do about reduced benefits

An additional voluntary contributions plan allows you to make additional contributions towards your retirement benefits. At retirement, you can use your AVC to 'buy' extra benefits (subject to Revenue limits), such as:

- A tax-free lump sum (gratuity)
- An investment in a retirement fund
- An additional pension.

Other benefits include:

- AVCs are deducted from your payslip, so you get tax relief directly at source. For example, if you are a higher rate tax payer at 40%, for every €50 you invest in your AVC the actual cost to you is €30
- Unlike a savings plan, the money that you invest in your AVC cannot be accessed until you retire, which is a good thing.

If you start an AVC today

It's important to note that with an AVC you can stop, start, increase or decrease your AVC payments whenever you want. Here is an example of the savings fund you could have at retirement if you start an AVC today:

Weekly contribution	After 30 years
€12.50	€36,602
€25	€73,611
€50	€148,887

Assumptions: 2% contribution charge, 1% annual management charge, assuming 4% investment growth per annum, contribution increases by 2% annually. The actual charges on your AVC may differ.

Table: Pension case study comparison of those who joined the public sector before April 1995 and after January 2013

Paul and Laura are in different pension schemes. They are both retiring at age 60, with 36 years' service, on a salary of €60,000 per annum:	**Paul**	**Laura**
Joined public sector	Before April 1995	After January 2013
Income before retirement	€60,000	€60,000
Employer pension at age 60	€27,000	€10,670
State pension at age 68	€0	€12,965
Total pension at age 68	€27,000	€23,635

All figures are estimates

For the eight years between retirement at age 60 and receiving the State Pension at age 68, Laura who is in the Single Public Sector Pension Scheme could be on an annual income of just €10,670 – over €16,000 a year less than Paul. When Laura reaches 68, the State Pension will close some of this gap but will still leave Laura approximately €3,500 worse off each year. These differences would total almost €200,000, if Laura receives the pension until the age of 88

For more information, you can contact Cornmarket at Tel: 01-4206794.

Ivan Ahern is a director at Cornmarket Group Financial Services Ltd

Warning: The figures quoted in this article are estimates only. They are not a reliable guide to the future performance of an investment.

Warning: The value of an investment may go down as well as up.

Warning: This product may be affected by changes in currency exchange rates.

Warning: If you invest in this product you may lose some or all of the money you invest.

Warning: If you invest in this AVC product you will not have any access to your money until you receive your superannuation benefits

'Training Delivery and Evaluation' proves a hit among members

Congratulations to all the nurses and midwives who completed the 'Training Delivery and Evaluation' 6N3326 QQI Level 6 programme on April 10, 2019 at the Richmond Education and Event Centre. Pictured left are course participants with trainer, Margaret Nolan. Due to the demand for this programme it is scheduled again for September 24, 25 and 26 and November 14 and 15, 2019. For further details on this programme, see page 38

Oncology nurse specialists' meeting focuses on immunotherapy treatment

More than 120 oncology nurse specialists from across the country attended the second 'Foundation for the Future' nurse educational meeting held in Kilkenny recently, which focused on optimising patient management for cancer immunotherapy treatment. Pictured at the meeting were the Oncology Nurse Steering Committee (l-r): Aileen O'Meara, Maureen O'Grady, Caroline Gittens, Sheila Talbot, Olivia O'Grady, Annemarie O'Shea, Noeleen Sheridan, Pauline O'Dea and Kathryn Carney, Roche

CNSs honoured at CFI annual conference

Cystic Fibrosis Ireland (CFI) held its annual conference in April ahead of the charity's annual fundraiser, 65 Roses Day. The conference heard from medical experts on the latest developments in CF drug therapies and transplantation. Pictured at the conference was CNS Cathy Shortt (right) from Cork University Hospital, receiving a special recognition award for services to the CF community from CFI chief executive, Philip Watt (left). Also recognised at the conference was Peig Harnett, a CNS from University Hospital Limerick

THE ROYAL COLLEGE OF MIDWIVES

INMO
Irish Nurses and Midwives Organisation
Working Together

SAVE THE DATE

All Ireland Annual Midwifery Conference

'Being a midwife - love it or leave it'

Thursday, 17 October 2019

Armagh City Hotel, Armagh, Northern Ireland

Call for Posters

Poster addressing the Conference theme may be submitted by individual midwives, groups of midwives, midwifery students or service users.

Application forms and guidelines are available to download from **www.inmo.ie/midwives** or by contacting **jean.carroll@inmo.ie**

May

Thursday 16
Student Allocation Liaison Officers networking group. INMO HQ.

Saturday 18
School Nurses Section meeting. INMO HQ. From 10.30am

Tuesday 21
Telephone Triage Section meeting and education workshop. INMO Limerick office

Saturday 25
CNN/CNM Section meeting and tools for safe practice workshop. INMO HQ. Section meeting from 10am. See *page 32* for details

June

Wednesday 5
Orthopedic Nurses Section meeting. 11am, via teleconference

Saturday 8
PHN Section meeting. INMO HQ. 11am-1pm

Saturday 8
Community RGN Section meeting. INMO HQ. 11am-1pm

Saturday 8
Midwives Section meeting. Galway University Maternity Hospital. From 2pm

Tuesday 11
National Care of the Older Person Section meeting. Richmond Education and Event Centre

Friday 14
Third Level Student Health Nurses Section meeting. Richmond Education and Event Centre. From 11am

Wednesday 26
CPC Section meeting. Richmond Education and Event Centre. 10.30am

September

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

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

Saturday 14
School Nurses Section meeting. Midland Park Hotel, Portlaoise. 10am

Thursday 19
Retired Section meeting. Richmond Education and Event Centre. From 11am

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

October

Saturday 12
PHN Section meeting. INMO HQ. 11am

Saturday 12
Community RGN Section meeting. INMO HQ. From 11am

Thursday 17
All Ireland Midwifery Conference Armagh

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

INMO Professional DEVELOPMENT CENTRE
Library Opening Hours

May
Monday-Thursday: 8.30am-5pm
Friday: 8.30am-4.30pm
by appointment

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

INMO Membership Fees 2019

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

Condolences

- The INMO Limerick Branch would like to extend its deepest sympathy to the family, friends and nursing colleagues of Mary Cregan, staff nurse at University Hospital Limerick, following her recent death. May she rest in peace.
- Our deepest sympathy is extended to Karen Reilly, INMO representative for the Daughters of Charity Services, Limerick following the recent loss of her father, John Hannan. May he rest in peace.
- The death has occurred of John (Jack) Godley, father of Marian Godley who works in the Richmond Educational and Event Centre. Our sympathies are with Marian and her family at this difficult time.