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WIN

World of Irish Nursing & Midwifery

INMO
Journal of the
Irish Nurses and
Midwives Organisation

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Strength, safety and solidarity

INMO members get ready for ADC 2024

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Strength, safety and solidarity

AS WE prepare for the 105th INMO annual delegate conference (ADC) the theme 'Strength, Safety and Solidarity' could not be more relevant. We have seen evidence of this over the past two weeks where our collective solidarity and strength led to the outcomes we sought.

In the first instance, I am referencing the long struggle the INMO has engaged in to achieve recognition of the lived experience of nurses and midwives who are assaulted at work, who suffer because of stressful work situations, who are exposed to biological hazards and become injured as a result, or who suffer from burnout due to the continuing unrealistic demands on them.

After many years of lobbying the HSE, Department of Health, Department of Business, Enterprise and Innovation, the political system and making several appearances before Oireachtas committees, we finally achieved the first step in change. On the first day of our annual delegate conference 2023, we met the then minister with responsibility for the Health and Safety Authority (HSA), Simon Coveney and junior minister Neale Richmond to set out the reasons to establish an advisory committee to the HSA specifically for health services.

This meeting resulted in Mr Coveney writing to the HSA and a proposal was made at the September Board meeting establishing the advisory committee. The first meeting of the committee was held in April 2024, which in essence marked the first step of State authorities taking the health and safety of health service workers seriously.

We cannot leave this to employers, the requirement for preventative measures using the precautionary principle must be imposed on them. The cost of keeping workers safe – and preventing incidents from occurring – cannot be secondary to the need to provide services.

The construction industry has been very successful in this area and the advisory committee to the HSA contributed significantly in shifting the focus from employers' push for productivity, to the safety of the workforce. This is where we must shift the focus of health employers. We are determined that this change will result from our participation in the HSA's advisory committee. Our collective strength will ensure that safety at work becomes the priority it needs to be.

Please take the time to read the HSE's Service Plan for 2024, the focus on provision of services ignores the reality of workforce wellbeing – with not one mention of the health and safety measures needed to keep staff in overcrowded, increasingly dangerous workplaces safe.

This is the reason we continue to call on State agencies who have a responsibility for workers' health to ensure that employers grasp that workers in the health services deserve similar protections to workers in any other part of the economy.

This month we celebrated the outcome of another longstanding campaign for justice when the Stardust families finally got the verdict that their loved ones had died by unlawful killing. The Richmond Hospital was one of the receiving hospitals for the injured on the night of the fire and, as an organisation, the INMO has become close to many of the campaigners over the past number of years. When we offered the families a memorial tribute to their relatives in the garden of the Richmond Education and Event Centre in 2021, they were truly delighted. We salute their strength and solidarity in never giving up until they achieved justice for their loved ones who never came home.

Strength, safety and solidarity are more important than ever.

We are looking forward to seeing all delegates at conference 2024. A full report of the 105th ADC will be included in the summer issue of *WIN* which you will receive in late June.

Phil Ní Sheaghdha
General Secretary, INMO

Only measure of success in UHL will be permanently reducing trolleys

NEW measures announced by the Minister for Health last month to alleviate overcrowding at University Hospital Limerick have been cautiously welcomed by the INMO.

INMO assistant director of industrial relations for the Midwest and Northwest, Mary Fogarty said: "As a union we have long been sounding the alarm and exposing the scale of overcrowding in University Hospital Limerick. The problems in the hospital have been allowed to escalate to an unsafe and unacceptable level. According to our INMO trolley figures, over 6,579 patients have gone without a bed in UHL since the beginning of 2024. Ten years ago in 2014 the *annual* overcrowding figure for UHL was 6,150.

"On a visit last month to the hospital, the Minister for Health met a group of over 20 INMO members who work in the hospital who gave him a very grave account of how difficult it is for nurses working in University Hospital Limerick.

"The only measure of success for the hospital will be a permanent reduction in the number of patients on trolleys. On many occasions we have had specialist measures introduced in UHL which saw a temporary reprieve in overcrowding only for the problems within the hospital to worsen. Strong, sustained and tangible action is required to end the unacceptable suffering of patients and staff."

The measures announced by the Minister to deal with overcrowding at UHL include temporary step-down facilities until new bed blocks are opened and the procurement of further permanent step-down beds. In advance of next winter an additional 16 fast build beds are to be available. In addition, opening hours of the region's three acute medical assessment units at Nenagh, Ennis and St John's are to be extended to 24/7.

Safe staffing will be extended to all wards in UHL as per the national rollout. UHL is to provide GP and ANP services for the ED in an effort to allow the ED staff to treat urgent and emergency patients in a more timely manner.

INMO welcomes extension of long-Covid scheme

THE INMO has welcomed the decision by the Minister for Health to extend the Special Scheme of Paid Leave for eligible public health sector employees suffering from long-Covid.

The INMO said: "We very much welcome the extension of this scheme to a group of predominately women who are still suffering from a myriad of symptoms associated with long-Covid.

"We hope this is an indication of the future approach that will be taken by the Department of Health and the HSE at the Workplace Relations Commission."

The scheme was introduced in July 2022 for an initial 12-month period for certain eligible public health sector employees suffering from long-Covid. At the request of the Minister for Health, this scheme was extended a number of times, most recently in October 2023 when it was extended to run until the end of March 2024. While the Department of Public Expenditure, NDP Delivery and Reform said at the time that would be the final extension, the Health Minister sought a further extension due to industrial relations pressures and announced last month that a further three month extension has been granted. The conclusion of the scheme has been the subject of an industrial relations claim from the INMO and other unions and has been referred back to the Workplace Relations Commission.

Latest Govt report into health service is "divorced from reality and fails to prioritise patient safety"

THE INMO has said the latest Department of Health/HSE-commissioned IGEES report[1] into the public hospital system is divorced from the reality of the lived experience of frontline patient-facing hospital staff.

INMO general secretary Phil Ní Sheaghdha said: "This is all about saving money rather than patient safety and investing in services. This report presents a different reality to that experienced by our members who are working in the public hospital system.

"The reality is we have never denied there has been an increase in the nursing and midwifery workforce, however that does not take into account the unprecedented population growth we have seen in the last four years, coupled with increased attendances and overcrowding which no public hospital in the State has been immune from.

"The Minister for Health has supported a measurement tool to implement safe levels of nurse staffing in medical and surgical wards in our public hospitals. Before this framework started to be rolled out, staffing was wholly inadequate in public hospitals. The continued implementation of the HSE's recruitment moratorium continues to pose a threat to safe staffing.

"This report does not take into account the lived reality of nurses and midwives in Ireland who are working in understaffed and overcrowded wards with patients with complex co-morbidities, while grappling with an outflow of staff who are leaving for pastures new and early retirements.

"The lived experiences of our working nurses and midwives within the Irish public hospital system must be taken into account."

Reference

1. Shine C, Hennessy M. Hospital Performance: An Examination of Trends in Activity, Expenditure and Workforce in Publicly Funded Acute Hospitals in Ireland. Irish Government Economic and Evaluation Service (IGEES), Research Services & Policy Unit, Department of Health April 2024

‘Excellence and enthusiasm’: tribute to Karen McGowan’s presidency

AS KAREN MCGOWAN finishes up her term as INMO president, we reflect on the invaluable contributions she has made. From the moment she joined the INMO Executive Council in 2016, Karen has brought fresh ideas to advance the nursing and midwifery professions. She has made all of her colleagues in Beaumont Hospital and the North Dublin Branch very proud.

Throughout Karen's time as INMO president, she has shown steadfast determination while demonstrating exceptional professionalism and adaptability. Being the president of the INMO is not an easy task at the best of times but Karen took up the mantel in the middle of a pandemic when so much was unknown for our professions.

Ensuring that nurses and midwives took centre stage in the rebuilding of the health service has always been Karen's priority and this has never faltered. Whether tackling complex issues such as Covid, getting public sector pay ballots over the line or ably chairing our annual conferences, Karen has approached each and every challenge with the same unwavering enthusiasm and a commitment to excellence.

During her time as president of the INMO, Karen also impressed us all by making the switch from ED advanced practice nursing to advanced practice in women's health. Karen is a wonderful ambassador for advancing your practice and her participation in INMO future planning days for undergraduate students to set out her clinical pathway was always so well received. You will no doubt be hearing much more about what Karen achieves with her colleagues in Beaumont in the future.

Clockwise from top: Karen McGowan on the steps of INMO headquarters in Dublin; speaking with the national press; and laying a wreath in the Garden of Remembrance with minister of state Neale Richmond for Workers Memorial Day

As Karen embarks on the next chapter in her professional career we extend our heartfelt gratitude to her for leading the Executive Council and her significant contributions on behalf of members at all levels, participating in negotiation teams and lobbying the political system. We also thank Karen for offering her wholehearted support to the Stardust families.

More recently, Karen designed and organised a programme which we hope will be an annual event – the hugely successful INMO Ladies Lounge. The concept clearly hit the right note as the feedback from those who attended was extremely positive.

We know Karen will continue to be very involved as an INMO member as she was prior to joining the INMO Executive.

We wish her the best of luck and good health in all her future endeavours, both professional and personal.

Go raibh míle maith agat Karen agus go n-éirí an bhóthar leat.

– Phil Ní Sheaghdha,
INMO General Secretary

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3. Farage MA. The prevalence of sensitive skin. Front Med (Lausanne). 2019;6:98 The Prevalence of Sensitive Skin - PMC (nih.gov).

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

Unions push for timely payment of PSA increases

ON ACCEPTANCE of the Public Sector Pay Agreement 2024-2026, the INMO wrote to the HSE requesting that the pay increases due under it would be paid in a timely manner. The unions received correspondence setting out the timeline for the pay increases due for HSE employees. The proposed timing of many of these payments was not acceptable to the INMO, with some regions not to receive increases until November. The INMO has requested an urgent meeting with the HSE to resolve this issue and has requested the Ministers for Health and Public Expenditure and Reform to remedy this matter.

Unacceptable payment delays in Section 39s

OVER recent weeks, the INMO together with Congress, Fórsa and SIPTU, have been pressing the HSE to increase the pace of the payment of monies to Section 39 organisations to allow them to pay the terms of the interim pay agreement. The unions consider the delay in making the payments to be unacceptable and the management side needs to ensure that the payments are made without any further delay. At a recent meeting with the HSE, the unions were assured that the HSE had been encouraging Section 39s to submit outstanding information necessary for payments to be made. The HSE confirmed that it was disappointed with the rate of return to date and that it had put in place all necessary supports to assist Sections 39s to complete the process. Further meetings are scheduled to review progress on this matter.

Ongoing National Joint Council (NJC) issues

Regional Health Areas

AT A briefing provided to the National Joint Council on HSE restructuring, the HSE said that there would be no downsizing under the new structure. This will comprise six regions, within which there will be at least 120 'integrated health areas', which will be a combination of acute hospitals and community services. The new regions are expected to be in place by September 1, 2024. At a separate engagement with the HSE, the staff panel secured confirmation that the structure of the negotiations between the HSE and the unions in relation to terms and conditions of employment would remain at national level.

Long-Covid claim

The Department of Health and the HSE previously notified the unions that the current arrangements for Special Leave with Pay (SLWP) for long-Covid would cease with effect from March 31, 2024. A temporary 12-month SLWP scheme was introduced in July 2022 for certain eligible public health sector employees suffering from long-Covid. The scheme was extended a number of times, most recently in October 2023 when it was extended to run until the end of March 2024. The Department of Public Expenditure, NDP Delivery and Reform (DPER) made it clear that this was a final extension, meaning the scheme would end on March 31, 2024. The conclusion of the SLWP scheme has been the subject of an industrial relations claim from health sector staff representative bodies and has been referred back to the Workplace Relations Commission (WRC).

The INMO and other unions sought a further extension to allow for further conciliation to take place on the matter. The Department of Health confirmed that DPER has approved a three-month extension to facilitate this. The reinstatement of the scheme will be retrospective to April 1, 2024, and will apply only to those individuals who were previously on the scheme. This will not impact on sick leave entitlements for those affected as a result of the conclusion on March 31, 2024. Health service employees impacted will be notified of this without delay.

Children's Hospital Ireland

The unions are seeking a meeting with Children's Health Ireland and the HSE in relation to industrial relations generally within CHI. The unions emphasised that CHI is not an independent entity but is comprehended by the National Joint Council and therefore must comply with Public Sector Pay Agreements and pay policy. The HSE stated that it has recently appointed a new HR director and that a meeting will be arranged as requested.

Local injury units

At a meeting between the unions and management at Naas Local Injuries Unit (LIU), the union set out a number of issues in relation to the unit, noting that these had been referred to the WRC. The unions stated that they were surprised that a report had been carried out in relation to the injuries units programme, on which they had not been consulted. The HSE stated that it had been requested to carry out a review with a view to standardisation across all LIUs. It has now committed to sharing the report with the unions and ongoing consultation on any changes relating to LIUs.

Marriage leave claim

The unions have secured agreement that there would be harmonisation of marriage leave arrangements with those in the Civil Service. The Department of Health has undertaken to produce a circular to harmonise marriage leave arrangements.

Bereavement leave

Following standardisation of the HSE's bereavement leave policy with that of the Civil Service, the Civil Service policy was then amended to include bereavement leave for an aunt or an uncle. This amendment had not been included in the public service bereavement policy and the unions are seeking that this be rectified.

HSE Menopause Policy

The HSE launched a Menopause Policy, which came into effect on April 10, 2024, with the aim of guiding managers and employees on how to be supportive in the management of employees with menopause-related concerns.

Indian nurses network in Tipperary

Launch of Tipperary Indian Nurses Association

RECOGNISING the need for social contacts and support among their peers, nurses and midwives of Indian origin working in Tipperary recently launched the Tipperary Indian Nurses Association (TINA).

TINA is a social group similar to the Cork Indian Nurses Association, which aims to work closely with the INMO to recruit, organise, represent and support Indian nurses and midwives working in the public and private sector. At its inaugural meeting in Clonmel on March 22, 2014, Matthew Augustine was elected as TINA chairperson.

The association was officially launched by Lord Mayor of Clonmel Richie Molloy. INMO deputy general secretary Edward Mathews addressed the gathering of nurses and midwives from India who are working across Tipperary, as well as some of their colleagues from Cork. The entire industrial relations team from the INMO Cork Office was also in attendance at the launch.

Liam Conway, INMO IRO for the region, said: "TINA provides a base and an opportunity to continue to develop networks across Tipperary both in the public and private sectors for Indian nurses. Working in partnership with the INMO, TINA will work to address and lobby on issues key to our members across the county with employers and relevant governmental departments. We look forward to working collaboratively, to recruiting, organising and representing INMO members across Tipperary. Like the Cork Indian Nurses Association, TINA provides a platform to support migrant nurses in terms of encouraging union membership, and ensuring that the INMO meets members early on, particularly in the private sector, to make sure that they know their rights and entitlements and have representation. We look forward to a prosperous relationship in the coming years."

At the launch of the Tipperary Indian Nurses Association (TINA) were l-r): *Jibin Soman, INMO International Section; Liss Tayson; Pat English, Workers and Unemployed Action (WUA); Richie Molloy, Lord Mayor of Clonmel; Joseph Shalbin; Arun Augustin; Reema Anthony, chairperson of INMO International Section; and Richard Butler, INMO IRE*

(above): The launch attracted a large gathering of nurses and midwives from across the county; (right) Richard Butler, INMO IRE, in conversation with Reema Anthony, INMO International Section chairperson

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

Premium pay issue resolved in CHO3

A LONGSTANDING issue regarding the non-payment of premiums for unsocial hours to several nurses working in an older person service in the midwest has been resolved.

Members raised the issue of non-payment of the unsocial hours premium (time + one-sixth after 6pm) for a number of newly appointed nurses to an older persons service in CHO3.

Further to the INMO raising the matter with nurse management and HR, a coding error was identified and this group of nurses had their records amended and payment of the correct premiums commenced from the start of 2023.

The matter of retrospection for this group was outstanding as it was an arduous task as each individual record per shift per nurse had to be reviewed and amended. For some members up to two years of unsocial hours premium pay was owed.

The correct code has now been applied and all retrospection has been paid for any shifts outstanding to those individuals. This should have been reflected in pay periods between January and March 2024 for anyone who had premium pay owing. If any member has a remaining query on the amount received they should firstly contact their nursing management and, if unresolved, their INMO official. We urge members to regularly check their payslips to ensure the correct increment date, salary, premiums and allowances are paid.

– Karen Liston, INMO IRE

INMO spells out UHL's ills to Oireachtas Health Committee

THE INMO, along with other unions, met with a delegation of TDs and senators from the Oireachtas Joint Committee on Health regarding the ongoing dire overcrowding at University Hospital Limerick (UHL) last month.

The INMO highlighted the impact of the current recruitment embargo to the committee and the inability of nurses to maintain patient safety due to poor staffing levels and widespread overcrowding. As evidence of this, the INMO pointed to the stark increase in admitted patients being left on trolleys for long periods at the hospital. More than 6,500 admitted patients have been left on trolleys in UHL in the first quarter of this year – which is higher than for an entire year 10 years ago (6,150 patients on trolleys in UHL throughout 2014, which at the time was considered bad).

The Oireachtas Joint Committee on Health expressed concern about the acute overcrowding, congestion and delayed delivery of services that have been an ongoing feature of operations at the hospital and the Mid-West region. Following the meeting and a tour of the hospital, the committee called for speedy implementation of measures to address the situation which it intends to keep under review.

The committee recognised that the pressures were generating a particularly difficult working environment for staff in all roles, and that,despite previous commitments from the HSE to address these acute challenges, they have continued.

While welcoming the recently announced updated package of measures for both UHL and the wider region, the committee said: "It is imperative that no effort is spared, both in the region and centrally, to ensure that these measures are completed speedily to deliver the necessary improvement in services."

– Mary Fogarty, INMO assistant director of IR

Bon Secours confirms pay increases for 2024-2026

THE Bon Secours Group, Southern Region, has confirmed the implementation of pay increases in line with the public sector pay deal for 2024 to 2026 on lodging a claim to the employer in the Southern Region.

Bon Secours Group is implementing the terms of the Public Sector Pay Agreement 2024-2026 and communicated this to staff following the acceptance of the agreement by INMO members in the public sector. This will bring pay increases of over 10.5% to members working within the Bon Secours Group, over 2.5 years.

Bon Secours oncology services

Meanwhile, following representation in February, the INMO secured an increase in nursing hours for the Bon Secours Cork Oncology Day Services. An extra nurse is now rostered on days as a result of the INMO providing representation to members in the service.

– Liam Conway, INMO IRO

Transfer of paediatric services now underway in Cork

THE transfer of paediatric services from Cork's Mercy University Hospital (MUH) to Cork University Hospital (CUH) has begun. While the physical relocation of services will take place later this year, members have transferred across as employees of CUH as of April 1, 2024.

Throughout this process the INMO has been representing members transferring from MUH to CUH under Transfer of Undertakings Protection of Employment (TUPE) legislation. This follows the union's involvement in the negotiations and representation of members throughout the information and consultation process.

A new regional paediatric centre is currently under development at CUH, which will have 82 beds, a high dependency unit and four surgical theatres, providing a centralised paediatric service for Cork.

– Liam Conway, INMO IRO

SouthDoc non-payment of pandemic bonus referred to WRC

THE INMO has referred the non-payment of the Pandemic Special Recognition Payment to its members working at SouthDoc CIT to the Workplace Relations Commission.

SouthDoc CIT members join CareDoc CIT members in pursuing the matter through the auspices of the WRC. The matter has been referred for conciliation at this time.

The Pandemic Special Recognition Payment is €1,000, tax free, payable to those working in Covid-19 exposed healthcare environments between March 1, 2020 and June 30, 2021. For part-time employees, the bonus was €600.

– Liam Conway, INMO IRO

Listowel members accept HSE proposals

INMO members at Listowel Community Hospital have voted in favour of the HSE proposal to increase healthcare assistant staffing hours on the back of additional nursing hours on night duty.

This concludes a longstanding dispute on the opening of St Joseph's Unit at the hospital, which involved a change in the layout of the unit and the introduction of single occupancy rooms.

The local INMO reps involved played a significant part at all local and collective engagements on this issue, including throughout the WRC and Joint Review Group process.

– Liam Conway, INMO IRO

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

Call for further protection of health workers in WHO's Pandemic Accord

IN A recent statement the ICN said that there is still time for member states to the World Health Organization's (WHO) proposed Pandemic Accord to ensure that the nursing workforce is properly protected.

Member states to the WHO International Negotiating Body (WHO, INB) have so far failed to agree on a final draft of the treaty on pandemic prevention, preparedness and response, after 13 months of talks.

Before the conclusion of INB talks in late March, ICN and Public Services International (PSI), the global union federation of workers in public services, issued a joint statement expressing their alarm at the draft treaty's lack of commitment to protect health workers. They also argued that it should include the suspension of intellectual property rights on pandemic products such as vaccines during a pandemic, and that equity within and between countries should be explicitly included in the treaty.

ICN chief executive officer Howard Catton said that after the traumas of the Covid-19 pandemic, the laudable response from governments globally was to negotiate and agree a treaty that would maximise humankind's ability to prepare for and deal with the next pandemic and protect nurses and other healthcare workers.

He further noted that the clock is ticking and the INB now has only weeks until the start of the World Health Assembly meeting in Geneva, where the treaty is expected to be ratified. Failure to sign it off is not an option because it would condemn the world to repeating the terrible mistakes of Covid-19 that unnecessarily cost so many lives and took such a terrible toll on the wellbeing of nurses around the world. There is still time to ratify the draft treaty and ensure that ICN's concerns about the safety of nurses and the other issues in the ICN/PSI statement are properly addressed.

The treaty is due to be presented at the 77th World Health Assembly which begins on May 27, 2024, but the recent 9th meeting of the INB closed without producing a final draft of a treaty, and further talks are expected.

The INB was set up by WHO in December 2021 to draft a convention or treaty, based on the principles of inclusiveness, transparency, efficiency, member state leadership and consensus.

Shock reaction to killing of aid workers in Gaza

RESPONDING to the shocking and heartbreaking news of the seven international aid workers from World Central Kitchen (WCK) killed in Gaza, the ICN president sent its deepest condolences to the families and friends of the staff from WCK.

The president called for protection and accountability for all frontline workers, including humanitarian and health workers.

The ICN also reiterated its call that people in Gaza and other war zones be granted access to sufficient humanitarian aid, and that those delivering and providing that aid and care be given due protection as demanded by international law. The ICN has repeatedly called for the end to hostilities, the protection of innocent civilians, and the protection of healthcare workers and facilities in conflict zones across the world.

ICN backs WHO campaign for universal health care

The ICN welcomed the World Health Organization's World Health Day, on April 7, theme 'My Health, My Right'.

The World Health Organization (WHO) says at least 140 countries recognise health as a human right in their constitutions, but more than 4.5 billion people were not fully covered by essential health services in 2021, a situation since made worse by the effects of the pandemic.

ICN president Dr Pamela Cipriano, who is part of the UHC2030 (Universal Health Cover) Taskforce said that the ICN supports the work of WHO and the campaign to achieve UHC. However, she said unfortunately, collectively the member states of WHO have not invested sufficiently to bring about the changes that are so desperately needed to make UHC a reality.

Speaking ahead of World Health Day, Dr Cipriano d said: "Nurses hold the key to many of the healthcare burdens that are affecting communities around the world. They keep people healthy, support them to recover from health conditions and live full and independent lives, but nurses' commitment and professionalism are being undermined by lack of investment and the current nursing shortages which the ICN estimates to be at least 13 million."

The ICN president said that without substantial investment from governments, the ambition of achieving UHC will never be met but stated that it will be possible with the right political will and then "the call for this year's World Health Day – the right of everyone to have access to quality health services – can become a reality. Without a strong and well-funded nursing workforce, access to quality health services is limited. Nurses play a key and fundamental role around the world in being the providers and conduits of healthcare. Without nurses, health as a human right is merely a pipe dream."

and midwifery news

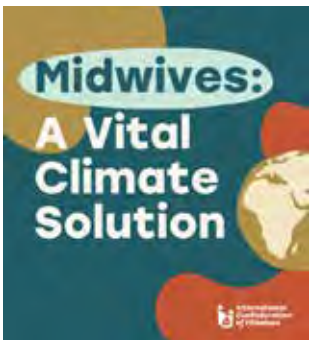
IDM toolkit designed to highlight midwives' role in climate challenge

THE ICM toolkit for the International Day of the Midwife (IDM) 2024, which takes place on May 5, is packed with resources to help midwives in Ireland and around the world to celebrate and advocate.

This year's theme is 'Midwives: A Vital Climate Solution'. Climate change poses unprecedented challenges to health, especially for women and babies.

Midwives play a pivotal role in reducing the effects of climate change. The midwifery model of care is inherently sustainable, and by promoting continuity of midwife care, we can ensure healthier outcomes while using a sustainable, low-resource model of care.

From ready-to-use social media messages to vibrant



flyers and banners, the ICM IDM toolkit has you covered. For the first time, the ICM toolkit includes easily editable graphics, allowing midwives everywhere to customise messages with personal photos. The INMO joins the ICM in encouraging midwives to celebrate this important day and share any images of celebrations with both the ICN and the INMO.

International Nurses Day focuses on how strategic investment in nursing is of benefit to all

SUPPORTING and investing in nursing not only improves the health and wellbeing of populations, but it also boosts economic growth and strengthens healthcare systems.

ICN's International Nurses Day (IND) theme this year, *'Our Nurses. Our Future. The economic power of care'* illuminates the benefits of elevating the value of the nursing profession with an in-depth analysis of how the nursing profession is transforming healthcare delivery, economic development, peace and societal wellbeing.

A special IND report on the economic power of care will be released on May 12.

In the run-up to IND, the ICN released a series of posters and a virtual background for use by nurses, nursing associations, clinics and supporters of nursing to celebrate this special day. We encourage you to celebrate this important day

and share any images of your celebrations with us, using the hashtags #IND2024 and #OurNursesOurFuture

International Nurses Day (IND) is celebrated around the world on May 12, the birthdate of Florence Nightingale. This year, the theme for the day reflects the aim to reshape perceptions, demonstrating how strategic investment in nursing can bring considerable economic and societal benefits.

ICM calls for end to formula milk sponsorship

Global and regional healthcare professional associations, including midwives, neonatal nurses, lactation consultants and paediatricians are advocating for an end to sponsorship by companies that manufacture commercial milk formula, citing the detrimental effects on infant and maternal health.

In the letter, published on *The Lancet*, the ICM and others urged other professional associations to cease partnerships with breastmilk substitute companies due to their aggressive marketing tactics. This call to action aligns with previous resolutions from the World Health Assembly and guidance from the World Health Organization, emphasising the conflict of interest created by such sponsorships.

The letter states that commercial milk formula marketing undermines breastfeeding, despite well-established health benefits, and contributes to poor health outcomes in children. The letter also highlights the influence of sponsorship on research and prescribing behaviour among healthcare professionals. It urges associations to discontinue sponsorships from formula companies by the end of 2024, offering support for this transition through training, advocacy and monitoring.

This initiative, supported by the WHO, aims to protect the health and wellbeing of infants, children and mothers by addressing the harmful effects of aggressive formula marketing.

Collaboration among healthcare professional associations is deemed essential to counteract the threat posed by formula company sponsorships and uphold the standard of quality care.

Homelessness: Connecting care in the community

Freda Hughes spoke to Liz Balfe of Housing First about how her team strives to provide continuity of care to those using homeless services

THERE are currently 9,671 adults and 4,170 children homeless or living in emergency accommodation, according to the most recent report on homelessness and housing need in Ireland from the Department of Housing, Local Government and Heritage.

Liz Balfe is a specialised public health nurse co-ordinator with Housing First covering the Dublin region working directly with some of these people. She was seconded to Northside Homeless Healthlink shortly after the pandemic as a public health nurse (PHN) liaison person to help with the co-ordination of child health related PHN charts for homeless families throughout Ireland.

Ms Balfe's current role with Housing First is to support integration of clients into mainstream health services and to foster and develop collaborative pathways within CHO6, 7 and 9 by integrating residents within community services.

Housing First is an integrated approach by the Department of Housing, Local Government and Heritage, local authorities, the Department of Health and the HSE. It provides a comprehensive and holistic approach to addressing homelessness for people experiencing mental or physical health issues, substance misuse and social, behavioural or other challenges. It takes people who were rough sleepers or in long term homelessness and provides a tenancy-based home for them. In Dublin alone, they are currently providing 531 people with tenancies and have 40 intense case managers. There are also 64 tenancies in Cork and numerous others dotted around the country.

Housing First aims for a participant-centred model that focuses on ending homelessness for people who have been homeless for many years or who are particularly vulnerable. They also offer wrap-around health supports for Housing First participants in line with Sláintecare.

Every child born in Ireland is allocated a PHN and will have a child health record. When the family are affected by homelessness, co-ordination is required to ensure the child meets their development milestones and has continuity of care. Ms Balfe took on continuing to coordinate this work to ensure that everybody has a PHN and that they were able to continue their childhood vaccinations and any other health needs that the child and family might need.

Ms Balfe explained that it was really important that the chart is allocated to the correct public health nurse for each family.

"It was a large body of work and it continues today. It involves a lot of joined up thinking as we don't want families to disappear from our public health service. PHNs build up a relationship with the child and family so we want to ensure continuity of care."

Another big part of her role with Northside Homeless Healthlink involves assessing homeless clients within the acute hospital services. If a homeless person is fit for discharge she will liaise with the acute hospital and make sure that they are discharged to the correct environment for that person depending on their medical needs. If a client is not registered as homeless they are referred to their local council who registers the client and then refers them to Dublin City Council.

Collaboration

Housing First works collaboratively and Ms Balfe is well known in most of the acute hospitals. "We often have people with acquired brain injuries and those people will have high dependency needs. Some clients are not suitable for our type of accommodation but linking with all of our primary care facilities, with our disability services and our integration pathways, we can find other accommodation more suitable for their needs.

"It's very important that we put the right people into the right accommodation for example, somebody who has suffered with a stroke or has a walking impairment or is using different mobility aids may not be suitable for some homeless accommodation if it doesn't have a lift. We take into consideration their wishes and preferences with the new laws and promote their cognitive ability. The patient's needs are always the priority," Ms Balfe said.

"I also deal with the delayed transfer of care. A bed in an acute hospital costs roughly €944 per day (including staff costs etc) and acute hospital beds are precious. It's all about collaboration between the community and acute sectors and that's how we free up those beds and allow people move to a more appropriate setting. Working with nurses on the wards we are getting first-hand information on our clients and this helps us meet their needs on discharge," she added.

Homeless and Housing First clients can go into respite care provided the organisation has an address for them to move to afterwards. It's a collaborative discharge approach that utilises many different services. Nobody is ever discharged to the streets, but obviously people can self-discharge. She also made it clear that her clients can and should make autonomous choices and acknowledges that some people do not engage with the service.

If no nursing staff are working at the weekend in homeless accommodation centres, PHNs and RGNs from the primary care services will administer medication to clients. It's a wrap-around service so clients will also be allocated a case manager and a key worker to help them apply for a medical card and so forth.

Ms Balfe noticed that among the key workers and case managers in the various homeless services she collaborates with, there was a need for education around chronic disease. The sector encounters a high proportion of patients with COPD and diabetes. Those with diabetes, might present with diabetic ulcers, leg wounds or as amputees. Ms Balfe observed that small interventions at the right time could make some complications avoidable for diabetes patients living in homeless services.

Pictured at a training session at the Peter McVerry Trust, Parnell Square, Dublin were (clockwise from top left) l-r: Alison McAlister, CNS Respiratory; Deirdre Mullally, senior dietitian; Caoimhe Russell, podiatrist; and Liz Balfe, Housing First specialist PHN co-ordinator Dublin Region with Wilson the orange basketball; (inset) Una Molloy, ANP palliative care; and Cara Synnott, ANP neurology with Caoimhe Russell

"A lot of our clients are dual diagnosed because unfortunately, it is a vicious circle, they get caught up in bad habits like drinking or taking illicit drug. Adverse childhood environments also have long-reaching effects," she said.

In 2023 Ms Balfe decided to roll out an education programme for non-medical staff working in the homeless sector. The programme is largely run by nurses and has been rolled out to Cross Care, The Salvation Army and The Peter McVerry Trust. Education is carried out on site in homeless services and involves practical demonstrations and workshops.

Participants can earn up to five professional development points for taking part. Participants are introduced to the community care pathways as well as the chronic disease teams and integrated care pathways. They are encouraged to make sure their clients keep their medical appointments and have an up-to-date medical card. On occasion Housing First can provide transport and a chaperone for these appointments.

Going forward Ms Balfe would like to roll out education in line with current best practice on how to take blood glucose readings and administer a glycogen pen – simple things that could save lives. They also hope to roll out training for those working with clients prone to seizure activity/epilepsy so that buccal midazolam can be administered on site in line with policy. Ms Balfe stressed that empowering staff and clients alike is hugely important.

Wilson the orange basketball

"We want staff in these organisations to feel empowered to work collaboratively with chronic diseases teams. It's also very important to empower people to look after themselves. So when we start off a training day I use 'Wilson', the orange basketball, to carry out an ice-breaker that acts as a metaphor for how people in homeless services often bounce between services with no joined up thinking. I throw Wilson all over the place. He's very erratic, jumping all over the place. He's hopping up and down everywhere. When we pass him carefully from one to another he's very calm and he reaches his destination."

Ms Balfe has built a team of predominantly nurse specialists who run these education days with her in various organisations addressing housing and homeless issues. The team is made up of Cara Synott, advanced nurse practitioner (ANP) neurology; Una Molloy, ANP palliative care, St Francis Hospice; Alison McAlister, CNS respiratory integrated care; Cherry Wynne, CNS respiratory integrated care; Abi Mani, CNS respiratory integrated care; Ciaran Lanigan, CNS mental health; Caoimhe Russell, senior podiatrist (diabetes); Deirdre Mullally, senior community dietitian; and Sonia McDermott, HSE Health Promotion.

Ms Balfe observed that the new health regions would align acute services and community services as one body and this would need a shift in mindset.

"We need to start thinking that we're all in the same health service and stop seeing the divide between community and acute care. It's about providing the right care in the right place at the right time in line with Sláintecare. Many of our clients are still extremely vulnerable. I want to develop and foster collaborative pathways between these people and community services. I'm not going to stand in judgement. It's not our place to do that. I feel that these workshops empower staff and clients at grassroots level. Its about joining the dots and thinking outside the box.

"It's important that we take on board the staff shortages at the moment and the pressure that staff in these organisations are under," she told *WIN*.

'Nothing for us without us'

The recent All-Ireland Midwifery Festival took stock of the progress made in maternity services but warned of the challenges that remain. **Freda Hughes** reports

THE phrase "nothing for us without us" is often the cry of workers demanding a seat at the policy-making table. This sentiment embodied the sense of progress felt at the All-Ireland Midwifery Festival, which took place in Dublin's Helix theatre in April. The festival looked at the future-proofing of the professions, and showed how midwives have progressed and successfully fought for their place at the table.

Sinead Heaney, midwifery advisor in the Department of Health, addressed the conference on her role in furthering the role of midwives at government level. "Funding follows policy. As midwives we must become aware of the important role policy has in shaping our futures," she said.

"Healthcare has made some incredible advances – including virtual medicine, our expanded roles, telemedicine, wearable devices and the use of data to improve health outcomes. As chief midwife, that data is crucial so I can highlight the work done and progress our roles and the services we offer further."

Ms Heaney is an experienced midwife leader, providing strategy and policy direction to support government health policy and the Sláintecare reform programme. She is a strong advocate for the development of leadership roles in healthcare. She believes that midwives are key to improving outcomes in women's health.

"The data shows us midwifery is best placed in the community. We need to look at recruitment and retention and advancing the community aspect of midwifery."

Ms Heaney is a former associate professor in clinical practice awarded by the University of Limerick for her contribution to clinical practice, particularly in the area of community midwifery. She is also a qualified coach with an advanced diploma in personal and team coaching. She holds a master's degree in advanced practice and a postgraduate degree in health professions education studies. She was formerly a senior implementation project lead with the South/Southwest Hospital Group and, prior to that, director of midwifery in Tipperary University Hospital.

Pictured at the festival were (l-r): Rhona O'Connell, UCC; Patricia Leahy-Warren, UCC; Lynda Moore, INMO Executive Council and CUMH; Mary O'Connor, CUMH; and Imelda Fitzgerald, CUMH

Ms Heaney has co-ordinated several regional learning engagements and has worked across national expert and steering groups involved in developing policies, programmes, models and frameworks to support midwifery leadership and practice. She is fully committed to the development and implementation of policy that will enable midwives and nurses to contribute to healthcare design, delivery and improvement by using their full scope of practice.

Dr Karn Cliffe, director of professional standards with the Nursing and Midwifery Board of Ireland (NMBI), told attendees that the NMBI was striving to facilitate a greater focus on midwifery in community healthcare by incorporating placements for students and enabling midwives to work to the full extent of their scope of practice. She also spoke of the importance of advanced practice roles in moving the profession forward, as well as allowing midwives to progress in their careers without moving away from patient-facing roles.

Verena Wallace is senior midwifery

advisor to the Nursing and Midwifery Council (NMC) in Northern Ireland. She told attendees that the NMC intends to take the Republic's lead in encouraging midwives to take up advanced practice roles.

Ms Wallace also picked up Ms Heaney's thread about community-based midwifery. "Funding follows policy but culture eats policy for breakfast. We need to have the data, the statistics and the evidence because anecdotal evidence is never enough," she said.

"There needs to be system reform, shifting the service into a community-based service where the hospital is the backup if needed but not the centre of care that it tends to be. We have higher expectations from women who will only likely do this up to three or four times in their lives. We need to gear our services towards the women we're dealing with today."

Ms Wallace was appointed as the NMC's senior midwifery advisor on policy in January 2019. Prior to that she was the midwifery and children's nursing officer at the Department of Health in Northern Ireland. She was the local supervising authority midwifery officer until 2015, having previously held senior roles as a deputy chief nurse, head of midwifery and consultant midwife for public health.

She stressed that midwifery is all about building relationships with the women you treat as well as with your colleagues.

"Good leadership leads to better care. If you're leading and no one is following, all you're doing is going for a walk. Leadership should inspire people to do more, dream more, become more and achieve more. Followers who tell the truth and leaders who listen to it are so important," she said.

"Showing we advocate for women and that they have a choice and enhancing our midwives' knowledge so they have skills to provide that care is vitally important. Women's needs must be at the centre of everything we do."

This point was reiterated by Caroline Keown, chief midwifery officer, Department of Health, Northern Ireland, who added: "It is essential that women are at the centre of all midwifery planning. Listening to women's voices and learning from other countries allows us to make brave, bold and courageous decisions."

Lynda Moore, INMO Executive Council member and midwife at Cork University Maternity Hospital (CUMH), added that women's voices are not being considered enough in developing policy.

Pictured above were UCD midwifery students (back row, l-r): Brona O'Keefe; Amandne Baar; Marta Bustamante Medina; Sarah McGrath; Emma Clohisey; Chloe Brennan (front row, l-r): Fatia Oyebanji; Aine Denise Castaneda; and Emeline Paquet

Pictured centre left were (l-r): Dearbhla Bowhan, Our Lady of Lourdes Hospital (OLOL), Drogheda; Aoife Hamill, OLOL Drogheda; Chantal Murdoch, Rotunda Hospital; and Claudia Moreno, OLOL Drogheda

Pictured below left were (l-r): Sinead Heaney, midwifery advisor, Department of Health; Dr Karn Cliffe, director of professional standards – midwifery, NMBI; Caroline Keown, chief midwifery officer, Department of Health, Northern Ireland; and Verena Wallace, senior midwifery advisor to the Nursing and Midwifery Council of Northern Ireland

"It's about women's choice but also about midwifery-led care. *The State of the World's Midwifery* report states clearly that reduced C-section rates are notable where midwifery-led care is provided. In Ireland we have the bones of midwifery-led care and yet in practice it's only a tiny fraction of what we offer. Not enough is being done in practice."

Ms Moore's team at CUMH offers domiciliary services, however this service hasn't expanded in 10 years. Referred to as Domino (Domiciliary care in and out of hospital), the service offers women living within a 15km radius of the hospital who are not experiencing a high-risk pregnancy the same team of midwives throughout their pregnancy, birth and home visits, including breastfeeding support.

Prof Mary Renfrew spoke about the importance of universal midwifery care.

"Evidence informed, safe, equitable, respectful and compassionate midwifery care should be available for all women and new born infants wherever and whenever care takes place," she told the conference.

Prof Renfrew is currently the lead for the *Independent Report on Enabling Safe, Quality Midwifery Services and Care in Northern Ireland*. She is a health researcher, educator and midwife who has conducted studies in maternal and newborn care, midwifery and infant feeding for more than 40 years. Her work has helped to shape policy, practice and education around the world, focusing on improving health and wellbeing, the quality of care and reducing inequality.

Quality & Safety

A column by Maureen Flynn

Walk and Talk Improvement Podcast: a resource for sepsis awareness

THIS month we talk about sepsis – a key safety topic relevant to every nurse and midwife. No matter where we work in healthcare we all have the opportunity to recognise, respond and treat a person with sepsis.

Sepsis is a potentially life threatening complication of an infection that can affect anyone of any age. One in five patients in Ireland who develop sepsis will die from it. Together, we can improve patient outcomes to give every person the best possible chance at survival.

Sepsis national campaign

You may have heard the HSE public awareness campaign for sepsis launched on March 7 this year. In collaboration with patient advocates, the campaign aims to improve public awareness of the signs and symptoms of sepsis *(see box)*.

Podcasts

As part of this campaign, the HSE National Quality and Patient Safety Directorate has released two new episodes of the All-Ireland podcast series: Walk and Talk Improvement. The podcasts aim to improve patient care by capturing the personal stories and expertise of people who work in and use health services.

Episode 12: Could it be sepsis?

In Episode 12, we hear from Maeve Murphy, a busy working mother of three, who shares her journey of surviving sepsis. Maeve walks us through her day, starting with packing lunch for her children and deciding to stay home in bed for what she thought was simply a 'head cold'. Within a matter of hours she was delirious, confused and unable to recognise her own sister. She was taken to Cork University Hospital by ambulance, where staff happened to be marking World Sepsis Day. Her symptoms were quickly recognised and she responded well to treatment, though as she reminds us, it took months before her body made a full recovery.

We also hear from Denise McCarthy, assistant director of nursing for sepsis, HSE, on the signs and symptoms (*see box*). Denise shares key information including:

- Who is more at risk of developing sepsis
- What you can do to reduce your risk
- Signs and symptoms of sepsis in adults and children
- How sepsis differs from the cold or flu.

The resounding message from both Maeve and Denise is to trust your gut and ask yourself, 'could this be sepsis?' Whether you're a parent, carer, family member or patient, have a listen to this important episode for all you need to know about sepsis.

Episode 13: Reducing and managing sepsis – what do you need to know as a healthcare professional?

In episode 13, we hear again from Ms McCarthy who talks about the resources and tools to help you identify or diagnose the symptoms of sepsis and what you can do to improve patient outcomes. As in Ms Murphy's case, in sepsis early recognition and intervention saves lives.

Ms McCarthy's advice is "I would say to healthcare care workers, rather than rule it in, if there's suspicion of infection, try to rule out sepsis." She highlights key sepsis tools in identifying sepsis early including:

- HSELand e-learning modules on sepsis (adult including maternity and paediatric)
- Sepsis forms (adult/maternity/paediatric)
- Irish National Early Warning Score
- Paediatric Early Warning Score
- Irish Maternity Early Warning Score
- Patient Safety Together sepsis alerts.

More importantly, she also shares why and how these tools help improve patient outcomes: "Using the sepsis form increased the instance of the correct diagnosis of sepsis by 43%".

What you can do next

When you are next out for a walk, or thinking about a topic for your unit or team discussion why not tune into episode 13 to learn more about the tools available to you to help identify and manage sepsis and improve patient outcomes. Help us spread the message and awareness by sharing episode 12 with family, friends and patients so they can learn the signs and symptoms of sepsis *(see box)*.

Know the signs of sepsis

- **S – Slurred speech and/or confusion**
- **E – Extreme shivering, muscle pain, fever**
- **P – Not passing urine**
- **S – Shortness of breath and/or fast heart rate**
- **I – If it feels like you are going to die**
- **S – Skin that looks blotchy or a rash that doesn't fade when you roll a glass over it**

Further information

The HSE sepsis resources can be found at: **www2.healthservice.hse.ie/organisation/sepsis/**

You can find the podcasts on Acast at the links below, on Spotify or wherever you listen and you can also scan the QR code (right):

- Episode 12: **shows.acast.com/walk-and-talk-improvement/episodes/could-it-be-sepsis**
- Episode 13: **shows.acast.com/walk-and-talk-improvement/episodes/reducing-and-managing-sepsis-what-do-you-need-to-know-as-a-h**

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

Acknowledgements:
A big thank you to my colleagues Sheema Lughmani and Juanita Guidera for assistance in writing this column along with hosting and co-producing the podcast episodes. A special thank you to Maeve Murphy and Denise McCarthy for sharing their experiences and expertise during the podcast conversations and the National Sepsis Programme team

Q and A Bulletin Board

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

Correct pay point for new graduates

Q. I am a new graduate nurse and started working in the public health service in November 2023. I have been working longer than 16 weeks and am still on the first point of the pay scale and I'm wondering if by now I should be on the third point of the scale?

If you started working in the public health service in November 2023 you would have been placed on the first point of the staff nurse/midwife salary scale for 16 weeks. After working for 16 weeks, you should have benefited from the revised new entrant measures and skipped point 2 and gone directly to point 3. When your next increment is due one year later, instead of progressing normally to point 4 of the old scale, you will become eligible to move to point 1 of the new enhanced practice salary scale. I would advise you contact your HR department about your current point of salary scale.

Do I have to pay back an overpayment?

Q. I recently moved from an area where I was paid a location allowance. My new role does not qualify for payment of an allowance. My manager advised HR that I am no longer in receipt of the allowance. However, I recently received a phone call from my employer advising that I have been paid the allowance in my new role in error which I was not aware of. I have been advised that I have an overpayment. Do I have to pay back this overpayment?

The general rule is that if an employer has overpaid an employee, the overpayment of wages should be repaid even if the mistake was the employers. In other words, the employer is legally entitled to recover any salary overpayment from the employee. The Payment of Wages Act, 1991, section 5(5), affords an employer a legal right to recover any overpayment of wages, allowances or expenses from the wage of employees.

For overpayment greater than €200 the employer must put the overpayment in writing as outlined below:

- Gross or net value of the overpayment
- Reason for the overpayment
- Period to which the overpayment relates
- Proposed repayment schedule. The employee may request a change to the method or time period for repayment
- Employee obligations
- Procedure if employee questions the amount of the overpayment
- Any change in future income when negotiating a repayment schedule
- A copy of the National Financial Regulations document (NFR B3) setting out the full process in detail (these regulations are currently under review).

It is important to note that you should always check your payslip.

Falling sick before annual leave

Q. I was due to go on annual leave and had booked a week off work. However, I became ill on the weekend before the leave was due to start and was on sick leave for that week. Will I be able to avail of this annual leave at a later date?

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

Public holiday entitlements for job sharers

Q. I am currently working as a job sharing community RGN. I realised that I am not benefiting from the public holidays that fall when I am not scheduled to work. Prior to this I had been working full time and was receiving my public holidays. The service is usually closed on public holidays and if I work that day, I get a paid day off.

Your entitlement to public holidays is set out in the Organisation of Working Time Act 1997. To be entitled to the public holiday if you are part-time or job sharing you must have worked at least 40 hours in the five weeks before the public holiday. Job-sharing nurses/midwives who work Monday to Friday and who are not scheduled to work on the day on which the public holiday falls are entitled to one-tenth of their normal fortnightly pay for the public holiday.

Know your rights and entitlements

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

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

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

Section focus

INMO Professional

Jean Carroll, Section Development Officer

COOP Section set for Portlaoise conference

THE National Care of the Older Person Section is looking forward to a packed programme at its annual conference, which will be returning to Portlaoise this year.

Taking place on Tuesday, May 28, 2024, this year's event promises to be an excellent day. The conference will feature a varied line up of expert speakers who will cover a broad array of topics, including the ICPOP pre-assessment tool, resident-on-resident aggression, diabetes, management of sexualised behaviour, assisted decision-making and a national update on gerontology.

Amanda Phelan, professor in ageing and community nursing in Trinity College Dublin, is one of the main speakers. Prof Phelan has previously presented on matters relevant to the care of the older person, and the section is grateful that she will once again address the annual conference.

Also presenting will be Maurice Healy, an ANP in intellectual disability who specialises in behaviour. Mr Healy will be covering the *Meas* (Irish for 'respect') model of support.

Aoife Dillon, who is an ANP in older person care in St James's Hospital, Dublin, will speak to the conference on 'transforming care'. This involves inclusion, respect and dignity for older LGBTQ+ people.

This is merely a snapshot of the conference programme and not an exhaustive list.

See *page 29* for further details and how to book your place.

ADC to keep sections busier than ever

THE final section meetings ahead of the INMO annual delegate conference (ADC) took place in April, at which sections had the opportunity to review the motions to be put forward for debate and decide how representatives from each section will vote.

This year will see the largest number of sections ever represented at ADC, and the INMO looks forward to the networking opportunities this will afford. If you would like to become more involved in your section, the ADC is a great opportunity for you to do so.

Retired Section heads for the open seas

THE social committee of the INMO Retired Section has organised a trip to Dublin for the Dublin Bay Cruise.

Section members will set sail from Sir John Rogerson's Quay in the city centre at 11am on Friday, July 5, ahead of dropping anchor in Dun Laoghaire harbour.

Booking is essential for those who wish to come on board our mini cruise. To book your place, Tel: 01 9011757 or email: booking@dublinbaycruises.com.

For further details about the trip, please contact Ger from the social committee at Tel: 087 2794701 .

Meet the National Children's Nursing Section

THE aim of the National Children's Nursing (NCN) Section is to promote the specialty of children's nursing as a highly specialised discipline by raising its profile at national level. The section also aims to expand the opportunities for the children's nursing qualification and to raise issues that pertain to children's nurses. It hopes to achieve these aims by being active at Executive Council level and at the INMO annual delegate conference.

Who can join?

Any qualified nurse who consistently works with children can join the section.

Why join?

It is important to know what is happening within your discipline and any proposed changes as they occur. Section members learn what is happening in the children's hospitals and the 16 paediatric units around the country from each other and also provide peer support to each other. It is important that voices from all units and hospitals are represented.

Achievements to date

- Paediatric trolley watch was instigated by the NCN Section in 2018. Prior to that children on trolleys were not counted unless included as part of the overall trolley figure from an acute hospital. In 2018 the CHI hospitals at Temple Street, Crumlin and Tallaght were added to the count
- Advocated for the location allowance to be paid to RGNs working on children's wards
- Brought a motion to the ADC seeking to rectify a situation where registered children's nurses were losing their qualification allowance on promotion to CNM3. This has since been rectified and will be implemented soon and backdated to September 2023
- The section has kept the INMO team informed of members' concerns about the new children's hospital regarding travel, parking and accommodation. This ensures that when the INMO meets with officials they are aware of your concerns and can highlight them at HSE and government level.

When does the section meet?

In order to include as many members as possible, the NCN Section conducts its meetings via Zoom.

The section meets at 11am on Monday mornings. If you are off duty, you can dial in. Meetings generally last around 60-90 minutes.

Get in touch

For more information, contact Jean Carroll at Tel: 01 6640648 or by email at: jean.carroll@inmo.ie

INMO Professional

Continuing professional development for nurses and midwives

INMO EDUCATION PROGRAMMES

In the pull-out this month…

Falls reduction, assessment and review

May 14

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

Fee: €50 INMO members; €85 non members

Time management

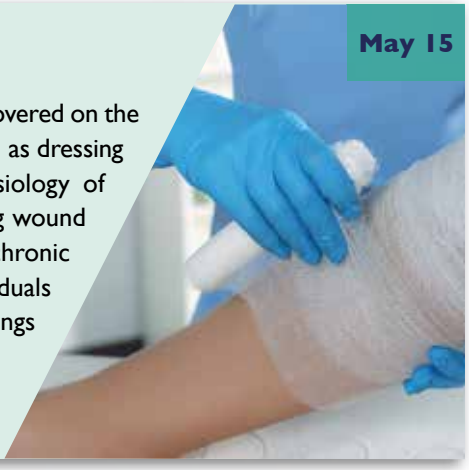
May 14

This new online courses will help nurses and midwives recover lost time and take some pressure off themselves. This course will enable participants to learn critical techniques and practices to help eliminate some of the key time thieves. We all have them and we can all learn how to manage our time more effectively

Fee: €50 INMO members; €85 non members

Wound care

May 15



This short online course will advise participants on wound care management. Topics covered on the day will include wound healing, wound bed preparation and treatment options, as well as dressing selections. Learning outcomes will include: understanding the anatomy and physiology of wound management; understanding and being able to identify the factors influencing wound healing; understanding and being able to identify the differences between acute and chronic wounds; understanding and being able to implement a holistic assessment of individuals with wounds; and understanding the current modalities of different types of dressings and their application.

Fee: €50 INMO members; €85 non members

INMO Professional

May is the month of ADC and international celebration days

Steve Pitman
Head of Education and Professional Development

INMO Professional is looking forward to welcoming you all to the INMO annual delegate conference at Croke Party this month. Come and say hello at the INMO Professional stand.

We would also like to wish all nurses and midwives a happy International Day of the Midwife for May 5 and International Nurses Day for May 12. These days bookend the European Week of Nursing and Midwifery.

The ICM's theme for 2024 is 'Midwives: a vital climate solution'. This reflects the importance of sustainability for both the environment and the midwifery workforce. The model of care delivered by midwives is inherently sustainable, and by promoting continuity of midwife care, it ensures healthier outcomes while following a sustainable, low-resource model of care.

The ICN theme for International Nurses Day 2024 is 'Our Nurses. Our Future. The economic power of care'. This theme highlights the economic power of care which is central to creating healthy societies and driving healthy economies. Dr Pamela Cipriano, ICN president, has called for a reshaping of perceptions that recognise how strategic investment in nursing can bring considerable economic and societal benefits. The ICN will be releasing a special report on the economic power of care on International Nurses Day.

European Nursing and Midwifery Week

European Nursing and Midwifery Week 2024 is a celebration that was launched last year by the European Forum of National Nursing and Midwifery Associations. The week is a fantastic opportunity for nurses and midwives across the WHO European Region to come together and celebrate the tireless dedication and remarkable achievements of nurses and midwives across the continent. It enables the professions to highlight the challenges that are faced every day, and advocate for better working conditions and healthcare for all. One of the central messages delivered as part of European Nursing and Midwifery Week is to call on decision-makers to prioritise support and investment in nursing and midwifery.

The European Forum is encouraging nurses and midwives to share the activities and events that have been organised to raise awareness and celebrate the professions. This information will be added to a map showing all activities taking place across the European Region. The forum also invites you to share your case studies highlighting the success stories and valuable lessons learned by nurses and midwives in primary care. Your contributions will help to highlight the vital role that nurses play in our communities and to build a dedicated report. Further information is available at **efnnma.org/enmw2024**

ICN workforce summit

The International Council of Nurses at its recent workforce summit in February has highlighted the ever-worsening global shortage of nurses. The striking similarities across countries have reinforced the ICN's call that this issue is of such significance that it should be considered a global health emergency.

The ICN believes that the safety of patients and nurses must be at the centre of government response, and nurse leaders must be at the heart of developing policies to deal with this crisis. In addition, there is a need to make major improvements to the available nurse staffing data and evidence if these critical aspects of safety are to be defined, measured and their progress tracked. These are crucial to enable us to understand the extent of the crisis and to act.

Sláintecare Nursing Festival

This year's Sláintecare Nursing Festival will take place on Tuesday, June 11, 2024 at The Helix event centre, located at DCU, Dublin. This will be an opportunity to hear about the changes in nursing in Ireland and to learn more about the innovations and developments in nursing practice. Tickets are available on Eventbrite.

On-site education

INMO Professional is eager to offer members the opportunity to work with us in delivering education courses. If you are an advanced nurse or midwife practitioner, a clinical nurse/midwife specialist or a nurse/midwife with expertise in clinical or management practice, we would like to hear from you by email: education@inmo.ie or Tel: 01 6640618/41.

Writing for *WIN*

INMO Professional would like to hear from members who would like to write professional and clinical articles for *WIN*. Please email an outline of your ideas to steve.pitman@inmo.ie

INMO Professional

Education Programmes

Tel: 01 6640618/41
Email: Linda Doyle and Deborah Winters at education@inmo.ie

All of the following programmes are category 1 approved by the NMBI and allocated continuous education units
Online course fee: €50 members; €85 non-members
Time: 10am-1pm

In person and online at **www.inmoprofessional.ie**

Keep your CPD up to date • Extensive range of programmes • NMBI category 1 approved • Digital certification provided

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

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

May 14 **Time management**

This new online courses will help nurses and midwives recover lost time and take some pressure off themselves. This course will enable participants to learn critical techniques and practices to help eliminate some of the key time thieves. We all have them and we can all learn how to manage our time more effectively

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

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

May 15 **Wound care and management**

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

May 15 **Phlebotomy** *(in person)*

This course will cover topics such as sites used for phlebotomy, criteria for evaluating a vein, principles of an aseptic technique as well as complications that may arise during and after the procedure. The course will teach the knowledge and skills required to undertake phlebotomy; however, it will be necessary for each nurse and midwife attending to ensure that they abide by their local policy on phlebotomy in their place of work. Fee: €110 members; €185 non-members.

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

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

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

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

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

May 21 **Understanding epilepsy**

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

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

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

May 28 **Competency-based interview skills**

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

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

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

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

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

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

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

Jun 12 **Leg ulcer assessment**

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

Jun 13 **Tracheostomy care study day**

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

Jun 14 **Management skills**

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

INMO Professional

Irish Nurses and Midwives Organisation
Working Together

Scan the code
to view our courses

HAVE YOU BOOKED YOUR PLACE?

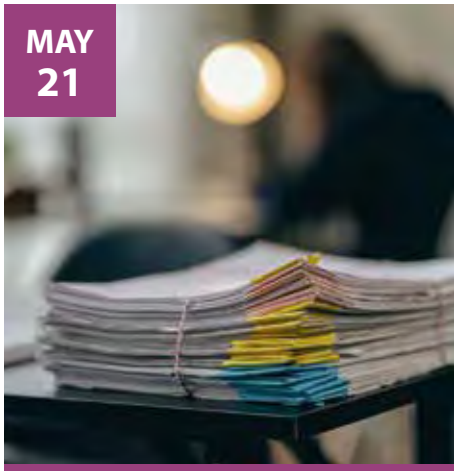
Below are some of our online courses scheduled in May 2024 for nurses and midwives.

MAY 14

Falls reduction, assessment and review

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

MAY 21



Nursing records under the spotlight (in person)

This course is designed to equip nurses & midwives, with the knowledge to maintain nursing records in accordance with legal and professional standards.

MAY 21

Understanding epilepsy for nurses & midwives

This course will provide a foundation on which to build increasing knowledge epilepsy and care of the patient.

MAY 28

Competency based interview skills

This course will explore preparation, presentation and performance during the interview.

MAY 29

Complaints management

This course provides senior nurse managers the key skills of communication tools to minimise the negative impact complaints can have in their workplace.

MAY 30

An introduction to basal and mealtime insulin management in people with Type 1 diabetes.

An insight into activity and effects of activity on insulin.

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

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

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Scan the code
to view the course

Telephone assessment & advice skills

Live online course 10am - 1pm

MAY 15

This short online programme is for nurses and midwives providing telephone assessment and advice, in A&E, minor injury clinics, general practice, chronic disease management and other community settings. Such calls assess patients' needs and provide advice for self-care, prompt the caller to seek immediate medical attention or refer the patient to another healthcare professional or agency. This programme will provide strategies and guidance on how best to communicate with each caller and handle calls in a professional and tactful manner. Participants will also work on case scenarios.

Fee: €50 for INMO members; €85 for non members

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

www.inmoprofessional.ie/course

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INMO
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Working Together

Scan the code
to view the course

Phlebotomy course

In person in The Richmond Education and Event Centre, Dublin

MAY 15

JUN 19

This course provides the nurse and midwife with the skill, theory and practice of phlebotomy. It will cover topics such as sites used for phlebotomy, criteria for evaluating a vein, principles of an aseptic technique as well as complications that may arise during and after the procedure. This course will provide the necessary knowledge and skills to undertake phlebotomy; however, it will be necessary for each nurse and midwife attending to ensure that they abide by their local policy on phlebotomy in their place of work.

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

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

www.inmoprofessional.ie/course

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

Jun 19 **Competency-based interview skills**

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

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

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

Jun 25 **Risk management and incident reporting**

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

Jun 28 **Best practice for clinical audit**

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

Sep 3 **Nursing records under the spotlight** *(in person)*

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

Sep 10 **Competency-based interview skills**

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

Sep 17 **Stroke management** *(in person)*

This programme facilitates nurses working in the community setting to gain a greater understanding of caring for a person with a stroke, post discharge. The course provides an outline of the importance of the health promotion and the educational role of the nurse. Signs and symptoms of stroke are discussed, as well as communication challenges, and psychological and psychosocial changes within the person. The course examines family adjustment and also the development of a care pathway within the community setting. This introduction to stroke care programme promotes excellence in stroke care amongst community nurses. €110 INMO members; €185 non-members.

Sep 17 **Understanding epilepsy**

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

Digital health and technology

The INMO library looks at articles and papers on the technologies becoming increasingly popular in health systems in Ireland and around the world

Nurse attitudes

- Caton E, Philippou J, Baker E, Lee G. Exploring perceptions of digital technology and digital skills among newly registered nurses and clinical managers. Nursing Management – UK. 2024 Feb; 31(1): 27-33
- Maddison C, Wharrad H, Archard PJ, O'Reilly M. Exploring young people's perspectives on digital technology and mental healthcare: pilot study findings. Mental Health Practice. 2024 Jan 4; 27 (1): 34-41
- Macalindin BV, Ahmed HF, Granaghan RM et al. Improving nurses' digital literacy and engagement with digital workflows through a data-driven education model. Nursing Management. doi: 10.7748/nm.2023.e2113

Digital technology use

- Bennett-Day S, Nice C. Clinical helpline: communicating and improving inpatient experience and safety using digital health records. British Journal of Nursing. 2023 Oct 12; 32 (18): 890-6
- Dowding D, Skyrme S, Randell R, Newbould L, Faisal M, Hardiker N. Researching nurses' use of digital technology during the Covid-19 pandemic. Nursing Standard. 2023 ;38(7):63-8
- Wynn M, Garwood CL, Vasilica C, Griffiths M, Heaslip V, Phillips N. Digitizing nursing: A theoretical and holistic exploration to understand the adoption and use of digital technologies by nurses. Journal of Advanced Nursing. 2023;79(10):3737-47
- Borges do Nascimento IJ, Abdulazeem H, Vasanthan LT, Martinez EZ, Zucoloto ML, Østengaard L, et al. Barriers and facilitators to utilizing digital health technologies by healthcare professionals. NPJ Digital Medicine. 2023 ;6(1):1-28

Leadership

- Agnew T. Digital nursing 3: nursing leadership in digital technology. Nursing Times. 2022;118(10):51-3
- Laukka E, Hammarén M, Pölkki T, Kanste O. Hospital nurse leaders' experiences with digital technologies: A qualitative descriptive study. Journal of Advanced Nursing. 2023; 79 (1): 297-308
- Wilton AR, Sheffield K, Wilkes Q, Chesak S, Pacyna J, Sharp R et al. The Burnout Prediction Using Wearable and Artificial Intelligence study: a decentralized digital health protocol to predict burnout in registered nurses. BMC Nursing. 2024 Feb 13;23(1):1-14

Nursing and midwifery students

- Høium K, Erichsen T, Johannessen LM, Raaheim A, Torbjørnsen A. What characterizes the use of digital technology in bachelor-level practice placements in health programs? Nurse Education in Practice. 2024 Feb; 75: N.PAG. doi 10.1016/j.nepr.2024.103883
- Freeman S, Fletcher J, Clouston K, Higson A. Gamifying simulated nursing education: a digital technology approach to enhancing pedagogy and student experience. British Journal of Nursing. 2024 Feb 22;33(4):206-14

INMO library access

The Nurse2Nurse website is no longer available. The INMOILibrary is now only available through OpenAthens and the INMO website (**inmo.ie**). Please contact the library for further information regarding access or library services by email at library@inmo.ie or at Tel: 01-6640614/25. Please also contact us if you require any articles in full text or if you would like to make an appointment to visit in person.

Older people

- Garner A, Lewis J, Dixon S, Preston N, Caiado CCS, Hanratty B, et al. The impact of digital technology in care homes on unplanned secondary care usage and associated costs. Age & Ageing. 2024; 53 (2): 1-7
- Eost-Telling C, Yang Y, Norman G, Hall A, Hanratty B, Knapp M et al. Digital technologies to prevent falls in people living with dementia or mild cognitive impairment: a rapid systematic overview of systematic reviews. Age & Ageing. 2024 Jan; 53 (1): 1-16
- Turner A, Flood VM, LaMonica HM. Older adults' needs and preferences for a nutrition education digital health solution: A participatory design study. Health Expectations. 2024; 27 (1): 1-10
- Lievevrouw E, Marelli L, Van Hoyweghen I. Weaving EU digital health policy into national healthcare practices. The making of a reimbursement standard for digital health technologies in Belgium. Social Science & Medicine. 2024; 346
- Blondino CT, Knoepflmacher A, Johnson I, Fox C, Friedman L. The use and potential impact of digital health tools at the community level: results from a multi-country survey of community health workers. BMC Public Health. 2024; 24(1): 1-14

World Health Organization

The WHO has unveiled a digital health promoter using generative AI for public health. SARAH is a 'Smart AI Resource Assistant for Health' that represents an evolution of AI-powered health information avatars, using new language models and cutting-edge technology. It is available 24 hours a day in eight languages on any device. See **who.int/campaigns/s-a-r-a-h** for further information.

Online – Introduction to Effective Library Search Skills

Next course date: Wednesday, June 10

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

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

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

Care of the Older Person Nurses Section Conference 2024

MAY 28

Midland Park Hotel, Portlaoise, Co Laois

Fee: €85 INMO members; €130 non members

IN PERSON EVENT

DRAFT PROGRAMME

09.00	Registration ad trade exhibition
09.30	**Welcome address** - Tony Fitzpatrick, Director of Professional Services, INMO
09.45	**A national perspective of gerontology** Speaker: Deirdre Lang, Director of Nursing, National Lead in Older Person Services
10.15	**Diabetes - a life long condition** Speaker: Georgina Conroy RANP in Diabetes, Midland Regional Hospital Portlaoise
10.45	Coffee break and trade exhibition
11.15	**Transforming care: inclusion, respect and dignity for older LGBT+ people** Speaker: Aoife Dillon, RANP Older Person Care, St James Hospital & LGBTQI Champion
11.45	**Assisted decision making** Speaker: Eithne NiDhomhnaill, Nurse Consultant
12.15	**Resident to resident aggression - current perspectives** Speaker: Amanda Phelan , Professor in Ageing and Community Nursing, Trinity College Dublin
12.45	Lunch, trade exhibition and networking
14.00	**Alzheimer's clinical Trial & ReMind supplement to support eye and brain health**
14.15	**Sexualised behaviour – managing ethically and safely** Speakers: Brian McDonald, Behaviour Support Specialist
15.00	**Positive behaviour support: The MEAS model of support** Speaker: Maurice Healy , ANP Behaviour Specialist
15.45	**ICPOP pre-assessment tool** Speaker: Debora Muresan, CNS Nursing Home Outreach Integrated Care Team for Older Persons
16.15	Evaluation, draws and close

Book now at **01 6640618/41** or **education@inmo.ie**

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

INMO Professional

Midwifery library update

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

International Day of the Midwife

On May 5 midwives across the world will be celebrating International Day of the Midwife 2024. This year's theme *Midwives: A Vital Climate Solution* is at the core of COP28 and strategies to improve the health and status of women. Midwives are key players in designing eco-friendly, community-based care to support and empower parents to make decisions that benefit themselves, their families and the planet.

Midwives might not immediately see themselves as a part of the climate solution but, it is obvious that the midwifery model of care is environmentally friendly. Evidence shows that continuity of midwife care leads to optimal and safe outcomes, uses fewer resources, results in less medical waste and a reduced ecological footprint.

By offering continuity of care in communities, midwives reduce the need for avoidable travel to health facilities, thereby cutting the carbon footprint of healthcare while ensuring accessibility. Continuity of midwife care also empowers mothers to meet their breastfeeding goals, meaning they will often breastfeed for longer. Helping mothers meet their breastfeeding goals is good for the short- and long-term health of babies and mothers, and is a win for the planet.

For more information and inspiration check out the ICM Midwives and Climate resource available **midwivesandclimate.webflow.io**

Midwifery students/newly qualified midwives

- Marsh A. Could negative treatment of student midwives during training affect staff retention and care provisions for women and birthing people, families and neonates? MIDIRS Midwifery Digest 2024; 34(1):24-9

Trauma-informed care

- Benton M, Wittkowski A, Edge D, Reid HE, Quigley T, Sheikh Z, Smith DM. Best practice recommendations for the integration of trauma-informed approaches in maternal mental health care within the context of perinatal trauma and loss: A systematic review of current guidance. Midwifery, 2024; 131:103949
- Long T, Aggar C, Grace S. Trauma-informed care education for midwives: Does education improve attitudes towards trauma-informed care? Midwifery 2024; 131:103950
- Farrow L, McEwan T. Embedding trauma-informed practice in maternity care in Scotland. MIDIRS Midwifery Digest 2024; 34(1):19-23

Labour and birth

- Mylod DCM, Hundley V, Way S, Clark C. Using a birth ball to reduce pain perception in the latent phase of labour: a randomised controlled trial. Women and Birth 2024; 37(2):379-86. doi.org/10.1016/j.wombi.2023.11.008
- Staras TaniaJesse M. How do women make decisions about declining induction for a pregnancy that is postdate? An exploratory phenomenological study MIDIRS Midwifery Digest 2024; 34(1) 63-8
- Rogers S, Pollard K. Midwives' experiences of caring for women having rainbow pregnancy. MIDIRS Midwifery Digest 2024; 34(1):43-8
- Mackellar B. An exploration of how television portrayals of the intrapartum period influence women's perceptions and expectations of birth. MIDIRS Midwifery Digest 2024; 34(1):69-74.

RCM iLearn

A new 10-minute course has been released this month on the RCM iLearn platform called 'Down Syndrome: Breastfeeding'. Many babies with Down syndrome will go on to breastfeed successfully. However, there are some physical and wider societal challenges that may present. These issues will not apply to all babies with Down syndrome but are the most common challenges identified through research and talking to parents.

On completion of the course, you should:

- Have found out the issues surrounding breastfeeding babies with Down syndrome
- Have looked at supports available to women who wish to breastfeed their baby with Down syndrome.
- Become familiar with best practices around breastfeeding babies with Down syndrome.

Contact the library

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

RCM i-learn access for INMO midwife members

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

Royal College of Midwives

Student and new graduate update

With Jamie Murphy

Preparing for your first job interview

LATELY, I've been receiving numerous enquiries from internship students nationwide regarding job interviews and how to navigate them successfully. Job interviews, especially at the onset of one's career, can be perceived as daunting and uncertain. However, with thorough preparation, they can be approached with confidence and readiness.

Nursing and midwifery interviews typically involve panels comprising human resources (HR) representatives, clinical professionals and senior management members. While the panel may seem intimidating, maintaining focus through all documentation and enquiries is vital. Anticipate competency-based questions and tailor responses to showcase your suitability for the role.

Re-familiarise yourself with your CV and the application form you completed, as any details that you provided may be explored during the interview. You should use your CV to provide a snapshot of your achievements and it should be no longer than two pages.

It is also important to tailor your CV to the particular job you are applying for. It is also imperative you research the hospital or organisation you are applying to. This is important for many reasons, including investigating a hospital or organisation as a potential future workplace. It is also important you are aware of and ready to answer possible questions on current projects in which the hospital or organisation may be involved.

Before the interview

Begin preparation well in advance. Ensure adequate rest, nutrition and hydration to optimise focus and performance. Familiarise yourself with the interview location and plan for unforeseen delays.

'STAR' technique	
Situation	Describe the event or situation that you were in
Task	Explain the task you had to complete
Action	Describe the specific actions you took to complete the task
Result	Close with the results of your efforts

Present yourself professionally, whether in person or via video call. If you are doing a video call be mindful of your surroundings. In preparation for your interview, it is also beneficial to reflect on events that may have stood out to you during your training, this is to showcase your insightful practice using reflection.

During the interview

Try to make a positive impression through eye contact and a welcoming demeanour. Be mindful of body language and communication style, seeking feedback if needed. Utilise techniques like STAR (Situation, Task, Action, Result – *see box above*) to structure responses effectively. Avoid limiting language and instead emphasise your potential as a staff nurse/midwife.

After the interview

Demonstrate continued interest by asking thoughtful questions and expressing gratitude for the opportunity. You can also use this time to ask your interviewer any questions that you might have. The interview is also an opportunity for you to further evaluate your desire to work in the hospital or organisation you applied for. I would also advise you to seek feedback to enhance future interview performances.

The INMO provides interview skills sessions for interns. If this is something your class would be interested in, please contact me to organise a session for your group.

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

KEYTRUDA®
(pembrolizumab)

KEYTRUDA—A Key to More Possibilities for Treating Your Patients[1]

KEYTRUDA® (pembrolizumab)
ABRIDGED PRODUCT INFORMATION Refer to Summary of Product Characteristics before prescribing. **PRESENTATION** KEYTRUDA 25 mg/mL: One vial of 4 mL of concentrate contains 100 mg of pembrolizumab. **INDICATIONS** • KEYTRUDA as monotherapy is indicated for the treatment of adults and adolescents aged 12 years and older with advanced (unresectable or metastatic) melanoma. • KEYTRUDA as monotherapy is indicated for the adjuvant treatment of adults and adolescents aged 12 years and older with Stage IIB, IIC or III melanoma and who have undergone complete resection. • KEYTRUDA as monotherapy is indicated for the adjuvant treatment of adults with non-small cell lung carcinoma who are at high risk of recurrence following complete resection and platinum-based chemotherapy. • KEYTRUDA as monotherapy is indicated for the first-line treatment of metastatic non-small cell lung carcinoma (NSCLC) in adults whose tumours express PD-L1 with a ≥50% tumour proportion score (TPS) with no EGFR or ALK positive tumour mutations. • KEYTRUDA, in combination with pemetrexed and platinum chemotherapy, is indicated for the first-line treatment of metastatic non-squamous NSCLC in adults whose tumours have no EGFR or ALK positive mutations. • KEYTRUDA, in combination with carboplatin and either paclitaxel or nab-paclitaxel, is indicated for the first-line treatment of metastatic squamous NSCLC in adults. • KEYTRUDA as monotherapy is indicated for the treatment of locally advanced or metastatic NSCLC in adults whose tumours express PD-L1 with a ≥1% TPS and who have received at least one prior chemotherapy regimen. Patients with EGFR or ALK positive tumour mutations should also have received targeted therapy before receiving KEYTRUDA. • KEYTRUDA as monotherapy is indicated for the treatment of adult and paediatric patients aged 3 years and older with relapsed or refractory classical Hodgkin lymphoma (cHL) who have failed autologous stem cell transplant (ASCT) or following at least two prior therapies when ASCT is not a treatment option. • KEYTRUDA as monotherapy is indicated for the treatment of locally advanced or metastatic urothelial carcinoma in adults who have received prior platinum-containing chemotherapy. • KEYTRUDA as monotherapy is indicated for the treatment of locally advanced or metastatic urothelial carcinoma in adults who are not eligible for cisplatin-containing chemotherapy and whose tumours express PD L1 with a combined positive score (CPS) ≥ 10. • KEYTRUDA as monotherapy or in combination with platinum and 5-fluorouracil (5-FU) chemotherapy, is indicated for the first-line treatment of metastatic or unresectable recurrent head and neck squamous cell carcinoma (HNSCC) in adults whose tumours express PD-L1 with a CPS ≥ 1. • KEYTRUDA as monotherapy is indicated for the treatment of recurrent or metastatic HNSCC in adults whose tumours express PD-L1 with a ≥ 50% TPS and progressing on or after platinum-containing chemotherapy. • KEYTRUDA, in combination with axitinib, is indicated for the first-line treatment of advanced renal cell carcinoma (RCC) in adults. • KEYTRUDA, in combination with lenvatinib, is indicated for the first line treatment of advanced renal cell carcinoma in adults. • KEYTRUDA as monotherapy is indicated for the adjuvant treatment of adults with renal cell carcinoma at increased risk of recurrence following nephrectomy, or following nephrectomy and resection of metastatic lesions. Microsatellite instability high (MSI-H) or mismatch repair deficient (dMMR) cancers. *Colorectal cancer (CRC).* • KEYTRUDA as monotherapy is indicated for adults with MSI-H or dMMR colorectal cancer in the following settings: - first line treatment of metastatic colorectal cancer. - treatment of unresectable or metastatic colorectal cancer after previous fluoropyrimidine based combination therapy. *Non-colorectal cancers.* • KEYTRUDA as monotherapy is indicated for the treatment of the following MSI H or dMMR tumours in adults with (a) advanced or recurrent endometrial carcinoma, who have disease progression on or following prior treatment with a platinum containing therapy in any setting and who are not candidates for curative surgery or radiation, (b) unresectable or metastatic gastric, small intestine, or biliary cancer, who have disease progression on or following at least one prior therapy. • KEYTRUDA, in combination with platinum and fluoropyrimidine based chemotherapy, is indicated for the first-line treatment of locally advanced unresectable or metastatic carcinoma of the oesophagus in adults whose tumours express PD-L1 with a CPS ≥ 10. • KEYTRUDA, in combination with chemotherapy as neoadjuvant treatment, and then continued as monotherapy as adjuvant treatment after surgery, is indicated for the treatment of adults with locally advanced, or early stage triple negative breast cancer at high risk of recurrence. • KEYTRUDA, in combination with chemotherapy, is indicated for the treatment of locally recurrent unresectable or metastatic triple negative breast cancer in adults whose tumours express PD L1 with a CPS ≥ 10 and who have not received prior chemotherapy for metastatic disease. • KEYTRUDA, in combination with lenvatinib, is indicated for the treatment of advanced or recurrent endometrial carcinoma in adults who have disease progression on or following prior treatment with a platinum containing therapy in any setting and who are not candidates for curative surgery or radiation. • KEYTRUDA, in combination with chemotherapy with or without bevacizumab, is indicated for the treatment of persistent, recurrent, or metastatic cervical cancer in adults whose tumours express PD L1 with a CPS ≥ 1. • KEYTRUDA, in combination with trastuzumab, fluoropyrimidine and platinum-containing chemotherapy, is indicated for the first-line treatment of locally advanced unresectable or metastatic HER2-positive gastric or gastro-oesophageal junction adenocarcinoma in adults whose tumours express PD-L1 with a CPS ≥ 1. • KEYTRUDA, in combination with fluoropyrimidine and platinum-containing chemotherapy, is indicated for the first-line treatment of locally advanced unresectable or metastatic HER2-negative gastric or gastro-oesophageal junction adenocarcinoma in adults whose tumours express PD L1 with a CPS ≥ 1. • KEYTRUDA, in combination with gemcitabine and cisplatin, is indicated for the first-line treatment of locally advanced unresectable or metastatic biliary tract carcinoma in adults. **DOSAGE AND ADMINISTRATION** See SmPC for full details. Therapy must be initiated and supervised by specialist physicians experienced in the treatment of cancer. The recommended dose of KEYTRUDA in adults is either 200 mg every 3 weeks or 400 mg every 6 weeks administered as an intravenous infusion over 30 minutes. The recommended dose of KEYTRUDA as monotherapy in paediatric patients aged 3 years and older with cHL or patients aged 12 years and older with melanoma is 2 mg/kg bodyweight (up to a maximum of 200 mg), every 3 weeks administered as an intravenous infusion over 30 minutes. For use in combination, see the Summary of Product Characteristics (SmPC) for the concomitant therapies. KEYTRUDA must not be administered as an intravenous push or bolus injection. When administering KEYTRUDA as part of a combination with intravenous chemotherapy, KEYTRUDA should be administered first. Treat patients until disease progression or unacceptable toxicity (and up to maximum duration of therapy if specified for an indication). For the adjuvant treatment of melanoma, NSCLC, or RCC, KEYTRUDA should be administered until disease recurrence, unacceptable toxicity, or for a duration of up to one year. Refer to the SmPC for dosing in neoadjuvant and adjuvant treatment of locally advanced, or early stage triple-negative breast cancer at high risk of recurrence. KEYTRUDA, as monotherapy or as combination therapy, should be permanently discontinued (a) For Grade 4 toxicity except for: endocrinopathies that are controlled with replacement hormones; or haematological toxicity, only in patients with cHL in which KEYTRUDA should be withheld until adverse reactions recover to Grade 0-1; (b) If corticosteroid dosing cannot be reduced to ≤10 mg prednisone or equivalent per day within 12 weeks; (c) If a treatment-related toxicity does not resolve to Grade 0 1 within 12 weeks after last dose of KEYTRUDA; (d) If any event occurs a second time at Grade ≥ 3 severity. Patients must be given the Patient Card and be informed about the risks of KEYTRUDA. *Special populations Elderly:* No dose adjustment necessary. *Renal impairment:* No dose adjustment needed for mild or moderate renal impairment. No studies in severe renal impairment. *Hepatic impairment:* No dose adjustment needed for mild or moderate hepatic impairment. No studies in severe hepatic impairment. *Paediatric population:* Safety and efficacy in children below 18 years of age not established except in paediatric patients with melanoma or cHL. **CONTRAINDICATIONS** Hypersensitivity to the active substance or to any excipients. **PRECAUTIONS AND WARNINGS** *Assessment of PD-L1 status* When assessing the PD-L1 status of the tumour, it is important that a well-validated and robust methodology is chosen to minimise false negative or false positive determinations. *Immune-mediated adverse reactions* Immune-mediated adverse reactions, including severe and fatal cases, have occurred in patients receiving pembrolizumab. Most immune mediated adverse reactions occurring during treatment with pembrolizumab were reversible and managed with interruptions of pembrolizumab, administration of corticosteroids and/or supportive care. Immune mediated adverse reactions have also occurred after the last dose of pembrolizumab. Immune-mediated adverse reactions affecting more than one body system can occur simultaneously. Immune-mediated adverse reactions are immune-mediated pneumonitis, immune-mediated colitis, immune-mediated hepatitis, immune-mediated nephritis, immune-mediated endocrinopathies (including adrenal insufficiency, hypophysitis, type 1 diabetes mellitus, diabetic ketoacidosis, hypothyroidism, and hyperthyroidism), immune-mediated skin adverse reactions (also including Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN)). Refer to SmPC for more information and management of immune-mediated adverse reactions. *Complications of allogeneic Haematopoietic Stem Cell Transplant (HSCT):* Cases of graft-versus-host-disease (GVHD) and hepatic veno-occlusive disease (VOD) have been observed in patients with classical Hodgkin lymphoma undergoing allogeneic HSCT after previous exposure to pembrolizumab. Infusion-related reactions: Grades 1, 2, 3 or 4 infusion reactions including hypersensitivity and anaphylaxis, could be seen with pembrolizumab treatment. Refer to SmPC for more information and management of infusion-related reactions. Patients with Biliary tract carcinoma (especially those with biliary stents) should be closely monitored for development of cholangitis or biliary tract infections before initiation of treatment and, regularly, thereafter. *Overdose:* There is no information on overdose with pembrolizumab. In case of overdose, monitor closely for signs or symptoms of adverse reactions and treat appropriately. **INTERACTIONS** No formal pharmacokinetic drug interaction studies have been conducted with pembrolizumab. No metabolic drug drug interactions are expected. The use of systemic corticosteroids or immunosuppressants before starting pembrolizumab should be avoided because of their potential interference with the pharmacodynamic activity and efficacy of pembrolizumab. Corticosteroids can be used as premedication, when pembrolizumab is used in combination with chemotherapy, as antiemetic prophylaxis and/or to alleviate chemotherapy-related adverse reactions. **FERTILITY, PREGNANCY AND LACTATION** *Women of childbearing potential* Women of childbearing potential should use effective contraception during treatment with pembrolizumab and for at least 4 months after the last dose of pembrolizumab. *Pregnancy* No data on use in pregnant women. Do not use during pregnancy unless the clinical condition of the woman requires treatment with pembrolizumab. *Breast-feeding* It is unknown whether pembrolizumab is secreted in human milk. A risk to newborns/ infants cannot be excluded. *Fertility* No clinical data available. **SIDE EFFECTS** Refer to SmPC for complete information on side effects. Pembrolizumab is most commonly associated with immune-mediated adverse reactions. Most of these reactions resolved with appropriate medical treatment or withdrawal of pembrolizumab. The most serious adverse reactions were immune-mediated and infusion-related adverse reactions. When pembrolizumab is administered in combination with axitinib or lenvatinib, refer to the SmPC for axitinib or lenvatinib prior to initiation of treatment. For additional lenvatinib safety information related to advanced RCC see the SmPC for Kisplyx and for advanced EC see the SmPC for Lenvima. **Monotherapy:** *Very Common:* anaemia, hypothyroidism, decreased appetite, headache, dyspnea, cough, abdominal pain, nausea, vomiting, constipation, musculoskeletal pain, arthralgia, asthenia, oedema, pyrexia, diarrhoea, pruritus, rash, fatigue. *Common:* pneumonia, thrombocytopenia, neutropenia, lymphopenia, hyponatraemia, hypokalaemia, hypocalcaemia, insomnia, neuropathy peripheral, lethargy, dry eye, cardiac arrhythmia (including atrial fibrillation), hypertension, hyperthyroidism, dizziness, dysgeusia, pneumonitis, colitis, dry mouth, hepatitis, severe skin reactions, vitiligo, dry skin, eczema, alopecia, dermatitis acneiform, erythema, dermatitis, myositis, pain in extremity, arthritis, influenza like illness, chills, AST and ALT increases, increase in blood alkaline phosphatase, hypercalcaemia, blood bilirubin increased, blood creatinine increased, infusion related reaction. **In combination with chemotherapy:** *Very Common:* Anaemia, neutropenia, thrombocytopenia, hypothyroidism, hypokalaemia, decreased appetite, insomnia, neuropathy peripheral, headache, dyspnoea, cough, diarrhoea, vomiting, nausea, abdominal pain, constipation, alopecia, pruritus, rash, musculoskeletal pain, arthralgia, pyrexia, fatigue, asthenia, ALT increase, AST increased. *Common:* pneumonia, febrile neutropenia, leukopenia, lymphopenia, infusion related reaction, adrenal insufficiency, thyroiditis, hyperthyroidism, hyponatraemia, hypocalcaemia, lethargy, dizziness, dysgeusia, dry eye, cardiac arrhythmia (including atrial fibrillation), hypertension, pneumonitis, colitis, gastritis, dry mouth, hepatitis, severe skin reactions, erythema, dermatitis, dry skin, dermatitis acneiform, eczema, myositis, pain in extremity, arthritis, acute kidney injury, oedema, influenza-like illness, chills, blood bilirubin increased, blood alkaline phosphatase increased, blood creatinine increased, hypercalcaemia. **In combination with axitinib or lenvatinib:** *Very Common:* urinary tract infection, anaemia, hypothyroidism, decreased appetite, headache, dysgeusia, hypertension, dyspnoea, cough, diarrhoea, abdominal pain, nausea, vomiting, constipation, rash, pruritus, arthralgia, musculoskeletal pain, myositis, pain in extremity, fatigue, asthenia, oedema, pyrexia, lipase increased, alanine aminotransferase increased, aspartate aminotransferase increased, blood creatinine increased. *Common:* pneumonia, neutropenia, thrombocytopenia, lymphopenia, leukopenia, infusion-related reaction, adrenal insufficiency, hyperthyroidism, thyroiditis, hyponatraemia, hypokalaemia, hypocalcaemia, insomnia, dizziness, neuropathy peripheral, lethargy, dry eye, cardiac arrhythmia (including atrial fibrillation), pneumonitis, colitis, pancreatitis, gastritis, dry mouth, hepatitis, severe skin reactions, dermatitis, dry skin, erythema, dermatitis acneiform, alopecia, arthritis, nephritis, influenza like illness, chills, amylase increased, blood bilirubin increased, blood alkaline phosphatase increased, hypercalcaemia. **PACKAGE QUANTITIES** KEYTRUDA 25 mg/mL: 4 mL of concentrate in a 10 mL Type I clear glass vial. **Legal Category:** POM. **Marketing Authorisation numbers:** EU/1/15/1024/002. **Marketing Authorisation holder** Merck Sharp & Dohme B.V., Waarderweg 39, 2031 BN Haarlem, The Netherlands. **Date of revision:** December 2023. **Further information is available on request from:** MSD, Red Oak North, South County Business Park, Leopardstown, Dublin, D18 X5K7 or from www.medicines.ie. II135_II138

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

Reference
1. KEYTRUDA Summary of Product Characteristics, Available at www.medicines.ie. Accessed March 2024.

Scan the QR code with your phone to view the KEYTRUDA SPC on **medicines.ie**

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

Date of Preparation: March 2024
IE-KEY-00855

CLINICAL FOCUS: *Cervical and breast cancer*

WIN looks at some recent findings in cervical and breast cancer research

Researchers identify new genetic risk factors for persistent HPV infections

HUMAN papillomavirus (HPV) is the second most common cancer-causing virus, causing 690,000 cervical and other cancers each year worldwide. While the immune system usually clears HPV infections, those that persist can develop into cancer. New research, recently published in *European Journal of Human Genetics* has suggested that certain women might have a genetic susceptibility to persistent or frequent HPV infections. These genetic variants, identified in a study led by University of Maryland School of Medicine researchers, could increase the risk of getting cervical cancer from a high-risk HPV infection.

The research team conducted a genome-wide association study of high-risk HPV infections in a cohort of over 10,000 women, whose data were collected as part of the African Collaborative Center for Microbiome and Genomics Research (ACCME) cohort study. A total of 903 of the participants had high-risk HPV infections when the study began, with 224 having HPV infections that resolved, and 679 having persistent HPV infections. More than 9,800 HPV-negative women from the ACCME study served as controls.

Study leader, Sally Adebamowo, associate professor of epidemiology and public health at the University of Maryland School of Medicine, explained that they found certain genetic variants were associated with having high-risk HPV infections, while other variants and human leukocyte antigen (HLA) genes were associated with persistent infections, which increased the risk of developing cervical cancer.

"This is a critical finding that suggests genetic underpinnings for cervical cancer risk. It is the first sufficiently powered genome-wide association study of cervical high-risk HPV infections. Our polygenic risk score models should be evaluated in other populations," she added.

Specifically, she and her colleagues found that the top variant associated with prevalent high-risk HPV infection was rs116471799, on the fourth chromosome near the LDB2 gene, which encodes for proteins. They found persistent HPV was associated with variants clustered around the TPTE2, a protein encoding gene associated with gallbladder cancer. The genes SMAD2 and CDH12 were also associated with persistent high risk HPV infections, and significant polygenic risk scores. Together the findings enabled the research team to develop polygenic risk scores to determine the likelihood that a certain genetic profile would increase the risk of having prevalent or persistent HPV infections.

The findings can be used for risk stratification of persistent high-risk HPV infections for precision or personalised cervical cancer prevention.

DOI: 10.1038/s41431-023-01521-7

AI-assisted breast-cancer screening may reduce unnecessary testing

Using artificial intelligence (AI) to supplement radiologists' evaluations of mammograms may improve breast-cancer screening by reducing false positives without missing cases of cancer, according to a study by researchers at Washington University School of Medicine and Whiterabbit.ai, a technology startup. The study was published in the journal *Radiology*: *Artificial Intelligence*.

The researchers developed an algorithm that identified normal mammograms with very high sensitivity. They then ran a simulation on patient data to see what would have happened if all of the very low-risk mammograms had been taken off radiologists' plates, freeing the doctors to concentrate on the more questionable scans. The simulation revealed that fewer people would have been called back for additional testing but that the same number of cancer cases would have been detected.

Senior study author Richard Wahl, a professor of radiology at Washington University's Institute of Radiology and a professor of radiation oncology, said that false positives caused a lot of unnecessary anxiety for patients and consumed medical resources.

For the study, the researchers developed a way to rule out cancer using AI to evaluate mammograms. They trained the AI model on 123,248 2D digital mammograms (containing 6,161 showing cancer) that were largely collected and read by Washington University radiologists. They then validated and tested the AI model on three independent sets of mammograms, two from institutions in the US and one in the UK.

The researchers figured out what the doctors did: how many patients were called back for secondary screening and biopsies; the results of those tests; and the final determination in each case. Then, they applied AI to the datasets to see what would have been different if AI had been used to remove negative mammograms in the initial assessments and physicians had followed standard diagnostic procedures to evaluate the rest.

For example, taking the largest dataset which contained 11,592 mammograms, AI identified 34.9% as negative. If those negative mammograms had been removed from the workload, radiologists would have made 897 callbacks for diagnostic exams, a reduction of 23.7% from the 1,159 they made in reality. At the next step, 190 people would have been called in a second time for biopsies, a reduction of 6.9%.

At the end of the process, both the AI rule-out and real-world standard-of-care approaches identified the same 55 cancers.

In other words, this study of AI suggests that out of 10,000 people who underwent initial mammograms, 262 could have avoided diagnostic exams and 10 could have avoided biopsies, without any cancer cases being missed.

Co-author Jason Su, chief technology officer at Whiterabbit.ai, said that by accurately assessing the negatives, AI can "help remove the hay from the haystack so doctors can find the needle more easily". More importantly, he added that the results showed that automating the detection of negatives could lead to the reduction of false positives without changing the cancer detection rate.

DOI: 10.1148/ryai.230033

Betmiga™

mirabegron 50mgs once daily

BETMIGA 25 mg prolonged-release tablets &
BETMIGA 50 mg prolonged-release tablets.

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

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

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

Date of preparation: January 2023

References: 1. Freeman R, et al. Current Medical Research and Opinion 2017. https://doi.org/10.1080/03007995.2017.1419170.

MAT-IE-BET-2023-00003

Focus on: Urinary incontinence

Part two of our series on urinary incontinence discusses disease management and treatment

IN THE previous issue of *WIN* we gave an overview of the various types of urinary incontinence (UI) and looked at diagnosis. In this article we focus on disease management.

Disease management

The management of UI depends on its type and severity. Treatment options aim to improve symptoms, restore quality of life and address the underlying causes. Approaches to managing UI range from conservative management, lifestyle modifications, behavioural and physical therapies to treatment with medications and surgical management.

Conservative management

Non-surgical therapies are tried first because they usually carry the least risk of harm. These include:

Management of underlying medical disease: UI especially in older people, has been associated with multiple comorbid conditions such as cardiac and renal failure, diabetes, chronic obstructive pulmonary disease (COPD), neurological disease including stroke and multiple sclerosis, general cognitive impairment, sleep apnoea and depression. It is possible that improvement of associated disease may reduce the severity of urinary symptoms.[1]

Management of constipation: Several studies have shown strong associations between constipation and UI. Constipation can be improved by behavioural, physical and medical treatments.[1]

Containment: Containment devices such as absorbent pads, urinary catheters and external collection devices play an important role, especially for individuals who prefer to avoid the risks of interventional treatments, or in whom active treatment is impossible for any reason.[1]

Lifestyle modifications

Caffeine reduction: Urinary symptoms are aggravated by excessive caffeine intake which lead to more sensation of urgency.[1] Many drinks contain caffeine, particularly tea, coffee and cola.

Physical exercise: Regular physical activity may strengthen the pelvic floor musculature and possibly decrease the risk of developing UI. However, heavy physical exercise may aggravate UI.[1]

Weight loss: Being overweight or obese is a risk factor for developing UI. Weight loss was shown to be beneficial in improving UI in many studies.[1]

Smoking cessation: This has been shown to be associated with improving urgency, frequency and UI.[1]

Behavioural and physical therapies

This includes all treatments which require a form of self-motivated personal retraining by the patient. This treatment modality encompasses techniques which are used to augment this effect, including:

Prompted voiding: Also known as timed voiding which means fixed, pre-determined, time intervals between voiding[1]

Bladder training: A series of scheduled voiding and patient education to restore the bladder function and to correct the faulty habit patterns of urination.[1]

Pelvic floor exercise: Certain exercises, such as Kegels, improve the function of the pelvic floor and urethral stability.[1]

Electrical stimulation: Stimulation of the pelvic floor muscles or of the sacral nerve and the percutaneous tibial nerve can help in controlling symptoms of OAB.[1]

Medications

Antimuscarinic drugs: Antimuscarinics are offered for urgency urinary incontinence (UUI) which have failed conservative treatment. These drugs can reduce urgency and frequency. They can be taken orally or by transdermal method. Dry mouth is the most common side effect, though constipation, blurred vision, fatigue and cognitive dysfunction may occur.[1]

Mirabegron: Mirabegron is the first clinically available beta3 agonist. Beta3 adrenoceptors are the predominant beta receptors expressed in the smooth muscle cells of the bladder muscle and their stimulation induces bladder relaxation, thus increasing capacity. This results in significantly greater reduction in incontinence episodes, urgency episodes and micturition frequency. The most common treatment adverse events found in the mirabegron groups are hypertension, nasopharyngitis and UTI.

Oestrogen: Oestrogens are used as hormone replacement therapy (HRT) for women with natural or therapeutic menopause. Oestrogen treatment for UI has been tested using oral, transdermal and vaginal routes of administration.[1]

Surgical management

Sling procedures: In stress incontinence cases, a sling may be surgically placed to support the urethra and reduce leakage. Sling procedures are surgical interventions that encompass incisions in both the lower abdomen and vagina. In these procedures, a supportive sling of tissue is positioned around the bladder's neck to provide reinforcement, effectively preventing unintended urine leakage. A commonly employed approach involves the use of an autologous sling, crafted from a section of the tissue layer that envelops the abdominal muscles, known as the *rectus fascia*. By placing this sling, surgeons aim to bolster bladder control and mitigate the occurrence of accidental urine leaks.

The HSE has temporarily stopped the use of synthetic mesh for urinary stress incontinence and pelvic organ prolapse surgeries in hospitals until new recommendations are implemented.[11]

Bladder neck suspension: This procedure can provide additional support to the bladder neck and urethra, it can be performed laparoscopically, by open approach or with a minimally invasive approach. This raises the neck of the bladder, securing it in this

elevated position. This helps stop unintentional leaks in women who have stress incontinence, providing them with relief from this issue.[1]

Botulinum toxin A injections: Botulinum toxin A, commonly known as Botox, can be administered via injections into the bladder walls. The mechanism of Botox in this context involves its ability to induce relaxation in the bladder muscle so it reduces the spontaneous contractions of the bladder. This relaxation effect can alleviate the frequent and intense urge to urinate that often accompanies these conditions. One of the advantages of using Botox for bladder issues is that its effects are relatively long-lasting, typically lasting for several months, and can be repeated. Side effects include, urinary tract infection, haematuria and, in some cases, urinary retention.[2]

Bulking agents: This procedure uses intra or periurethral injection of agents to form artificial cushions around the urethra, which increase the resistance to urine flow and facilitate continence. These agents, typically injectable materials, are introduced into the tissues around the urethra and bladder neck to increase tissue bulk and create a tighter seal. This helps to reduce the instances of urinary leakage, especially in cases of stress incontinence. This procedure is minimally invasive and offers an alternative to more invasive surgical interventions for managing UI.[1]

Medical devices: External compression devices are still widely used in the treatment of recurrent SUI after the failure of previous methods and this should be confirmed by urodynamic evaluation. Pessaries are also used by inserting this device into the vagina to support the bladder and reduce stress incontinence.[1]

Artificial urinary sphincter: AUS is a surgical implanted device used to treat UI, particularly stress urinary incontinence in men.[2] Also in men, the use of prostate medications or surgical interventions can be effective in alleviating symptoms of UI. These interventions are often recommended for addressing UI-related to prostate issues.

Conclusion

Urinary incontinence is a common issue that can usually be addressed and it is important to stress to patients not to overlook or feel ashamed about it. In order to empower individuals to regain control over their lives, it is essential to comprehend the reasons behind it, the various types of UI and the available treatment choices. Whether it involves making lifestyle changes, taking medication, engaging in physical therapy or opting for surgery, there are numerous effective strategies to manage UI.

By being proactive in preventing and addressing this condition, individuals can enhance their quality of life and preserve their independence and dignity.

Seeking medical advice and support is the crucial first step that a patient can take towards a life unaffected by urinary incontinence.

Anas Musa is a urology registrar at Our Lady of Lourdes Hospital, Drogheda, Syed Jaffry is a consultant urologist, at the Galway Clinic and Bon Secours Hospital, Galway and Asadullah Aslam is a consultant urologist at the Bon Secours Hospital, Limerick and Kingsbridge Private Hospital, Sligo

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A recent meeting involving continence nurses highlighted the need for patient support to be person centred and rooted in policy

Acting with urgency

THE Ireland branch of the Association of Continence Professionals held its ninth Annual National Education conference in Athlone in early March.

The conference – themed 'All Kinds of Everything: A Guide to Continence Care' – focused on the impact of incontinence on quality of life and the deficit in resources allocated to supporting patients with the condition. The audience comprised nurses, physiotherapists and allied healthcare professionals working in community, hospital, private and voluntary services from north and south of the border.

The keynote speaker, Maria Walsh, MEP for the Midlands-North West constituency, discussed the EU Continence Health Summit Manifesto for Policy Reform – 'The Urge to Act' – which was launched in Brussels in November 2023. The manifesto acknowledges the hidden challenge of incontinence and its impact on individuals and families, often with debilitating and chronic consequences across gender, age and socioeconomic background.

Optimising care

Incontinence can have a serious impact on a person's quality of life both physically and psychosocially, not to mention economically. This creates a barrier to full participation in society for individuals suffering with incontinence, as well as for their carers.

Optimal continence health should be a realistic achievement for all concerned. Incontinence is projected to be become a major health problem across Europe, exacerbated by an ageing population. While healthcare professionals are making every effort with existing resources in various EU countries, current systems are not yet fully adapted to support continence care.

'The Urge to Act' calls for concrete policy changes that recognise the importance of patient-centred continence care and calls on national and European policy-makers to develop a continence strategy that facilitates knowledge sharing and provides a framework for action in EU states.

Clinical presentations

Following a welcome address from Roisin Lynch, secretary of the Ireland branch, Prof Eamonn Rogers, national clinical lead for urology, RCSI, spoke about the current funding and rollout of the urology model of care, and in particular the pathway for urinary incontinence. This is a dedicated management pathway that integrates primary and secondary specialist continence care services. A pilot of this pathway has commenced in CHO areas 1 and 2 with the Saolta University Health Care Group. New posts for integrated clinical nurse specialists in continence care and specialist physiotherapists have been funded across both CHO areas for this pathway.

Ann Costigan, CNS in children's continence, Children Health Ireland Crumlin, gave an informative presentation on constipation and the importance of supporting the child and their family. Childhood constipation affects one in three children. It can be poorly recognised by parents and healthcare professionals alike. Ms Costigan went on to discuss the importance of early recognition, appropriate treatment with osmotic laxatives as per NICE guidelines, and highlighted the value of parental education and support.

Beatrice McGinley, a physiotherapist in Galway, spoke about the management of post-prostatectomy urinary incontinence and the impact of incontinence post operatively on a man's quality of life. Ms McGinley described the management strategies and support available for these men and the role of the physiotherapist in their care.

Dr Sumita Sarma, obstetrician and urogynaecologist, Galway University Hospital, presented on the genito-urinary symptoms of menopause. Dr Sarma said some women encounter distressing urinary symptoms both pre and post menopause. She looked at the assessment process and interventions to address these issues.

Stefano Terzoni, a nurse researcher from Milan, spoke about pelvic health and the need for a multidisciplinary approach to diagnosis and management.

Poster presentations

A poster competition was also held at the conference, with the award for best poster going to Olivia O'Connor, practice development nurse, Community Healthcare West, for a poster on the assessment of continence and catheter management. Ms O'Connor accepted the award on behalf of her colleagues on the Practice Development Continence Working Group in CHO2.

Other poster competition entrants who received highly commended awards included teams from Cavan General Hospital and the Royal College of Surgeons; CHO 7 and Trinity College Dublin; the CRANN Centre Registered Charity in CHO4; and CHO 1.

Feedback from delegates highlighted the overall value of the conference and the opportunity it afforded them to network, disseminate research and share best practices. In addition, attendees reported that the conference was an inspiring event that addressed this debilitating and taboo condition, with 99% of delegates rating the event as 'excellent' or 'very good'.

Further information

The Ireland branch of the Association of Continence Professionals is dedicated to supporting nurses and allied healthcare care professionals in the provision and delivery of continence care in Ireland through education, research and the sharing of best practice and service improvements.

For further information about the group, visit **acpcontinence.co.uk**

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

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Home parenteral nutrition for the oncology patient

While the number of cancer patients being discharged home on parenteral nutrition is increasing, it is a complex area to manage, writes **Deirdre Burke**

WHILE home parenteral nutrition (HPN) for oncology patients appears to be a growing area, it is a complex process with many factors that need to be considered. These include the patient's physical and psychological health at time of proposed discharge, support of family/friends, and ongoing suitability for treatment and prognosis.

Parenteral nutrition is the provision of fluids, macronutrients (carbohydrates, lipids and protein) and micronutrients (vitamins, trace elements and minerals) via an intravenous route.[1] It may be used as a life preserving method for those with intestinal failure who are unable to meet their nutritional requirements via the enteral route.[2]

An individual may require total parenteral nutrition if they are unable to tolerate or absorb any enteral intake.[1] Supplemental parenteral nutrition is used if an individual can absorb some fluids and/or nutrients enterally.[1] Parenteral nutrition is more commonly given in the hospital setting but can also be given if required longer term in the home setting.

Home parenteral nutrition can be a life preserving treatment for patients with non-malignant and malignant disease that result in intestinal failure.[3,4]

While an intestinal failure registry has been established in the Republic of Ireland, full numbers of patients at home on parenteral nutrition due to cancer have not yet been collated.

The British Artificial Nutrition Survey (BANS) 2016 report stated that there was an increase in new referrals for HPN with a malignancy from 12% in 2005 to 27% in 2015.[5] It is unknown how many of these patients are palliative but it is assumed that the majority are.[5] It is likely that the number of oncology patients at home on parenteral nutrition is also increasing in Ireland.

This can be a complicated patient group to manage from a parenteral nutrition, psychosocial, ethical and disease progression perspective.[6] People with cancer at home with parenteral nutrition are likely to have an inoperable gastrointestinal obstruction, making them unsuitable for feeding via an enteral feeding tube. Some cases may be due to malabsorption secondary to treatment, enterocutaneous fistulae and/or previous surgeries and dysmotility.[4,6]

Patient selection

Home parenteral nutrition is only recommended if a person is unable to meet their nutritional requirements via the enteral route and if they can be managed safely at home on parenteral nutrition.[2,3] This also applies for oncology patients. HPN can be considered in:[4,6,7]

- Patients whose quality of life and/or length of survival would be drastically reduced by malnutrition
- Those receiving ongoing anti-cancer treatments
- Patients with a performance status of 0, 1 or 2, or Karnofsky score ≥ 50 (ideally 70)
- Patients on completed cancer treatments but good performance status
- Those with an expected survival likely greater than two to three months
- Where the patient is in agreement, with a good understanding of the positives and negatives of parenteral nutrition
- Patients willing to be physically active
- Patients where it is not going to cause excessive burden
- Greater benefit if weight loss due to obstruction or minimal weight loss
- Where there is no or minimal inflammation present.

There is a paucity of evidence for HPN in the oncology patient group, as excluding these patients from treatment for a randomised control trial is not an option.[8] A Cochrane review, which identified 13 studies with 721 participants, was unable to conclude if HPN resulted in any improvement to either quality of life or length of survival due to a very low evidence base.[8]

Therefore, HPN needs to be considered on an individual basis based on the patient's disease prognosis, physical and psychological health.[9] Parenteral nutrition is likely detrimental to oncology patients without gastrointestinal failure due to higher rates of complications and infections. It may also have a negative impact for those with a prognosis of weeks, when the main aim of treatment should be comfort.[6]

Nutritional requirements

The calculation of nutritional requirements by the dietitian will be as follows:

- *Energy*: For non-obese cancer patients, the aim is 20-25kcal/kg body weight for bed-ridden patients and 25-35kcal/kg body weight for ambulatory patients[10]
- *Protein:* 1.2-1.5g protein/kg body weight.[10] For patients with cancer cachexia the aim will be on the higher end of the requirements[4]
- *Lipids:* For parenteral nutrition, the aim is 1-1.5g lipids/kg body weight.[10]

The provision of lipids should not exceed 1g/kg from parenteral nutrition if it is predicted that the individual will require parenteral nutrition for six months or more in non-oncology patients.[10] However, if patients are likely to live less than 18 months, additional lipids should be given as it is well tolerated in cancer and they are less likely to develop parenteral nutrition-associated liver disease.[7]

For cachexia, additional lipids may be

considered (up to 50% of energy from lipids for non-protein energy) due to increased efficiency in lipid utilisation combined with glucose resistance.[4] The calculation of nutritional requirements for obesity in the oncology setting may be challenging due to a lack of research in this cohort.[10] Close monitoring of patients is important as sarcopenic obesity is prevalent in this group. The roles and responsibilities of the members of the multidisciplinary team may vary across different hospital sites depending on dietetic funding and the experience of the dietitian. Roles may also differ across different hospitals depending on hospital policy and availability of certain staff, for example, a nutrition nurse/pharmacist.

Complications of home parenteral nutrition

Parenteral nutrition may increase the risk of serious complications including catheter-related bloodstream infections, thrombosis, line occlusions, electrolyte disturbances, fluid overload, liver failure and bone disease.[1,3,4,7,8]

HPN can be burdensome for patients and/or carers and family members. The time to connect and disconnect from parenteral nutrition will vary but can take approximately an hour per day. In most cases, patients will also be connected to parenteral nutrition for 12 hours or more per day. If they are unable to consume any oral intake, in particular fluids, they will require parenteral nutrition daily to prevent dehydration. This may influence a patient's decision to be discharged home on parenteral nutrition.

Other factors

When a patient is discharged home on parenteral nutrition, the process may take several weeks to organise, and patients should be made aware of this. The process involves the following steps:

- Referral to the homecare company
- An application for funding is made
- Patient and family members are trained on HPN
- Referral to the community intervention team
- Ordering of equipment including ancillaries, fridges and bags of parenteral nutrition.

Patients can be discharged home on patient-specific bags of parenteral nutrition if they have been formulated in time. However, standard parenteral nutrition bags may also be appropriate for this group and waiting for compounding of patient-specific bags should not delay discharge. If a patient is stable, they may also remain on a standard parenteral nutrition bag.[7]

Nursing support

Additional home support may also be required and should be considered prior to discharge.[7] Nursing support for connection and disconnection may be available from the homecare provider or insurance company depending on where the patient lives, and with additional funding from the HSE/insurance company. This can be difficult to achieve. In the majority of cases, the patient and their family look after the parenteral nutrition. It is also important to consider training more than one family/friend of the patient to reduce the burden on one person. However, discharge home should not be delayed for training of all family members or friends prior to discharge. Patients can often have other care needs including, but not limited to, additional medications intravenously, care of venting PEG if in place, assistance with housework and personal hygiene.[7] Patients may at times feel too unwell to care for themselves due to treatment or disease progression and this must also be considered.

Individual care plan

A clear individual care plan for each patient should be created prior to discharge home. This may include blood ordering and monitoring, follow-up appointments, what to do if complications arise and who should be involved with the care of the patient, including palliative care home teams, GP, primary medical team and dietitian.[7] The care plan will be determined by the clinical requirements and the patient's current condition so this will need to be adapted.[7,11]

Funding

HPN is expensive. Funding is applied for through the HSE in the patient's local area and/or, if available, health insurance. Health economics analyses has shown that there is a high economic cost for discharge home for a short period of time.[12] Funding for this patient group is area dependent and the time it takes for funding to come through varies.

This can be challenging for the person, who will be concerned about the limited time they have left. When applying for funding, it is useful to note that the patient has a limited life expectancy and to follow-up sooner with funding officers to help expedite approval.

Equipment

Another consideration is that HPN equipment can take up a lot of space for ancillaries and the fridge. Patients may also require additional hospital equipment and this should be considered before delivery to the home.[7]

Withdrawal

Withdrawal of HPN at end of life should be discussed with the patient prior to discharge.[6,7] Ongoing discussions during the patient's treatment is recommended so that it is less distressing when the time comes for this to be weaned and stopped.[7]

Summary

Evidence in this area remains limited. It appears to be a growing but complex area. Choosing the patient who will benefit from HPN in terms of quality of life and increased survival is not always straight forward. A number of factors need to be considered including the patient's current physical and psychological health, support of family/friends, and ongoing suitability for treatment and prognosis.

A number of areas require research in HPN for the oncology patient, including measurements for HPN, such as quality of life, length of survival and when anthropometric measurements should be quantified.

Deirdre Burke is a senior dietitian in intestinal failure at University Hospital Galway

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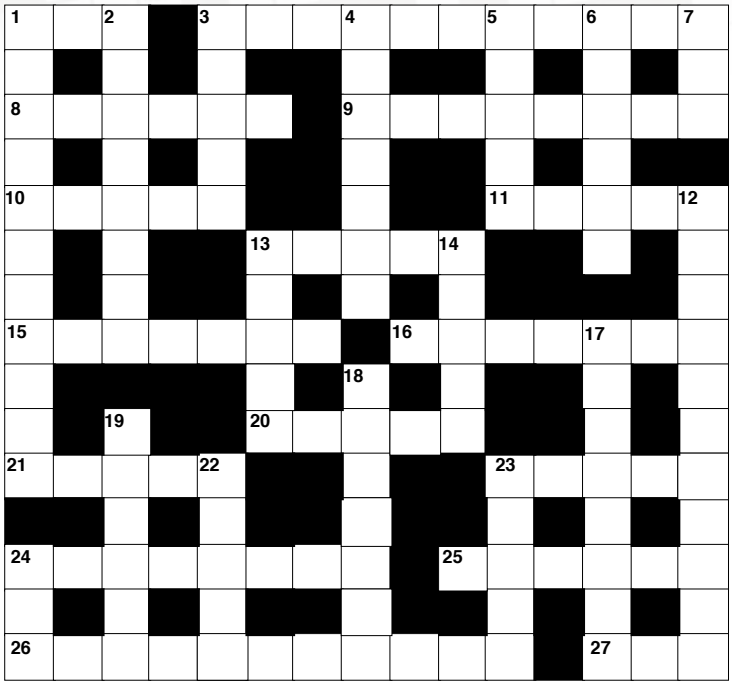
Across

1 Bestow a knighthood on one from the capital (3)
3 Characterised by peaks, more than hilly (11)
8 Northernmost province (6)
9 The piano lit up when an artist used this (3,5)
10 Hobbles (5)
11 Telling 'porkies' (5)
13 In classical mythology, the goddesses who shaped our destiny (5)
15 Dublin maternity hospital (7)
16 Do well from a situation (7)
20 Dig (5)
21 Fracas (5)
23 Trumpet (5)
24 Viking craft (8)
25 Car pedal you use when changing gear (6)
26 Gardener's transport equipment (11)
27 Bituminous substance, pitch (3)

Down

1 Rich dairy produce (6,5)
2 Underground room (8)
3 Encounters (5)
4 Gas consumed - identifying a newborn child! (7)
5 Urge forward (5)
6 Source, beginning (6)
7 Drunkard (3)
12 Informal social gathering (3-8)
13 Lost vividness of colour (5)
14 Brushed leather (5)
17 Counterfeit a songbird? That's certainly not going to happen! (6,2)
18 Item of bedroom footwear (7)
19 Fair-haired person (6)
22 Artist's stand (5)
23 Statute enacted by a local authority (5)
24 This bovine sound is not high (3)



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You can email your entry to us at **nursing@medmedia.ie** by taking a photo of the completed crossword with your details included and putting *'Crossword Competition'* in the subject line. Closing date: **June 11, 2024.** Alternatively post your entry to: WIN Crossword, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Dublin A96E096

April crossword solution

Across: 1 Ski 3 Vexillology 8 Refill 9 Feathers 11 Croft 13 Finer 15 En route 16 Swerved 20 Lobby 21 Stake 23 Glaze 24 Carriage 25 Mohair 26 Wine glasses 27 Act

Down: 1 String beans 2 Inferior vena cava 3 Value 4 Inferno 5 Optic nerve 6 Oregon 7 Yes 12 Trade secret 13 Fatal 14 Rowdy 18 Abscess 19 Macron 22 Eying 23 Goods 24 Cow

The winner of the April crossword sponsored by MedMedia is Gerardine Flanagan, Dromahair, Co Leitrim

Navan nurses highlight colon cancer symptoms

AN awareness day on colon cancer was held by a group of endoscopy nurses at Our Lady's Hospital, Navan last month. Information on the signs and symptoms of bowel cancer was provided throughout the event. A quiz was also held, and leaflets on preventive measures were distributed, including tips on maintaining a healthy diet, taking regular exercise and limiting alcohol and processed foods, as well as how to register on the National Bowel Screening Programme.

Pictured at the awareness event were (l-r): Maria Fe Diestro, Annemarie Evans, Karen McCabe, all endoscopy senior staff nurses; and Cathriona Cahill, CNM2 in endoscopy triage at Our Lady's Hospital, Navan

Symptoms of bowel cancer include:

- A lasting change in your bowel habit – going more often, looser motions or constipation
- Blood in stool or bleeding from back passage
- Pain or discomfort in abdomen or back passage
- Trapped wind or fullness in abdomen
- A lump in abdominal area or rectum
- Feeling of not having emptied the bowel fully after going to the toilet
- Unexplained weight loss
- Feeling tired and breathless due to anaemia.

Nurse-led study to look at adult cancer patients receiving CAR-T therapy

AN investigation of the experiences and unmet needs of adult cancer patients receiving chimeric antigen receptor t-cell (CAR-T) therapy in Ireland is set to be launched soon.

The study, which is co-funded by Trinity College and St James's Hospital and led by nurse and PhD researcher Isabel Girleanu, aims to explore the voice of individuals living with a cancer diagnosis.

Phase one of the study will comprise a national survey, which will seek to ascertain the experiences and needs of adult (18 years and older) patients undergoing CAR-T therapy at the national CAR-T centre.

In phase two, semi-structured interviews will be carried out with a subsequent sample of survey respondents to provide a more in-depth and contextualised understanding of the nuanced experiences and unmet needs of this group of cancer patients.

CAR-T therapy has been developed for patients with subtypes of leukaemia and lymphoma, with growing demand to establish its benefit for additional subtypes.

In current literature, the pattern of outcomes of interest is largely clinical, rather than patient-related or with the healthcare system in focus. Research undertaking a more person-centred approach is required to understand the complexities of patient experiences and unmet needs to improve patient outcomes and guide delivery of care.

It is hoped the study will identify and provide a holistic understanding of the unmet needs of patients receiving CAR-T therapy, providing valuable insight into patient specific outcomes, with a focus on improving the pathways of care for those undergoing this innovative and growing treatment for haematological cancers.

This will seek to improve the delivery of CAR-T therapy by informing the development of services and aiding in policy-making.

If you would like to take part in this study, contact Isabel Girleanu by email: girleani@tcd.ie

New non-hormonal option to reduce menopausal symptoms

A NEW non-hormonal treatment to reduce moderate to severe vasomotor symptoms associated with menopause was recently launched in Ireland.

Fezolinetant is a first-in-class selective neurokinin 3 receptor antagonist providing a non-hormonal option to reduce moderate to severe VMS associated with menopause.

Vasomotor symptoms of menopause, such as hot flushes and/or night sweats, affect more than half of women aged 40 to 64 years globally. Furthermore, the prevalence of moderate to severe vasomotor symptoms in postmenopausal women in Europe has been reported at 40%.

Such symptoms have a disruptive effect on women's daily activities and overall quality of life.

Dr Deirdre Lundy, clinical lead in the Complex Menopause Service at the National Maternity Hospital, Dublin said: "I'm delighted to see the availability of fezolinetant in Ireland. This advancement in women's health provides a novel, non-hormonal option for menopausal women to control their moderate to severe vasomotor symptoms, which can be so debilitating and which have a huge impact on these women's daily lives."

The approval of fezolinetant is based on the results from the BRIGHT SKY programme, which included three phase 3 clinical trials that collectively enrolled more than 3,000 individuals across Europe, the US and Canada.

Fezolinetant (sold under the brand name Veoza) was first approved by the European Medicines Agency in December 2023 for the treatment of moderate to severe vasomotor symptoms associated with menopause.

The drug is an oral, non-hormonal medicine that works by blocking neurokinin B binding on the kisspeptin/neurokinin/dynorphin (KNDy), which helps to restore the balance in the brain's temperature control centre (the hypothalamus) to reduce the number of hot flushes and night sweats as well as reduce their intensity.

May

Saturday 18
Midwives Section meeting online

Tuesday 21
Inclusion Health Section meeting. 11am online and at the Richmond Education and Event Centre

Thursday 23
Community Intervention Team Section meeting. 10am online

Tuesday 28
National Care of the Older Person Section annual conference, Midlands Park Hotel, Portlaoise, *(see page 29)*

Tuesday 28
Integrated Care Section meeting. 2pm online

Wednesday 29
Orthopaedic Nurses Section meeting. 4pm online

June

Saturday 8
Midwives Section webinar. 9.30am online

Wednesday 12
Clinical Placement Co-ordinators Section meeting. 11am online

Thursday 20
Assistant Directors Section meeting. 2.30pm online

Monday 24
Education Section meeting. 9am online

July

Monday 8
Children's Nurses Section meeting. 11am online

September

Tuesday 3
Retired Section meeting. 11am

Friday 13
Inclusion Health Section conference. The Richmond

Saturday 14
PHN Section meeting. 10.30am online

Monday 16
Education Section meeting. 9am online

Tuesday 17
Operating Department Nurses Section meeting. 7pm online

Tuesday 24
Telephone Triage Section conference. The Richmond

Thursday 26
Assistant Directors Section meeting. 2.30pm online

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

Condolence

❖ We extend our deepest sympathies to INMO staff member Deborah Winters on the recent passing of her mother, Marie Winters. She will be sadly missed by her extended family, neighbours and friends.

INMO Membership Fees 2024

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

Exciting changes coming to Nurse2Nurse

As part of our commitment to providing you with an enhanced online experience, the library is changing how members will access our online resources, including databases and journals.

What does this mean?

- The Nurse2Nurse website will cease to exist
- All library resources will be accessible via **inmo.ie/library**
- Access to library resources will be via OpenAthens

This change will occur over the coming months, so to ensure uninterrupted access, register for OpenAthens by emailing niamh.adams@inmo.ie or call 01 6640625

Nurse On Call

Nursing services and recruitment

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

- Do you want to be able to work around family life and work when it suits you?
- Do you want to be in charge of your own work schedule?
- Do you want to make some extra money for holidays or for something special?
- Do you want to avoid a stressful work environment?
- Do you want to try out a hospital/worksite before committing to a permanent position?

Join Nurse On Call, an approved supplier of agency nurses, student nurses and HCAs to every HSE/HSE-funded worksite in the Republic of Ireland – we would love to have you!

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

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

Irish Nurses and Midwives Organisation
Working Together

2024 Nurse and Midwife Representative Training

The INMO provides Representative Training to our members.

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

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

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

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

Month	Date	Location
MAY	28 & 29 Advanced course	Dublin
JUNE	05 & 06	Waterford
	12 & 13	Galway
	19 & 20	Dublin
JULY	16 & 17	Dublin
SEPTEMBER	10 & 11	Dublin
OCTOBER	03 & 04	Sligo
	08 & 09	Cork
	14 & 15	Dublin

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

CONTACT YOUR INMO OFFICIAL

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

CWHT
Construction Workers Health Trust
Trade Unions Working to protect the health of construction workers

OPPORTUNITIES FOR HEALTH SCREENING NURSES

The Construction Workers Health Trust (CWHT) was established in 1994 by trade unions under the Irish Congress of Trade Unions. It focuses on improving construction workers' health through on-site screenings, health awareness, and promoting healthy habits.

The CWHT is recruiting a small team of nurses to provide on-site health screenings to construction workers, mostly in Dublin, parts of Leinster and Munster.

Desirable Qualifications:

- Registered Nurse with NMBI with minimum of 5 years general nurse experience
- Knowledgeable in health promotion and interest in preventative health
- Interest and awareness of innovative digital technologies to support practice
- Excellent clinical knowledge, assessment and reasoning skills and evidence-based practice
- Works within and understands their own scope of practice
- An ability to practise effectively within the role
- Ability to work on their own initiative with good problem-solving techniques in the decision-making process
- Excellent interpersonal, communication skills and IT skills.
- Driver's licence essential

On offer:

- Flexible daytime working conditions - minimum 2/3 day p/week commitment required.
- Attractive salary, training and option of CWHT vehicle offered

Send CV and cover letter to CWHT General Manager alison.gilliland@cwht.ie
Closing date Thursday 9th May 2024

Night nurses needed

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

Irish Cancer Society

HCI
Transforming Healthcare Quality and Safety

We are hiring nurses!

Are you interested in Quality and Safety?

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

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

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

Nurses
More income with less stress
Consider Agency Homecare

With Misneach Healthcare

- **Agency** Nurses
- **€45.00** per hour (All **Agency** shifts)
- Bank Holiday Premiums
- **3-5 years** acute **Irish** hospital experience, Respiratory Ward/ICU/HDU/CCU
- NIV Nocturnal BiPap - **One Patient Only**
- Home Care **Agency** - Dublin based
- HSE funded
- **Agency Night & Day** Shifts
- Flexible Self Rostering
- 2 x Training Shifts provided
- Weekly payroll
- Free on-site parking
- NMBI Registered
- Excellent **Interpersonal** Skills
- English Language **Fluency**

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

ARAG LEGAL

Here to support our frontline workers

If you are asked for your insurer on the call, simply indicate that you are covered by the scheme as INMO union member. You do not need a separate insurance package to access the service.

Legal Advice & Domestic Assistance Helpline
0818 670 707 or (01) 670 7472
Counselling Helpline
1800 670 407 or (01) 881 8047

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

www.arag.ie

KEYTRUDA®
(pembrolizumab)

KEYTRUDA: multiple treatment options for more patients with mNSCLC[1]

Line	Histology	PD-L1 <1% or unknown	PD-L1 1-49%	PD-L1 >50%
1st line Combination* Therapy[2]	NON-SQUAMOUS	√	√	√
1st line Combination** Therapy[3]	SQUAMOUS	√	√	√
1st line*** Monotherapy[4]	NON-SQUAMOUS AND SQUAMOUS	X	X	√

* KEYTRUDA, in combination with pemetrexed and platinum chemotherapy, is indicated for the first-line treatment of metastatic non-squamous NSCLC in adults whose tumours have no EGFR or ALK positive mutations.

** KEYTRUDA, in combination with carboplatin and either paclitaxel or nab-paclitaxel, is indicated for the first-line treatment of metastatic squamous NSCLC in adults.

*** KEYTRUDA, as monotherapy, is indicated for the first-line treatment of metastatic non-small cell lung carcinoma (NSCLC) in adults whose tumours express PD-L1 with a≥ 50% tumour proportion score (TPS) with no EGFR or ALK positive tumour mutations.

KEYTRUDA® (pembrolizumab)
ABRIDGED PRODUCT INFORMATION Refer to Summary of Product Characteristics before prescribing. **PRESENTATION** KEYTRUDA 25 mg/mL: One vial of 4 mL of concentrate contains 100 mg of pembrolizumab. **INDICATIONS** • KEYTRUDA as monotherapy is indicated for the treatment of adults and adolescents aged 12 years and older with advanced (unresectable or metastatic) melanoma. • KEYTRUDA as monotherapy is indicated for the adjuvant treatment of adults and adolescents aged 12 years and older with Stage IIB, IIC or III melanoma and who have undergone complete resection. • KEYTRUDA as monotherapy is indicated for the adjuvant treatment of adults with non-small cell lung carcinoma who are at high risk of recurrence following complete resection and platinum-based chemotherapy. • KEYTRUDA as monotherapy is indicated for the first-line treatment of metastatic non-small cell lung carcinoma (NSCLC) in adults whose tumours express PD-L1 with a ≥50% tumour proportion score (TPS) with no EGFR or ALK positive tumour mutations. • KEYTRUDA, in combination with pemetrexed and platinum chemotherapy, is indicated for the first-line treatment of metastatic non-squamous NSCLC in adults whose tumours have no EGFR or ALK positive mutations. • KEYTRUDA, in combination with carboplatin and either paclitaxel or nab-paclitaxel, is indicated for the first-line treatment of metastatic squamous NSCLC in adults. • KEYTRUDA as monotherapy is indicated for the treatment of locally advanced or metastatic NSCLC in adults whose tumours express PD-L1 with a ≥1% TPS and who have received at least one prior chemotherapy regimen. Patients with EGFR or ALK positive tumour mutations should also have received targeted therapy before receiving KEYTRUDA. • KEYTRUDA as monotherapy is indicated for the treatment of adult and paediatric patients aged 3 years and older with relapsed or refractory classical Hodgkin lymphoma (cHL) who have failed autologous stem cell transplant (ASCT) or following at least two prior therapies when ASCT is not a treatment option. • KEYTRUDA as monotherapy is indicated for the treatment of locally advanced or metastatic urothelial carcinoma in adults who have received prior platinum-containing chemotherapy. • KEYTRUDA as monotherapy is indicated for the treatment of locally advanced or metastatic urothelial carcinoma in adults who are not eligible for cisplatin-containing chemotherapy and whose tumours express PD L1 with a combined positive score (CPS) ≥ 10. • KEYTRUDA as monotherapy or in combination with platinum and 5-fluorouracil (5-FU) chemotherapy, is indicated for the first-line treatment of metastatic or unresectable recurrent head and neck squamous cell carcinoma (HNSCC) in adults whose tumours express PD-L1 with a CPS ≥ 1. • KEYTRUDA as monotherapy is indicated for the treatment of recurrent or metastatic HNSCC in adults whose tumours express PD-L1 with a ≥ 50% TPS and progressing on or after platinum-containing chemotherapy. • KEYTRUDA, in combination with axitinib, is indicated for the first-line treatment of advanced renal cell carcinoma (RCC) in adults. • KEYTRUDA, in combination with lenvatinib, is indicated for the first line treatment of advanced renal cell carcinoma in adults. • KEYTRUDA as monotherapy is indicated for the adjuvant treatment of adults with renal cell carcinoma at increased risk of recurrence following nephrectomy, or following nephrectomy and resection of metastatic lesions. Microsatellite instability high (MSI-H) or mismatch repair deficient (dMMR) cancers. *Colorectal cancer (CRC).* • KEYTRUDA as monotherapy is indicated for adults with MSI-H or dMMR colorectal cancer in the following settings: - first line treatment of metastatic colorectal cancer. - treatment of unresectable or metastatic colorectal cancer after previous fluoropyrimidine based combination therapy. *Non-colorectal cancers.* • KEYTRUDA as monotherapy is indicated for the treatment of the following MSI H or dMMR tumours in adults with (a) advanced or recurrent endometrial carcinoma, who have disease progression on or following prior treatment with a platinum containing therapy in any setting and who are not candidates for curative surgery or radiation, (b) unresectable or metastatic gastric, small intestine, or biliary cancer, who have disease progression on or following at least one prior therapy. • KEYTRUDA, in combination with platinum and fluoropyrimidine based chemotherapy, is indicated for the first-line treatment of locally advanced unresectable or metastatic carcinoma of the oesophagus in adults whose tumours express PD-L1 with a CPS ≥ 10. • KEYTRUDA, in combination with chemotherapy as neoadjuvant treatment, and then continued as monotherapy as adjuvant treatment after surgery, is indicated for the treatment of adults with locally advanced, or early stage triple negative breast cancer at high risk of recurrence. • KEYTRUDA, in combination with chemotherapy, is indicated for the treatment of locally recurrent unresectable or metastatic triple negative breast cancer in adults whose tumours express PD L1 with a CPS ≥ 10 and who have not received prior chemotherapy for metastatic disease. • KEYTRUDA, in combination with lenvatinib, is indicated for the treatment of advanced or recurrent endometrial carcinoma in adults who have disease progression on or following prior treatment with a platinum containing therapy in any setting and who are not candidates for curative surgery or radiation. • KEYTRUDA, in combination with chemotherapy with or without bevacizumab, is indicated for the treatment of persistent, recurrent, or metastatic cervical cancer in adults whose tumours express PD L1 with a CPS ≥ 1. • KEYTRUDA, in combination with trastuzumab, fluoropyrimidine and platinum-containing chemotherapy, is indicated for the first-line treatment of locally advanced unresectable or metastatic HER2-positive gastric or gastro-oesophageal junction adenocarcinoma in adults whose tumours express PD-L1 with a CPS ≥ 1. • KEYTRUDA, in combination with fluoropyrimidine and platinum-containing chemotherapy, is indicated for the first-line treatment of locally advanced unresectable or metastatic HER2-negative gastric or gastro-oesophageal junction adenocarcinoma in adults whose tumours express PD L1 with a CPS ≥ 1. • KEYTRUDA, in combination with gemcitabine and cisplatin, is indicated for the first-line treatment of locally advanced unresectable or metastatic biliary tract carcinoma in adults. **DOSAGE AND ADMINISTRATION** See SmPC for full details. Therapy must be initiated and supervised by specialist physicians experienced in the treatment of cancer. The recommended dose of KEYTRUDA in adults is either 200 mg every 3 weeks or 400 mg every 6 weeks administered as an intravenous infusion over 30 minutes. The recommended dose of KEYTRUDA as monotherapy in paediatric patients aged 3 years and older with cHL or patients aged 12 years and older with melanoma is 2 mg/kg bodyweight (up to a maximum of 200 mg), every 3 weeks administered as an intravenous infusion over 30 minutes. For use in combination, see the Summary of Product Characteristics (SmPC) for the concomitant therapies. KEYTRUDA must not be administered as an intravenous push or bolus injection. When administering KEYTRUDA as part of a combination with intravenous chemotherapy, KEYTRUDA should be administered first. Treat patients until disease progression or unacceptable toxicity (and up to maximum duration of therapy if specified for an indication). For the adjuvant treatment of melanoma, NSCLC, or RCC, KEYTRUDA should be administered until disease recurrence, unacceptable toxicity, or for a duration of up to one year. Refer to the SmPC for dosing in neoadjuvant and adjuvant treatment of locally advanced, or early stage triple-negative breast cancer at high risk of recurrence. KEYTRUDA, as monotherapy or as combination therapy, should be permanently discontinued (a) For Grade 4 toxicity except for: endocrinopathies that are controlled with replacement hormones; or haematological toxicity, only in patients with cHL in which KEYTRUDA should be withheld until adverse reactions recover to Grade 0-1; (b) If corticosteroid dosing cannot be reduced to ≤10 mg prednisone or equivalent per day within 12 weeks; (c) If a treatment-related toxicity does not resolve to Grade 0 1 within 12 weeks after last dose of KEYTRUDA; (d) If any event occurs a second time at Grade ≥ 3 severity. Patients must be given the Patient Card and be informed about the risks of KEYTRUDA. *Special populations Elderly:* No dose adjustment necessary. *Renal impairment:* No dose adjustment needed for mild or moderate renal impairment. No studies in severe renal impairment. *Hepatic impairment:* No dose adjustment needed for mild or moderate hepatic impairment. No studies in severe hepatic impairment. *Paediatric population:* Safety and efficacy in children below 18 years of age not established except in paediatric patients with melanoma or cHL. **CONTRAINDICATIONS** Hypersensitivity to the active substance or to any excipients. **PRECAUTIONS AND WARNINGS** *Assessment of PD-L1 status* When assessing the PD-L1 status of the tumour, it is important that a well-validated and robust methodology is chosen to minimise false negative or false positive determinations. *Immune-mediated adverse reactions* Immune-mediated adverse reactions, including severe and fatal cases, have occurred in patients receiving pembrolizumab. Most immune mediated adverse reactions occurring during treatment with pembrolizumab were reversible and managed with interruptions of pembrolizumab, administration of corticosteroids and/or supportive care. Immune mediated adverse reactions have also occurred after the last dose of pembrolizumab. Immune-mediated adverse reactions affecting more than one body system can occur simultaneously. Immune-mediated adverse reactions are immune-mediated pneumonitis, immune-mediated colitis, immune-mediated hepatitis, immune-mediated nephritis, immune-mediated endocrinopathies (including adrenal insufficiency, hypophysitis, type 1 diabetes mellitus, diabetic ketoacidosis, hypothyroidism, and hyperthyroidism), immune-mediated skin adverse reactions (also including Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN)). Refer to SmPC for more information and management of immune-mediated adverse reactions. *Complications of allogeneic Haematopoietic Stem Cell Transplant (HSCT):* Cases of graft-versus-host-disease (GVHD) and hepatic veno-occlusive disease (VOD) have been observed in patients with classical Hodgkin lymphoma undergoing allogeneic HSCT after previous exposure to pembrolizumab. Infusion-related reactions: Grades 1, 2, 3 or 4 infusion reactions including hypersensitivity and anaphylaxis, could be seen with pembrolizumab treatment. Refer to SmPC for more information and management of infusion-related reactions. Patients with Biliary tract carcinoma (especially those with biliary stents) should be closely monitored for development of cholangitis or biliary tract infections before initiation of treatment and, regularly, thereafter. *Overdose:* There is no information on overdose with pembrolizumab. In case of overdose, monitor closely for signs or symptoms of adverse reactions and treat appropriately. **INTERACTIONS** No formal pharmacokinetic drug interaction studies have been conducted with pembrolizumab. No metabolic drug drug interactions are expected. The use of systemic corticosteroids or immunosuppressants before starting pembrolizumab should be avoided because of their potential interference with the pharmacodynamic activity and efficacy of pembrolizumab. Corticosteroids can be used as premedication, when pembrolizumab is used in combination with chemotherapy, as antiemetic prophylaxis and/or to alleviate chemotherapy-related adverse reactions. **FERTILITY, PREGNANCY AND LACTATION** *Women of childbearing potential* Women of childbearing potential should use effective contraception during treatment with pembrolizumab and for at least 4 months after the last dose of pembrolizumab. *Pregnancy* No data on use in pregnant women. Do not use during pregnancy unless the clinical condition of the woman requires treatment with pembrolizumab. *Breast-feeding* It is unknown whether pembrolizumab is secreted in human milk. A risk to newborns/ infants cannot be excluded. *Fertility* No clinical data available. **SIDE EFFECTS** Refer to SmPC for complete information on side effects. Pembrolizumab is most commonly associated with immune-mediated adverse reactions. Most of these reactions resolved with appropriate medical treatment or withdrawal of pembrolizumab. The most serious adverse reactions were immune-mediated and infusion-related adverse reactions. When pembrolizumab is administered in combination with axitinib or lenvatinib, refer to the SmPC for axitinib or lenvatinib prior to initiation of treatment. For additional lenvatinib safety information related to advanced RCC see the SmPC for Kisplyx and for advanced EC see the SmPC for Lenvima. **Monotherapy:** *Very Common:* anaemia, hypothyroidism, decreased appetite, headache, dyspnea, cough, abdominal pain, nausea, vomiting, constipation, musculoskeletal pain, arthralgia, asthenia, oedema, pyrexia, diarrhoea, pruritus, rash, fatigue. *Common:* pneumonia, thrombocytopenia, neutropenia, lymphopenia, hyponatraemia, hypokalaemia, hypocalcaemia, insomnia, neuropathy peripheral, lethargy, dry eye, cardiac arrhythmia (including atrial fibrillation), hypertension, hyperthyroidism, dizziness, dysgeusia, pneumonitis, colitis, dry mouth, hepatitis, severe skin reactions, vitiligo, dry skin, eczema, alopecia, dermatitis acneiform, erythema, dermatitis, myositis, pain in extremity, arthritis, influenza like illness, chills, AST and ALT increases, increase in blood alkaline phosphatase, hypercalcaemia, blood bilirubin increased, blood creatinine increased, infusion related reaction. **In combination with chemotherapy:** *Very Common:* Anaemia, neutropenia, thrombocytopenia, hypothyroidism, hypokalaemia, decreased appetite, insomnia, neuropathy peripheral, headache, dyspnoea, cough, diarrhoea, vomiting, nausea, abdominal pain, constipation, alopecia, pruritus, rash, musculoskeletal pain, arthralgia, pyrexia, fatigue, asthenia, ALT increase, AST increased. *Common:* pneumonia, febrile neutropenia, leukopenia, lymphopenia, infusion related reaction, adrenal insufficiency, thyroiditis, hyperthyroidism, hyponatraemia, hypocalcaemia, lethargy, dizziness, dysgeusia, dry eye, cardiac arrhythmia (including atrial fibrillation), hypertension, pneumonitis, colitis, gastritis, dry mouth, hepatitis, severe skin reactions, erythema, dermatitis, dry skin, dermatitis acneiform, eczema, myositis, pain in extremity, arthritis, acute kidney injury, oedema, influenza-like illness, chills, blood bilirubin increased, blood alkaline phosphatase increased, blood creatinine increased, hypercalcaemia. **In combination with axitinib or lenvatinib:** *Very Common:* urinary tract infection, anaemia, hypothyroidism, decreased appetite, headache, dysgeusia, hypertension, dyspnoea, cough, diarrhoea, abdominal pain, nausea, vomiting, constipation, rash, pruritus, arthralgia, musculoskeletal pain, myositis, pain in extremity, fatigue, asthenia, oedema, pyrexia, lipase increased, alanine aminotransferase increased, aspartate aminotransferase increased, blood creatinine increased. *Common:* pneumonia, neutropenia, thrombocytopenia, lymphopenia, leukopenia, infusion-related reaction, adrenal insufficiency, hyperthyroidism, thyroiditis, hyponatraemia, hypokalaemia, hypocalcaemia, insomnia, dizziness, neuropathy peripheral, lethargy, dry eye, cardiac arrhythmia (including atrial fibrillation), pneumonitis, colitis, pancreatitis, gastritis, dry mouth, hepatitis, severe skin reactions, dermatitis, dry skin, erythema, dermatitis acneiform, alopecia, arthritis, nephritis, influenza like illness, chills, amylase increased, blood bilirubin increased, blood alkaline phosphatase increased, hypercalcaemia. **PACKAGE QUANTITIES** KEYTRUDA 25 mg/mL: 4 mL of concentrate in a 10 mL Type I clear glass vial. **Legal Category:** POM. **Marketing Authorisation numbers:** EU/1/15/1024/002. **Marketing Authorisation holder** Merck Sharp & Dohme B.V., Waarderweg 39, 2031 BN Haarlem, The Netherlands. **Date of revision:** December 2023. **Further information is available on request from:** MSD, Red Oak North, South County Business Park, Leopardstown, Dublin, D18 X5K7 or from www.medicines.ie. II135_II138

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

References
1. KEYTRUDA Summary of Product Characteristics, August 2023, available at www.medicines.ie.
2. Gandhi L, et al. Pembrolizumab plus Chemotherapy in Metastatic Non-Small-Cell Lung Cancer. N Engl J Med. 2018;378:2078-2092.
3. Paz-Ares L, et al. Pembrolizumab plus Chemotherapy for Squamous Non-Small-Cell Lung Cancer. N Engl J Med. 2018;379:2040–2051.
4. Reck, M et al. Pembrolizumab versus chemotherapy for PDL1 positive-non-small cell lung cancer, N Eng J Med 2016, 375(19)1823-1833.

ALK=anaplastic lymphoma kinase; EGFR=epidermal growth factor receptor; mNSCLC=metastatic non–small cell lung carcinoma; PDL1=programmed death ligand 1.

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

IE-KEY-00945 Date of Preparation: February 2024