€5.75 Vol 31 No 7 October 2023

WIN

Journal of the Irish Nurses and Midwives Organisation

World of Irish Nursing & Midwifery

Latest INMO CPD education programme
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Protecting the future

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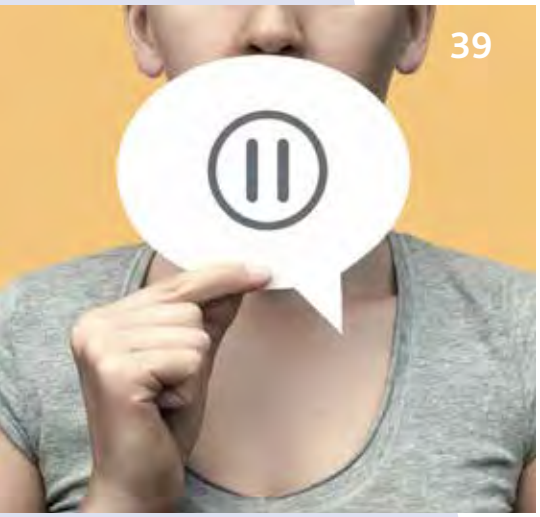

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WIN – World of Irish Nursing & Midwifery is distributed by controlled circulation to **more than 38,000** members of the INMO. It is published eight times a year and is registered at the GPO as a periodical. Annual Subscription: €155 incl. postage paid. Editorial Statement: *WIN* is produced by professional medical journalists working closely with individual nurses, midwives and officers on behalf of the INMO. Acceptance of an advertisement or article does not imply endorsement by the publishers or the Organisation.

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

(ISSN: 2009-4264)
Volume 31 Number 7
October 2023

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Dun Laoghaire,
Co Dublin.
Website: www.medmedia.ie

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

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Govt must tackle housing and staffing

IT'S THAT time of year when we welcome new students into our professions. If you are just starting your nursing or midwifery course remember that the INMO offers free membership to you throughout your degree programme. Our student and new graduate officer Róisín O'Connell will be meeting many of you over the coming weeks in workplaces and in your college. It is the perfect time to join our Student Section, here you can meet students from across the country and develop a peer network. Read more of Róisín's advice for new students on *page 35*.

Earlier this year, the Minister for Health confirmed that government would be funding additional public undergraduate places. We welcomed this announcement as we need significantly more places at the undergraduate level to grow our workforce. There is now a race against time to open additional beds, get on with Sláintecare and ensure the health service does not take shortcuts with safe staffing.

In April this year, the HSE announced that it had seen a growing demand for services in 2022 and projections show that this demand will increase. The HSE admits the increasing demand is taking place against a backdrop of increasing staff turnover, alongside an ageing workforce. We know from the INMO's annual survey that 85% of nurses and midwives surveyed in 2023 stated that existing staffing levels do not meet required clinical or patient needs and 66% felt that patient safety was at risk.

Following our annual delegate conference (ADC) in May, the issues we will campaign on for the coming months include:

Housing: While we acknowledge that recruitment of nurses and midwives is happening across the health service, unaffordable accommodation is a deterrent to both Irish and international nurses to work here. Time and time again, nurses, midwives and directors of nursing and midwifery raise the issue of affordable accommodation. Suitable and affordable accommodation within reasonable commuting distances of workplaces must be high on the HSE and the government's agenda. Housing, housing and housing will continue to be our message to all employers including the HSE, and to government parties in the months ahead.

Safety in the workplace: Workplaces are becoming more dangerous. Burnout and intention to leave are on the increase, the numbers of assaults both physical and verbal are rising and workplace infections remain a feature of daily life for nurses and midwives, especially those working in hospital buildings. Workplaces must be safe, especially healthcare workplaces.

Increasing capacity and matching it with safe staffing: Safe staffing saves lives. The rollout and implementation of the safe staffing policy and Birthrate Plus have been slow. It is necessary to underpin the measurement of staffing requirements with legislation to enforce full implementation.

Supporting preceptorship: The provision of additional clinical preceptors and support for learners was raised repeatedly at our ADC. The lack of focused growth and support of this on-the-job clinical guidance and supervision in all settings was highlighted as a barrier to safe provision of care. Preceptors and clinical support staff are doing their best, but there are not enough of them and protected time to undertake the necessary orientation and support is not provided for due to very busy work environments. This is an essential part of the provision of safe care and must be addressed by employers. Nurses and midwives on very busy wards and units of care, working without full staffing, cannot be expected to also undertake a growing preceptorship role. Rather this needs dedicated staff who are rostered to the areas of care for this purpose.

All the issues set out at the ADC that we will campaign on over the coming months have one thing in common – they can be corrected if the government has the will. The HSE and government must address these matters as a priority.

Phil Ní Sheaghdha
General Secretary, INMO

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

INMO Professional Events 2023

All conferences and webinars are Category 1 approved by NMBI

ONLINE AND IN-PERSON EVENTS

OCTOBER 14
Operating Department Nurses Section Conference
Knightsbrook Hotel
Co Meath

NOVEMBER 4
National Childrens Nurses Section Webinar
ONLINE

NOVEMBER 11
Public Health Nurse Section Webinar
ONLINE

NOVEMBER 16
All Ireland Midwifery Conference
Hillgrove Hotel,
Monaghan

NOVEMBER 22
Assistant Directors Section Masterclass
The Richmond
Education and Event Centre,
Dublin

NOVEMBER 30
Occupational Health Nurses Section Conference
The Strand Hotel,
Limerick

DECEMBER 6
International Nurses Section Conference
The Richmond
Education and Event Centre,
Dublin

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A positive focus
with the president

Karen McGowan, INMO president

Conference season

WINTER is almost upon us and the INMO has organised a wonderful line up of conferences for the coming months. The Operating Department Nurses Section conference will take place in Knightsbrook Hotel, Co Meath on October 14, the International Nurses Section conference in the Richmond Education and Event Centre on November 3, and the All-Ireland Midwifery Conference in Monaghan on November 16. These are fantastic events to learn from colleagues and network at the same time.

September saw a drive for sepsis awareness events across all hospitals. There was a very prominent pink t-shirt presence on all social media platforms. It is so important that the signs of sepsis are picked up early in the patient journey. I have been involved in many audits but the Irish Maternity Early Warning System (IMEWS) resonates so much with me as these patients can deteriorate rapidly and it is a mother and baby we are caring for. The subtle differences between the Irish National Early Warning System (INEWS) and IMEWS are so critical that formal action in the form of the ISBAR (Introduction, Situation, Background, Assessment and Recommendation) tool. It is vital that the high scores are acted on early to prevent the patient deteriorating. It was great to see the progression of awareness in the form of educational sessions to simulation scenarios in many hospitals, adopting a team-based approach.

Gynaecologic oncology awareness month

IT WOULD be remiss of me not to mention that September was gynaecology oncology awareness month. Education is key and as nurses and midwives we are ideally placed to share the knowledge we have.

Gynaecological cancers encompass all cancers of the female reproductive system, including the cervix, ovaries, uterus, vagina and vulva. All women are at risk for these cancers. Gynaecologic cancer awareness month is dedicated to increasing public understanding of gynaecological cancers and highlighting the risk factors, symptoms, early detection and prevention strategies related to the main types of gynaecological cancers that affect women. According to the National Cancer Registry of Ireland, around 1,400 gynaecological cancers are diagnosed in Ireland annually, representing over 12% of female cancers.

Health promotion in reducing our risk helps with all aspects of healthy living but in particular when reducing our risk of cancer. Knowing the signs and symptoms but taking action on those symptoms may be life changing. As women we often down play anything that concerns our bodies but I do feel there is a sea change.

The INMO survey on menopause inspired me to plan an event called the 'Ladies Lounge' for the staff of Beaumont Hospital. As busy nurses and midwives we need to look after ourselves; our vision is to open up the conversation on women's health and further support staff with the right information to make their own decisions. This will be a safe and confidential space to open up the conversation and support each other. This is an opportunity to be inclusive and empowering to fellow colleagues. The menopause is a different experience for everyone. What has changed is how we deal with it; knowledge is power. The Ladies Lounge will be a regular event with different topics to discuss. I will update you next month with more information about the event.

Executive Council update

THE Executive Council met virtually in August and again in person in September. Several issues were raised in terms of winter planning by a number of council members. These will be raised with the employer through various meetings such as the ED taskforce.

Your Executive Council members will be representing your interests nationally and internationally over the coming weeks. Lynda Moore will be taking part in a panel discussion at the Menopause Summit in Cork where the results of the INMO's survey on menopause in the workplace will be discussed. First-vice president Mary Tully will be representing the INMO at the Global Nurses United Conference in San Francesco this month.

I will be attending the European Federation of Nursing's (EFN) general assembly this month too. This will mark the final assembly under the presidency of Elizabeth Adams. There will be an election during this meeting to choose a new executive council and president. Elizabeth Adams has been a truly wonderful president and has represented Ireland so well at European level. The EFN continues to lobby at European level in the interests of nurses. This is important as achievements in one European country encourage and facilitate other countries to introduce new nursing standards themselves.

Planning for the INMO's 2024 annual delegate conference have begun in earnest. This will involve a lot of work from the Dublin North Branch which welcomes the fantastic opportunity to host our conference in Croke Park for the first time.

Get in touch

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

INMO calls for urgent meeting of ED Taskforce as trolley numbers soar

FOLLOWING the worst August for overcrowding *(see panel)* and with trolley figures already at dangerously high levels in early September, the INMO called for an urgent meeting of the Emergency Department Taskforce to discuss how the HSE plans to tackle the persistent overcrowding problem in hospitals nationwide.

INMO general secretary Phil Ní Sheaghdha said: "We are once again finding ourselves in a perilous situation when it comes to hospital overcrowding. It is unacceptable that we are seeing such high levels of overcrowding before the usual onslaught of winter viruses and respiratory illnesses. Before we even reached the midpoint of September we had already seen over 3,335 patients on trolleys, chairs or other inappropriate bed spaces so far in the month.

"The rising number of children under the age of 16 on trolleys is becoming a matter of huge concern for our members. Over 64 children had been on trolleys in the first 10 days of September, with schools only back in earnest for a week. Parents are sending their children to already overcrowded hospitals as a last resort as care options are not available in the community."

As co-chair of the Emergency Department Taskforce, Ms Ní Sheaghdha called on the HSE to convene an urgent meeting of the taskforce to discuss what measures would be taken on a week-by-week basis until the end of the year.

"We do not want to see a repeat of the trolley figures we saw earlier this year where all overcrowding records were broken", Ms Ní Sheaghdha said.

The Minister for Health indicated that he would attend the taskforce when it was convened. Ms Ní Sheaghdha said the HSE should not delay in getting all stakeholders around the table to come up with short, medium and long-term solutions to what is now a year-round crisis.

"Nurses are once again finding themselves having to apologise to patients and their families because of the state of hospital overcrowding. This is unacceptable. It is time for the health service and individual hospitals to be upfront with the public about the staffing and capacity shortfalls in our hospitals," she said.

A warning shot for perilous winter ahead

THE INMO's TrolleyWatch analysis at the end of August worryingly revealed that 2023 saw the worst August for hospital overcrowding since the INMO began counting trolleys, with over 9,720 patients admitted to hospital without a bed in the month.

The most overcrowded hospitals in the country in August again include:

- University Hospital Limerick, 1,885
- Cork University Hospital, 984
- University Hospital Galway, 920
- Sligo University Hospital, 737
- Letterkenny University Hospital, 539.

Of particular concern is that the number of children on trolleys is escalating at a rapid rate with over 167 children admitted to hospital without a bed in August.

Ms Ní Sheaghdha said: "There's no doubt this winter is going to continue the pattern of difficult and dangerous times in our hospitals.

"The summer period used to see an easing off in overcrowding figures but this year numbers admitted to inappropriate spaces, trolleys and chairs have been alarmingly high too early in the season. The new so-called target of no more than 320 people on trolleys set by HSE was only achieved on five days this year.

"Last year was the previous record for August overcrowding, and the winter that followed was honestly beyond what we could have imagined. This August is somehow worse again, and our members are worried, for themselves and for their patients about what is in store for them over the coming months.

"The ongoing increase shows how urgently we need to implement safe staffing legislation, so that hospitals have sufficient staff to diagnose, treat and discharge patients safely, and vulnerable people are not languishing on trolleys and chairs for days at a time.

"Medical evidence shows that spending more than six hours on a trolley is detrimental to a patient's long-term health outcomes. In stark terms it increases the mortality rate by over 8%.

"The INMO is of the view that this situation is not being met with the required urgency or focus required. The constant state of overcrowding in our hospitals is a leading cause of nurses and midwives intending to leave their current work areas and indeed the professions altogether."

Final pay rise under Building Momentum now due

THE final instalment under the current public service agreement is due to be paid this month. From October 1, 2023, an increase in annualised basic salaries of 1.5% or €750, whichever is greater, will apply to the salaries of public servants, including nurses and midwives working in the public health service.

This is the final instalment under the current public service agreement (Building Momentum extension), amounting to a total of 6.5% in general pay round increases since February 2022.

Senior staff and senior enhanced nurse/midwife

All staff nurses/midwives and enhanced nurses/midwives who have 17 years' post-qualification service are eligible for payment of either the senior staff nurse/midwife increment or the senior enhanced nurse/midwife increment. All service, inclusive of part-time/job sharing service, is reckonable.

Members should note that service constitutes all genuine nursing/midwifery experience in Ireland and abroad. The reference date for determination of years of service and payment is November 1 each year.

Application forms to apply for senior and senior enhanced service increments can be obtained from human resources departments.

See pages 16-18 for the recently updated HSE salary scales

Govt must act to ensure affordable housing for frontline HCWs – INMO

AS DÁIL Éireann returned from its summer recess, the INMO called for politicians to make affordable housing for healthcare workers a priority in Budget 2024 and beyond.

Speaking following a meeting of the INMO Executive Council, INMO president Karen McGowan said: "We are now reaching another crisis point when it comes to the recruitment and retention of nurses and midwives. A key factor in retaining highly trained nurses and midwives in the public system is the cost of affordable housing. Irish nurses and midwives and overseas nurses who have worked here for a number of years are now voting with their feet and moving to Sydney where they have safe staffing ratios underpinned by legislation, to the US which is heavily targeting nurses and midwives working in Ireland, and to the UK where many cities have a city-weighting allowance to help with the cost of accommodation.

"Unfortunately we have seen a dearth of ambition from government when it comes to bringing bespoke housing solutions for frontline healthcare workers. This is no longer just a Dublin problem – whether you are in Donegal, An Daingean, Douglas or Dundalk, our members are reporting that housing close to healthcare settings is no longer affordable.

"As a working nurse in a busy Dublin hospital, my colleagues and I are hearing of young nurses leaving to move home with their parents or to pastures new in the UK and Australia on a weekly basis. We cannot afford to be losing such talented young professionals from our hospital system. With no end in sight to the housing crisis, there is nothing to tempt these young nurses home. We need the government to spell out exactly what it is going to do to make housing affordable for healthcare workers while also introducing new laws to underpin the safe staffing framework, as the two go hand in hand."

INMO general secretary Phil Ní Sheaghdha added: "The INMO Executive Council, made up of 22 working nurses and midwives from different types of care settings from every corner of the country, has made it clear that they expect meaningful action from the government when it comes to making housing affordable for nurses, midwives and other workers who keep our health service going. With Budget 2024 and talks on a successor agreement to the current public service agreement being considered, the government has an opportunity to be ambitious when it comes to retaining young nurses and midwives. If action isn't taken on housing then unfortunately our already creaking health service will diminish under the pressure."

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

Update from National Joint Council

DISCUSSIONS continue on several issues at the National Joint Council (NJC), which is the primary forum for the management of industrial relations in the health service.

Pay award, October 1, 2023

Under the terms of Building Momentum, 1.5% or €750 whichever is the greater is due to be paid with effect from October 1, 2023. In view of recent delays unions have requested that payment is made within the calendar month of October 2023. The union side has written to the employer in this regard.

Sick leave policy

The Department of Public Expenditure and Reform (DPER) is due to issue a revised Circular on a review of the Sick Leave Scheme. While the main provisions of the Sick Leave Scheme have not been changed, there is a change in relation to the temporary rehabilitation remuneration (TRR).

Previously this was known as 'pension rate', and it applied where an employee had no reasonable prospect of returning to work and it effectively was linked to a calculation based on pensionable salary. It has now been agreed that this amount will be a fixed 37.5% of salary.

The effect of this on nurses and midwives who are in receipt of TRR is that they will be in a better position than the previous arrangement. In addition, the TRR payment will be processed as an automatic payment following three waiting days.

HR resourcing strategy

The unions were presented with a document from the HSE entitled 'Resourcing the HR Strategy'. The INMO has requested that the document be stood down as it was being launched without consultation with the unions. The INMO has a number of criticisms in relation to this document in that some of the assumptions are historically inaccurate and it underplays the number of posts that were suppressed during the financial crisis. Members will be kept informed of progress on this issue.

Changes to pension abatement rules

Since 2012 rules have applied in the public service in relation to pension abatement. This means that where a former public servant on pension comes back to work for the service, they cannot have full pension and salary.

The DPER has issued a circular which reinforces this rule and changes the basis for the abatement calculation. A meeting took place with the HSE and the unions have stated there is a clear requirement on the employers to notify the individuals concerned and support them to understand the effect of these changes.

The unions were unhappy with the HSE's response and requested a meeting with the national HR director and, as it may affect service provision, they also requested a meeting with the health service CEO. Members will be advised further on this matter following the meeting with management.

Serious physical assault support staff grades

At the Interim NJC meeting on August 29, 2023 the Department of Health confirmed that the DPER had approved the extension of the current scheme on serious physical assault for support staff from three to six months.

The unions are not in agreement with this proposal as it does not satisfy the claim. This matter has now been referred to the WRC.

Claim for marriage leave

The INMO lodged a claim at the NJC seeking that the marriage leave which exists in the civil service would also apply in the Department of Health.

Under the civil service arrangement, staff are entitled to take additional special leave on the occasion of marriage. The HSE has stated that it has carried out an analysis of this claim and is seeking approval from the Department of Health.

HSE proposals on matching work patterns to service needs over holiday periods

HSE chief executive Bernard Gloster started an initiative in May of this year, to have more staff working over public holiday weekends, including senior decision makers and those working in diagnostics.

The HSE has now formalised this request which was set out in a letter to trade unions in August and unions were invited to a meeting on September 15, 2023.

It was clarified at the meeting that the intention in the first instance is for the proposed measures to be in place from this October public holiday weekend until March 2024.

The purpose of the initiative is to deal with weekend discharges and measures will have an impact on acute hospitals, community hospitals and also on RGNs. It will also impact on pharmacy, diagnostics (radiographers, RADs and medical scientists).

The unions set out their position including:

- A national set of principles will be agreed in relation to the extended working week.
- That there are protections for earnings for members affected
- That the management side should put forward a proposal for each grade and category for whom they are seeking to change rosters.

From the discussion it would appear that the management side is open to the arrangement being on a voluntary basis in the period between October 2023 and March 2024 and that earnings would be protected.

It was made clear that this was not about saving money but about having the relevant decision makers available at weekends to assist with discharges from acute hospitals into the community etc.

The INMO has requested a copy of the document which underpins this proposal and has also requested that the management side proposal should cover all relevant aspects of this change.

It was agreed that a further meeting between the unions and the HSE on this issue would take place during the last week of September.

on recent national issues

Section 39s ballot on action

INMO members working in several Section 39 organisations have been balloted for industrial action and the INMO Executive Council met to consider the outcome on September 19, 2023.

The dispute mainly concerns Section 39 organisations which supply services to the health service in the disability area.

As part of the ICTU *'Pay Equality to Save Services'* campaign in Section 39 organisations, INMO members were balloted at the same time as members in Fórsa and Siptu.

The results of the three unions' ballots were set to be announced on Monday, September 25, following which three weeks' notice of industrial action will be given.

The ICTU has organised meetings with family groups concerned to harness support in the event of industrial action, as well as with the three employer organisations involved.

The INMO will communicate directly with members in the Section 39 organisations concerned on this issue.

Talks to streamline public health forms

THE INMO is in discussion with the HSE in relation to the streamlining of a number of documents and forms in use on a daily basis by public health nurses and community RGNs.

The HSE has engaged in a process with representatives of PHNs and community RGNs to review and streamline particular documents including those relating to

- Home support services
- Falls
- Primary care referrals
- Continence assessments
- Children's disability network teams referrals.

At the most recent meeting, it was confirmed that agreement within the groups has been reached regarding the Home Support Referral form and the Continence Assessment form. The NAP (national access policy) form was the subject of detailed discussion with the consensus being that the Ages and Stages Questionnaire (ASQ) form is preferred, pending availability of clerical administrative support to community nursing teams.

In relation to the Primary Care Referral form, eight separate forms in use were reviewed and it was recommended that this will now comprehend a one-page document. However, there are issues with some areas only accepting the NAP form.

In relation to the Falls group workstream, there remain two options in relation to a recommended form for same.

The INMO is seeking authorisation for PHNs to complete mandatory and other forms of training on an overtime basis when it is not possible for staff to be released during working hours.

A Circular has issued to the directors of public health nursing authorising same.

In relation to the prioritisation document and indemnity, the directors of public health nursing are seeking confirmation from the State Claims Agency that the prioritisation document covers them for any potential claims. This would be consistent with the arrangement under the ED Agreement.

Community support teams

Meanwhile, the HSE is proposing that community support teams will replace previous 'support teams', which were granted during the Covid-19 pandemic for private nursing homes.

The INMO has serious reservations in relation to the efficacy of nurses employed in the public health service providing assistance to private nursing homes and has set this out in a letter to the HSE.

RNID managers' out-of-hours claim

A DRAFT proposal has issued from the Workplace Relations Commission in relation to the out-of-hours/weekend RNID proposal.

This proposal is subject to approval from the Department of Health for funding and provides for:

- An on-call arrangement which had not existed previously
- The allowance to be pensionable
- The proposal be backdated to March 1, 2023.

Where there are preferential arrangements in employment these will be retained on a red circle basis.

It is expected that the Department of Health's position on these proposals will be known shortly and members will be updated.

Revised allowances for student nurses/ midwives

THE HSE has published a circular regarding the recent support for student nurses and midwives.

Accommodation allowance

The accommodation allowance has been revised, with the new allowance effective from the start of the 2022/2023 academic year. A student nurse/midwife on supernumerary placement is entitled to, on a vouched basis, an overnight accommodation allowance of up to €80 per night. This is subject to a weekly cap of €300. This will apply for the duration of placement where it is necessary for the student to get secondary accommodation away from their normal place of residence.

Travel expenses

Student nurses and midwives can also claim travel expenses when attending supernumerary placements. Where possible public transport should be used. If public transport cannot be used then student nurses and student midwives are entitled to claim mileage costs for driving and, importantly, this will be paid at the public sector mileage rates. These expenses will be claimed through the student allocation liaison officer (SALO).

Subsistence allowance

A new subsistence allowance has been introduced which entitles students in years 1-3 to flat-rate meal allowances of €500 per student per academic year. This is to be paid in two instalments of €250.

World news

Nurses and midwives in action around the world

Australia
- NSW hospital wards to get more nurses after union deal
- Midwife workloads 'dangerously high', Queensland union says

Brazil
- Nurses' union outlines strategies to guarantee a minimum wage in paychecks

Canada
- Ontario's registered nurse levels fall again – still the lowest in Canada

France
- Massive departures of nurses: "It's human and social waste", deplores the national nursing union

Italy
- Overcrowding in the emergency department, nursing union declares it an emergency

New Zealand
- Nurses vote to accept proposed pay equity agreement

Philippines
- Nurses group renews call for higher entry pay

Portugal
- Private sector nurses strike

Spain
- Union demands more university places for nursing degree

UK
- Two thirds of Scottish student nurses consider quitting due to financial pressures

Employer's attempt to recoup costs of recruitment in breach of legislation

AN INMO member had been working for a homecare service provider for over a year when, due to a stressful time in her employment, she handed in her resignation, giving two months' notice as per her contract of employment.

The employer argued that she had unilaterally breached the terms of her contract of employment by resigning within 18 months of joining the company, and advised her that 100% of the training and recruitment costs incurred by the company in direct connection with her recruitment were to be paid back.

The total cost that the employer was pursuing was €11,082 and the member was given one day's notice to advise how she was to reimburse the company for these costs, failing which, they would be referring the matter to their solicitors.

INMO IRE Karen McCann wrote to the employer on August 25 outlining Section 23 of the Employment Permit Acts 2006 which states: "The employer shall not make any deductions from the remuneration of, or seek to recover from, the holder of the employment permit concerned any charge, fee or expense arising out of or concerning one or more of the following:

(a) The application for the employment permit or a renewal of the permit under section 20 or any matter relating to or concerning such an application or the grant or renewal of the permit.

(b) The recruitment of the holder for the employment in respect of which the application was made; or

(c) Any amount previously paid to the holder in respect of travelling expenses incurred by the holder in connection with taking up the employment in the State.

On behalf of the member, INMO representatives argued that the employer was in breach of the legislation and that the member's statutory rights supersede any contractual terms that fall below what is provided for in legislation. A satisfactory outcome was reached with the employer agreeing to wipe all costs that they were pursuing, and that the member was to be paid in lieu of her two months' notice and any annual leave due to her.

The member contacted the INMO after the case was resolved saying: "I would like to extend my heartfelt appreciation for the unwavering dedication and guidance provided by you and your team at INMO while representing me. Your empathetic approach, strategic guidance and tireless efforts played an instrumental role in ensuring that my concerns were heard and addressed effectively. The assistance I received from you was truly invaluable. The circumstances surrounding my departure were complex and emotionally taxing, and I am immensely grateful for your expertise in navigating through them with professionalism and care."

Pay parity for South Doc CIT nurses

THE INMO has secured full implementation of Building Momentum increases for members working in South Doc Community Intervention Team (CIT). All increases, which were applicable from 2022, will be paid with full retrospection.

The INMO has also secured the 37.5 hour week for CIT nurses. This has been applied retrospectively to July 1, 2022.

Finally, the enhanced nurse contract will be introduced this year for members in South Doc CIT.

As a Section 39 organisation, members have welcomed the move following lengthy negotiations with the employer.

One issue remains outstanding which is the failure to award the pandemic payment for CIT nurses in South Doc. This payment was received by HSE CIT nurses.

A dispute on this issue has been raised nationally with the HSE.

– Liam Conway, INMO IRO

Inspections reveal positive impact of patient-flow and safe staffing measures

THE evidence is clear that when efficient patient-flow measures are in place and safe staffing levels are adhered to, hospital overcrowding can be avoided. This was demonstrated by two recent unannounced emergency department (ED) inspections by the Health Information and Quality Authority (HIQA).

The inspectors found that the EDs at Beaumont Hospital, Dublin, and University Hospital Waterford (UHW) both demonstrated good overall levels of compliance with national standards.

According to the report, at the time of inspection both hospitals had a full complement of nursing staff in their EDs and had established greater availability and access to consultants and senior decision-makers. Both hospitals also had good access to step-down facilities and beds which facilitated efficient patient flow within and from the hospitals.

HIQA also found that in recent years both services had managed to move from a situation of persistent overcrowding in the EDs to one where such crowding was well managed or not present. Both hospitals were seen to be adequately resourced to provide a good standard of care and had worked to reduce staff vacancy rates.

Both inspections were unannounced and were carried out in mid-April.

University Hospital Waterford

On the day of inspection, a total of 258 people attended the ED at UHW. Despite this there were no patients on trolleys awaiting admission to an inpatient hospital bed and all patients were receiving care in dedicated treatment areas. Care was noted as being delivered in a calm and controlled environment.

The creation of additional capacity in the hospital over recent years has positively impacted on patient flow and the hospital currently has 510 inpatient and day beds.

INMO assistant director of industrial relations Colm Porter said: "It's a credit to the hard work of INMO members that the ED in Waterford operates so efficiently. Staff throughout the hospital have worked so hard to ensure patient flow is at optimal levels.

"At the time of the inspection Wexford General Hospital ED was closed due to a fire that broke out in the hospital. Due to the goodwill of staff coming in and going above and beyond, UHW was able to take the bulk of emergency patients who would normally have attended ED in Wexford."

Beaumont Hospital

In relation to Beaumont Hospital, while its emergency department was busy on the day of inspection, it was found to be functioning well. At the time of the inspection, 69 patients were registered in the ED with eight patients on trolleys.

The report states that while the hospital had further work to do to meet the six- and nine-hour ED targets for admission or discharge, there were no patients waiting more than 24 hours to be admitted or discharged from this ED and that Beaumont Hospital consistently features in the top three better performing Irish hospitals in relation to maintaining a low number of admitted patients on trolleys in EDs. It also noted that the hospital had an escalation policy to manage delays in triage time.

The hospital's 'Beaumont in the Home' initiative, which supports the discharge home of patients awaiting a care package, was established in 2022 and the report notes that at the time of inspection, 100 patients had used the service since it was put in place.

INMO IRO for Beaumont Hospital, Maurice Sheehan welcomed the report saying:

"Although the HIQA report did not give Beaumont an overall score of "compliant" in respect of the standards the hospital was measured against, a score of "substantially compliant" was nevertheless a very good and satisfying result and INMO members and all staff in the ED in Beaumont are to be congratulated on this positive outcome."

Public holiday pay miscalculated for part-time staff

THE INMO has assisted a member regarding the miscalculation of payment for public holidays.

The member in question works on a part-time basis and her work attendance pattern is such that she is always rostered to work on Monday and the remainder of the days in her working week can vary.

When a public holiday fell on a Monday, management was applying one-fifth of the member's normal weekly pay for the day, citing this was the arrangement for part-time workers.

The INMO argued that this interpretation of the regulations was incorrect as there is an element of a fixed roster within the member's flexible roster.

National HR guidance on public holiday pay for part-time workers indicates:

- If a public holiday falls on a day that an employee usually works, then the employee is entitled to the pay they would have received for that day, as if the employee had worked it
- If an employee is not normally rostered to work on a public holiday, then the employee is entitled to one-fifth of their weekly pay for the public holiday.

The Labour Court has observed that: "The clear purpose of the Regulations is to ensure that during public holidays an employee receives no less (or no more) than he or she would have received if he or she was working during the period in question."

Following engagement with the employer, the INMO member will now be paid for 7.5 hours when a public holiday falls on a Monday and for one-fifth of her contracted hours on a public holiday that falls Tuesday to Friday.

Members are advised to link in with their local INMO official if they have any queries related to the calculation of public holiday pay for part time workers.

– Grainne Walsh, INMO IRO

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

ICN position statement on patient safety points to safe staffing as key

Further position statement highlights ways that digital health technology is facilitating the delivery of nursing care

AS BOTH a key worker and patient safety measure, the INMO has consistently advocated for the full roll out, continuous funding and further development of the Framework for Safe Nurse Staffing and Skill Mix, and called for the Framework to be underpinned by legislation as a key patient safety initiative. In this context, a recent position statement by the International Council of Nurses (ICN) in relation to safe staffing as a key priority for patient safety is very welcome.

Highlighting that patient harm from unsafe care is one of the leading causes of death and disability globally and a growing public health challenge, the new position statement calls on governments to substantially increase investment and recruitment, development and training and retention of the health workforce as a critical action to reduce patient harm and advance patient safety.

The position statement recognises that it is imperative that patient safety is genuinely at the centre of all our healthcare organisations and systems, which is reflected by a transparent workplace culture that encourages the reporting of concerns about practices and mistakes.

The position statement also calls on governments to be accountable for delivering needs-based safe nurse staffing by ensuring sufficient funding and establishing legislation and effective human resource planning, in order to guarantee an adequate supply of health workers to meet patient and population needs. It urges governments to sign the Health Worker Safety Charter and take urgent and sustainable action through its key measures.

Speaking at the World Economic Forum's Growth Summit: 'Jobs and Opportunity for All 2023' in May this year, ICN chief executive Howard Catton said: "When we do not have enough nurses available, we know that the risks to patients increase. We know that the number of nurses in different countries and different regions is related to mortality – you can see this across all regions. So this is clearly a patient safety issue. But we still seem to have this brick wall that when it comes to talking about investment in our healthcare systems, we struggle to make investment in the healthcare workforce."

A recent article in *The Lancet*,[1] co-written by Mr Catton, addressed the impact of the Covid-19 pandemic as a catalyst for accelerating global action on patient safety. This concluded that the pandemic has shown the urgency of preventing harm to patients and health workers and ensuring the delivery of safe health care. Global efforts to improve patient safety now need to be strengthened and accelerated.

The ICN has created a module on patient safety as part of its new global online learning platform designed to build professional practice knowledge through competency-based education to facilitate advancing the Global Patient Safety Action Plan 2021-2030 and the Global Strategic Directions of Nursing and Midwifery 2021-2025.

The ICN's new position statement on patient safety asserts that healthcare worker safety and patient safety are inextricably linked. Violence and abuse, burnout, stress, moral injury, physical illness and stigma experienced by nurses are associated with worsening safety and quality of care. Creating safe working environments and protecting the mental health of nurses and health workers have extensive positive outcomes, including preventing patient harm, and are essential to delivering quality care.

As well as calling for governments to take action to ensure patient safety, the position statement provides action points for national nursing associations and individual nurses *(see panel)*.

In Ireland, legislating for safe nurse and midwifery

Table 1. Action points for national nursing associations and individual nurses

• Contribute to the development of patient safety legislation and ensure its delivery and maintenance
• Advocate for nurses to be key members of clinical leadership groups that plan, develop and implement national patient safety improvement priorities
• Advocate for the use of incident reporting systems at all health facilities and for policies and processes that support nurses to report patient safety without detriment or fear of retribution
• Ensure that standards for undergraduate and postgraduate nursing education curricula include patient safety with an interprofessional team-based approach
• Collaborate with national patient safety organisations
• Support patient and family engagement and empowerment in patient safety
• Support nurses to participate in establishing, synergising and scaling-up patient safety surveillance systems
• Ensure that patient safety core competencies are part of nursing regulatory standards
• Advocate for national policies that promote functional multidisciplinary teams, investment in interprofessional learning and governance and funding models that support team-based care
• Leverage the policy priorities of the World Health Organization 'Global Strategic Directions for Nursing and Midwifery' to advance patient safety

and midwifery news

staffing levels is an essential patient safety initiative and a necessary next step to protect patients. Additionally, in terms of worker safety more generally, the establishment of a Health Advisory Committee within the Health and Safety Authority, following a campaign by the INMO, is an important additional step to ensuring we improve the safety of health workplaces across Ireland.

Nursing practice and digital health

A further ICN statement has highlighted the ways in which the digital technology revolution supports the rapid and positive transformation of healthcare systems and facilitates the delivery of nursing care and how people engage with their health and wellness.

The position statement entitled 'Digital health transformation and nursing practice', shows how digital technologies have the potential to support equitable and universal access to health services, increase the efficiency and reliability of health systems, improve patient and health worker safety, respond to health workforce shortages, reduce costs and, ultimately, improve people's health outcomes.

In March this year, ICN president Dr Pamela Cipriano, speaking on the occasion of International Women's Day – which had the theme 'DigitALL: Innovation and technology for gender equality' – noted that recent advances in digital health, including delivery of virtual care, the analysis of big data, the introduction of smart wearables and the dramatic developments in artificial intelligence, reinforce the need for nurses to be digital health experts so that they can maximise the advantages of these technologies, for the benefit of their patients.

Furthermore, she noted that empowering nurses through innovations in digital healthcare will advance gender equity and improve patient care, but these benefits will only come about if sufficient attention is paid to nurses' needs in an increasingly technological world.

The new ICN position statement shows how nurses are accessing and using digital technologies to improve patient care and access to healthcare services.

However, it warns that the digital divide – the gap that exists between those who have access to modern information and communication technology and those who do not – is creating a world where the benefits of digital transformation are not equal between countries or societal groups.

As the global voice of nursing, the ICN:

- Supports the advancement of appropriate digital health to meet population health needs, strengthen health systems and as a way to respond to health workforce shortages
- Believes that digital health must support integrated, people-centred health systems and promote health equity
- Promotes the alignment of digital health technology to patient and nurse safety policy and processes
- Believes that the development of digital health technology should be supported by the use of an international terminology standard, such as the International Classification for Nursing Practice (ICNP)
- Agrees that digital health should benefit people in a way that is ethical, safe, secure, reliable, equitable and sustainable
- Believes that nurses must be involved and participate in national and global digital health decision-making forums and included in the planning, design, testing and implementation of digital health products and digitised health systems
- Believes that nurses must participate in monitoring and evaluating new and emerging digital health technologies
- Believes that nurse leaders play a crucial role in positively shaping the advancement of digital health and should be supported and resourced to lead the digital transformation for the nursing workforce
- Recognises the barriers faced by some countries to implement appropriate digital health technologies, and believes that global collaboration and resourced mechanisms to support these countries to advance their digital health capabilities are essential to shrink the digital divide
- Believes that there is an urgent need for the nursing workforce to acquire the skills and competencies to deliver high-quality, safe, optimised person-centred care in a digital health environment
- Encourages collaboration with other stakeholders to include opportunities to work and learn from interdisciplinary colleagues
- Calls for an increased awareness on the environmental and health impact of digital waste and for digital health strategies to include plans to mitigate this impact.

This position paper is an important statement of principles, and certain cautionary notes, and is particularly relevant to the work the INMO is currently engaged in with the office of the chief nursing officer at the Department of Health in terms of the implementation of the *Report of the Expert Review Body on Nursing and Midwifery*.

Reference
1. Grant R, Benamouzig D, Catton H. Vincent Chi-Chung Cheng. COVID-19 pandemic: a catalyst for accelerating global action on patient safety Lancet Infect Dis 2023 (Aug 9); doi:https://doi.org/10.1016/S1473-3099(23)00485-1

Resources
All ICN position statements can be read in full and downloaded at https://www.icn.ch/what-we-do/position-statements

Nursing/midwifery salary scales

Application of 1.5% or €750, whichever is greater on October 1, 2023

Incremental point	1	2	3	4	5	6	7	8	9	10	11	12
Student nurse/midwife/ intellectual disability	18,838 (*degree students 36 weeks rostered placement)*											
Staff nurse/midwife (post qualification, pre registration)	29,289											
Staff nurse/midwife	33,943	35,876	36,863	38,168	39,813	41,456	43,091	44,506	45,924	47,335	48,748	50,135
LSI after three years on maximum												51,628
Senior staff nurse/midwife	54,079											
Enhanced nurse/midwife dual qualified nurse/midwife	40,827	43,286	44,599	45,609	46,721	48,202	49,645	51,783				
LSI after three years on maximum												53,300
Senior enhanced nurse/midwife dual qualified nurse/midwife	55,851											
Clinical nurse/midwife manager 1	52,712	53,668	55,017	56,388	57,752	59,124	60,653	62,077				
Clinical nurse/midwife manager 2/ specialist	57,198	58,146	58,947	60,255	61,701	63,120	64,539	66,137	67,621			
(plus allowance of €917 per annum payable on a red-circle basis to theatre/night sisters who were in posts on 5/11/'99)												
Clinical instructor	59,681	60,647	61,362	62,688	64,026	65,470	66,920	68,369	69,816			
Clinical nurse/midwife manager 3	65,818	67,121	70,413	71,708	73,010	74,329						
Nurse tutor	67,321	68,234	69,146	70,061	70,975	71,891	72,800	73,717	74,632	75,544		
Principal nurse tutor	70,603	71,935	73,151	76,952	78,281	78,330	79,884	82,004				
Specialist Co-ordinator nursing/ midwifery	67,321	68,234	69,146	70,061	70,975	71,891	72,800	73,717	74,632	75,544		
Student public health nurse	37,939											
Public health nurse	55,739	56,657	57,446	58,689	60,118	61,503	62,899	64,466	65,926			
(plus allowance of €1,834 per annum payable on a red-circle basis to staff who were in posts on 5/11/'99)												
Assistant director of public health nursing	65,823	69,438	70,924	72,294	73,677	75,571						
Director of public health nursing	86,413	89,033	91,661	94,398	96,911	99,539						
Advanced nurse practitioner	66,454	67,741	68,982	72,794	73,995	75,388	76,692	77,987	82,008			
Advanced nurse practitioner candidate	65,818	67,121	70,413	71,708	73,010	74,329						
Assistant director of nursing band 1	66,454	67,741	68,982	72,794	73,995	75,388	76,692	77,987	82,008			
Assistant director of nursing non band 1 hospitals	63,110	64,455	65,823	69,438	70,924	72,294	73,677	75,570				
Director of nursing band 1	88,146	90,596	93,051	95,496	97,944	100,403	102,850					
Director of nursing band 2	82,117	84,429	86,746	89,055	91,377	93,692	96,009					
Director of nursing band 2a	81,460	82,913	84,371	85,822	87,280	88,731	90,187					
Director of nursing band 3	76,900	77,386	79,035	80,734	82,425	84,130	85,822					
Director of nursing band 4	71,854	74,028	76,195	78,371	79,333	81,526	83,713					
Director of nursing band 5	67,219	68,674	70,127	71,578	73,030	74,489	75,944					
Area director – nursing & midwifery planning development unit	93,256	96,136	98,986	101,430	104,155	106,936	109,678					
Director – nursing & midwifery planning development unit	84,688	87,059	89,670	92,540	95,685	98,916						
Director centre of nurse education	77,289	78,492	80,906	83,342	85,775	88,211	90,644	93,182				
Hospital group director of nursing and midwifery	114,437	119,522	124,609	129,692	134,781	139,865						

Location and qualification allowances

1.5% due on October 1, 2023

Eligibility
Nurses/ Midwives eligible for payment of location/qualification allowances are Staff Nurses/Midwives, Senior Staff Nurses, CNMs 1 & 2 (incl. Theatre Sisters). Nurse/Midwife may benefit from either a qualification allowance or a location allowance when eligible - the higher of the two - when working on qualifying duties. Pro-rata arrangements apply to job-sharing and part-time staff.

Grade	Nature of Allowance	€
Registered general nurses	**Employed on duties in the following locations:** Accident and emergency departments, theatre/operating room, renal units, intensive/coronary care units, cancer/oncology units, geriatric units/long-stay hospital or units in county homes, high dependency units, neonatal units (ICU), endoscopy units, specialist ambulatory, dialysis units, units for severe and profoundly handicapped in mental handicap services, acute admission units in mental health services, secure units in mental health services, dedicated care of the elderly (excluding day care centres) and Alzheimer's units in mental health services and the intellectual disability sector (including psycho-geriatric wards, elderly mentally infirm units, psychiatry of later life services), medical/surgical wards, maternity departments. *(Allowance effective from March 1, 2019)*	2,554
Registered nurses	**a) Employed on duties in specialist areas appropriate to the following qualifications where they hold the relevant qualifications:** • Accident and emergency nursing course • Anaesthetic nursing course • Behaviour modification course • Behavioural therapy course • Burns nursing course • Child and adolescent psychiatry nursing course • Coronary care course • Diabetes nursing course • Ear, nose and throat nursing course • Forensic psychiatry nursing course • Gerontological nursing course • Higher diploma in midwifery • Higher diploma in paediatrics • Infection control nursing course • Intensive care nursing course • Neurological/neurosurgical nursing course • Operating theatre nursing course (including paediatric operation theatre) • Ophthalmic nursing course • Orthopaedic nursing course • Higher diploma in cardiovascular nursing/diabetes nursing/oncological nursing/palliative care nursing/accident and emergency nursing • Rehabilitation nursing course • Renal nursing course • Stoma care nursing course	3,835
With effect from March 1, 2002, payment of the Specialist Qualification Allowance is extended to all specialist courses confirmed as Category II or equivalent by the NMBI.		
Registered general nurses	b) Holding recognised post-registration qualifications in midwifery or sick children's nursing and employed on duties appropriate to their qualification	3,835
Public health nurses and assistant directors of public health nursing	Qualification Allowance	3,835
With effect from March 1, 2019, the location allowance is extended to public health nurses not holding a midwifery qualification but engaged in provision of midwifery services as part of their duties.		
Public health nurses		2,554

Dual Qualified Scale
Applies to nurses in possession of two of the five registered nursing qualifications where you must have held the qualification or in training for the second qualification on October 1, 1996. In the case of midwifery and sick children's nursing, the dual qualified scale is effective from August 1, 1998. A staff nurse can only receive either a dual qualified scale or an allowance whichever is the greater. The exceptions to this are:

(a) Nurses who were paid on the dual qualified scale on October 1, 1996 and in receipt of a location allowance at August 1, 1998 or eligible for a new location/qualification allowance from March 31, 1999. In such cases the value of the location/qualification allowance is **€1,597** which they receive in addition to their dual qualified scale.

(b) With effect from November 26, 2003, nurses who are paid on the dual qualified scale and who then move to an area that attracts a location/qualification allowance will continue to be paid on the dual qualified scale and will also receive the abated value of the location/qualification allowance of **€1,597**. Payment of the allowance will cease if the nurse moves out of the qualifying area.

Other allowances

1.5% due on October 1, 2023

Grade	Nature of allowance	€
Public health nurses	Island inducement allowance*	2,022
Public health nurses	Fixed payment	32.22
Weekend work	First call on Saturday and first call on Sunday Each subsequent call on Saturday and Sunday Payment in lieu of time off for emergency work	42.77 21.42 32.19
Theatre nurses/midwives who participate in the on-call/standby emergency services	**On-call with standby – each day** Monday to Friday Saturday Sunday and public holidays *All of these figures based on a 12-hour period. Pro rata to apply after hours.*	 48.48 62.27 84.17
	Call-out rate – Monday to Sunday (a) Fee per operation per 2 hours (17.00-22.00 hours) (b) (i) Operation lasting > 2 hours and up to 3 hours (17.00-22.00 hours) (ii) Operation lasting > 4 hours and up to 5 hours (c) Fee per operation per hour (after 22.00 hours)	 48.48 72.70 121.18 48.48
	On-call without standby (i) Fee per operation, call-in without standby (ii) overruns from roster at normal overtime rates (no time back in lieu)	96.96
	On-call over weekend In situations where no roster duty is available over the weekend, the following will apply on a pro-rata basis (ie. appropriate rate divided by 12, then multiplied by number of hours available). No time back in lieu will apply.	
	Nurse co-ordinator allowance A shift allowance of €20.71 will be paid to a staff nurse who undertakes the role of formalising the reporting and accountability relationship with the theatre superintendent. The allowance only applies to a nurse who fulfils specified duties when called in (DOH circular refers).	
	Specialist co-ordinator allowance	4,945
	Caseload Allowance (RGNs in the community undertaking certain specified duties of the PHN)	4,247

***Review of allowances:** Following Review of Allowances conducted by the Department of Public Expenditure and Reform, the Government has decided to abolish certain allowances for new beneficiaries with effect from 1st February 2012.

How to work out hourly rate of pay for nurses/midwives:
Example: senior enhanced salary scale €55,851. Take €55,851 divide by 52.18 and then by 37.5 equals hourly rate of pay €28.54. This formula applies for all grades.

Know your rights and entitlements

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

Catherine Hopkins and Catherine O'Connor at
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NOVEMBER 11
Public Health Nurse Section Webinar
ONLINE

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All Ireland Midwifery Conference
Hillgrove Hotel,
Monaghan

NOVEMBER 22
Assistant Directors Section Masterclass
The Richmond
Education and Event Centre,
Dublin

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The next generation

Freda Hughes asked two student members to share their experience and advice with those just starting out

Ryan Hayes and Elsie Cotterall

AS UNIVERSITIES begin the new academic year, we'd like to welcome all incoming first-year nursing and midwifery students to the professions of nursing and midwifery. You have chosen an extremely challenging yet hugely rewarding career path. There is no doubt that this will be a scary and exciting time for many of you, so *WIN* has asked some INMO student and intern members to share their experiences and advice with new students starting their training.

Ryan Hayes is a third-year nursing student at Dundalk Institute of Technology (DKIT). Originally from Cork, he always had an interest in working in healthcare and initially worked as a healthcare assistant in nursing homes in his home county before moving to Our Lady of Lourdes Hospital, Drogheda. It was during the pandemic while working there that he decided to go back to university to train as a nurse.

The first year of general nursing training covers anatomy, physiology and microbiology. It introduces students to the general concepts of nursing, and students will also do their first placement in this year. Later in the course, students take up specialised placements in areas such as care of the older person, emergency medicine, intellectual disability and ICU, through which they will gain a broader view of nursing.

In first year, Mr Hayes did his six weeks on surgical placement on the acute surgical wards at Our Lady's Hospital, Navan followed by four weeks on the medical ward at Cavan General Hospital. In second year, he started his specialty placements and spent four weeks working in care of the older person in a HSE-funded nursing home in Navan. He then did four weeks on surgical placement in second year. Now heading into third year, he will be working with public health nurses and getting out into the community to see that aspect of nursing, which he is looking forward to.

In the nursing degree in DKIT, there are about 40 students per class, so Mr Hayes said they have plenty of opportunities to

explore different areas and ask questions.

"In second year, we had modules on oncology and gastro nursing, and we had nurse specialists come in from both the acute and community settings to teach us. With Sláintecare, the community is where it's at and more and more care is being moved from the acute setting into the community so it's great to get exposure and experience of this type of nursing. It's easy to get kind of stuck in the acute hospital mindset," he told *WIN*.

"If you want to progress or do something completely different from that, the world very much is your oyster when it comes to community nursing."

Elsie Cotterall is just about to finish her training as a midwife. She started her midwifery degree as a mature student in Trinity College Dublin (TCD) in 2019 and was part of the first intake on the midwifery degree course. This course trains students as midwives exclusively, without general nursing. Ms Cotterall's class will be the first graduates of this specific degree course.

Ms Cotterall and her peers were the Covid-19 cohort, so they didn't really have the full college experience. TCD's midwifery degree has three six-week placements each year. While she had started her placements before Covid-19 hit, all placements from March 2020 until the end of that summer were postponed. This meant making up the practice placement time over the next three years.

TCD works with Dublin's Rotunda and the Coombe Hospitals for its student placements, but students also complete placements for their mental health modules in St Patrick's Hospital, Dublin, Midlands Regional Hospital, Portlaoise and the Hermitage Hospital, Dublin.

Ms Cotterall went into midwifery as a mature student. It was something that she always wanted to do having grown up on a mission in Zambia surrounded by healthcare professionals. Her godparents both worked in the mission hospital. One was the master of the hospital and the other was a nurse/midwife akin to a matron on the wards, so she had access to the hospital most afternoons after school and that piqued her interest in healthcare.

"I had an idea of the physical toll that nursing took on people but it's the emotional toll that surprised me. I wasn't prepared for that. You don't think about that aspect of midwifery and nursing. You expect the long hours, tiredness, and the physical side," she said.

"At the beginning, it was a bit scary because we didn't really know what to expect. But once you get used to being on placement, you'll enjoy it because you'll find you learn more. It's easy to learn the theory behind things but until you're actually practising it, it doesn't really sink in."

Mr Hayes also stressed the importance of placement work for helping students gain confidence in their roles. "I was really surprised by the amount of knowledge you need to have as a nurse. I also wasn't aware of just how much variety and opportunity there is in the world of nursing. Getting out on placements in your nurse's uniform and getting to apply what you've learned is so important. It's a privilege when you get to interact with patients and their families and be that reassuring voice they need to hear," Mr Hayes said.

Peer support

Both Ms Cotterall and Mr Hayes reiterated the importance of having a supportive peer group and supportive lecturers during such an intense programme. One of the pitfalls of the degree is that it's 50/50 in class and on placement and nursing and midwifery students sometimes miss out on social occasions, so having a smaller group that you can connect with means you can create a support network. Many students will set up a class WhatsApp group to help each other process the tougher days without disclosing sensitive details and to celebrate the good days and offer each other peer support.

Ms Cotterall said: "I would say for any student, it's really important to mind themselves and mind each other as well, and to have a good support network within their course. Taking care of your mental health is very important for midwifery students. Prepare well for lectures and placements, but don't get overly bogged down with achieving high grades in the first year.

"It's important not to be too hard on yourself and to give yourself a little bit of slack. Link in with your lecturers and clinical placement co-ordinators (CPCs) and don't be afraid to ask questions. Professors and CPCs are there to answer those questions and make you feel comfortable in your theory, as well as your clinical skills, so never stop asking questions."

Mr Hayes added that nursing is all about being organised. "Get your workplan flowing and get a good diary and that will stop you from getting overwhelmed. You'll feel like a duck out of water at first but that's perfectly okay. You're there to learn. It's important to embrace the feeling of terror. Always remember, you're on placement to learn, not to have responsibility. Supernumerary means you're not counted as staff."

Union support

All student nurses and midwives are entitled to free INMO membership. The role of the INMO is to promote the interests of our members in the workplace. As a student member, you can contact the union for free information, advice, support and representation if you experience any issues while on placement. You can also access a variety of other services, such as the INMO library and professional development courses.

"Getting involved with the INMO also provides huge support and expands your network," Mr Hayes said. "It really showed me the huge passion we have for our professions as nurses and midwives. It's great to meet others on the same journey too and to put faces to the people who will be there to support us if we ever need them."

Mr Hayes said he plans to stay in Ireland to get more experience after he qualifies but that he will likely work abroad at some stage in his career. Having seen the passion of the CPCs and clinical nurse specialists who taught him, he said he is also considering nurse education as a career pathway in the future.

"I like the acuity of emergency medicine or surgical, but I'm very much trying to keep my options open. I don't want to settle for what I'm used to. And I think that's a part of doing the degree; we learn to be uncomfortable and to get comfortable with being uncomfortable."

Ms Cotterall has accepted a job as a staff midwife in the Rotunda Hospital in Dublin, which she will start soon.

"The highlights of my training have been sharing the journey of motherhood with women and their families and just being there with them in that special moment. It really is a privilege to be in that position.

"At the moment, I just want to qualify. I'm really happy to get the job in the Rotunda so I'm eager to get started. Maybe after five or six years I might go down the diabetes management or perinatal mental health route but for the moment I'm happy as a staff midwife."

The INMO has a dedicated student officer, Róisín O'Connell, who is there to answer your questions. She can be contacted by email to: roisin.oconnell@inmo.ie

See also *page 35* for dedicated news and updates for student and new graduate members of the INMO.

Quality & Safety

A column by Maureen Flynn

Quality improvement terms and concepts

NURSES and midwives make a major contribution to improving care. Using quality improvement (QI) methods is the way we do this. In this month's column we share a quick reference guide on QI terms and concepts. This will be of interest to anyone wishing to improve practice and care provided to patients.

At its simplest, QI is the combined and unceasing efforts of everyone – healthcare professionals, patients and their families, researchers, commissioners, providers and educators – to make the changes that will lead to better patient outcomes, better experience of care and the continued development and support of staff to deliver quality care.

QI is a formal approach to the analysis of performance and systematic efforts to improve it. There are various methods or models of QI such the Institute for Healthcare Improvement (IHI) Model for Improvement, Continuous Quality improvement (CQI), Six Sigma, LEAN, and more. All QI models are aimed at improving performance. In health care, improving performance can result in a reduction of medical errors, morbidity and mortality, and improved quality of life for patients, communities and staff.

Terms and concepts

Language is important, as with all other sciences QI has terms and concepts that might initially seem puzzling. To assist you the National QPS Directorate has prepared an easily accessible document with an alphabetical listing of as many of the terms and concepts that you might come across in one place.

The QI Terms and Concepts document (*see cover image*) contains a collection of common terms and concepts used in the fields of quality improvement and improvement science in the Irish healthcare setting. You can appreciate that the list is not exhaustive and will be updated regularly. We would be delighted to hear of your suggestions for additions.

The document provides the reader with broad explanations of terms and concepts used in quality improvement work and provides links to additional information and resources. The terms, concepts and explanations have been collated from a wide variety of national and international resources. A resource section is also provided as an appendix to the document to support in-depth understanding of how these terms and concepts relate to improvement in practice.

Further QI learning

The QI Terms and Concepts document is one of a suite of resources and online learning programmes that can support your QI learning journey. Others include:

- *Quality Improvement Toolkit*: This toolkit contains a number of tools which should make carrying out an improvement project easier
- *Quality Improvement Knowledge and Skills Guide*: This guide will help you to discover what knowledge and skills you need to make effective, sustainable quality improvements in your area of work
- *E-learning Accredited QI Learning Opportunities on HSELanD*
  - *Introduction to Quality Improvement*: This 30-minute e-learning programme will introduce you to the core concepts of quality improvement in healthcare and will help you think about how you can play an active role in improving quality in your local service
  - *Foundation in Quality Improvement*: This e-learning programme typically takes three hours to complete, however you can stop and start the programme whenever you like and you will be able to pick up where you left off. The programme aims to help you to develop an understanding of the fundamentals of quality improvement in healthcare and will guide you in identifying the knowledge and skills you need to further your learning.

Get involved

Over the past number of months the NQPSD @NationalQPS have tweeted a QI word of the week. You can do something similar in your own healthcare setting, for example you could post a QI word of the week on your local notice board and get everyone involved.

Further information

Further information and resources as well as a copy of the terms and concepts document can be found at: **www.hse.ie/nqpsd** or by scanning the QR code right.

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

Acknowledgements : Thank you to the QPS Education team and a special thank you to my colleague Caroline Conneely HSE National QPS Directorate for assistance in preparing this column

Q and A Bulletin Board

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

Will a promotion affect my annual leave?

Q. I have been working in the HSE for the past 12 years as a midwife and have recently been promoted to a clinical midwife manager 2 (CMM). I'm aware that annual leave is based on service, but does this mean it will now be based on me having no prior service as a CMM?

No, this is not the case. You are correct that annual leave is based on service, however it is based on cumulative service where all genuine verifiable nursing/midwifery service should be taken into account. This means that your annual leave entitlement will increase from 27 days per annum to 28 days per annum, assuming you are working a 'five-over-five' roster (ie. only working between Monday and Friday). If you are going to be working a 'five-over-seven' roster (ie. liable to work any day Monday to Sunday), then you receive an additional 10 days of annual leave in lieu of the 10 public holidays.

Public holiday entitlements

Q. I am a staff nurse who works in a job share in an outpatient department. I am required to work every Monday in a specialist clinic and I am wondering about my public holiday entitlement as the employer gives me five days every year?

In the public service, an employee who normally works on the day on which the public holiday falls but has the day off by virtue of the fact that it is a public holiday (eg. the service closes) is entitled to their normal day's pay. Job sharing nurses and 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.

Sick-leave applications

Q. I am on sick leave and paying class A1 PRSI. I started working in the HSE in 2021. My employer has advised that I will have to apply for illness benefit. As an employee of the HSE I know I am paid full sick pay under normal rules for three months, but I was not aware I had to apply for illness benefit. Is this correct?

This is correct. You need to apply to the Department of Social Protection for illness benefit. To apply for illness benefit, you must be examined by a doctor (usually a GP) who will provide you with an illness benefit (IB1) claim form to complete. Alternatively, you can apply for illness benefit online at **MyWelfare.ie** if you have a verified MyGovID account and your GP has provided a medical certificate. You should claim the benefit within six weeks of becoming ill otherwise you risk losing part of your payment. Illness benefit is not paid for the first three days you are on sick leave. Depending on your employer's arrangements, the illness benefit may be paid directly to your employer in which case they will pay you your full sick leave inclusive of the benefit. If the illness benefit is paid directly to you, your employer will pay the balance to make up your full sick pay.

Enhanced contract and contracted hours

Q. I'm currently contracted to work 30 hours per week but I actually work 35 hours per week due to service needs. I'm due to move on to the senior staff nurse increment but I'm wondering about the enhanced salary for senior staff nurses. Will the enhanced practice contract be based on original contracted hours of 30 hours per week or is it only for full-time hours?

The enhanced practice contract is based on your contracted hours. You do not have to work 37.5 hours per week to access this contract. Most of the terms and conditions contained in the enhanced nurse/midwifery practice contract remain essentially the same as those contained in the staff nurse/midwife contract. This includes hours of work, annual leave, sick leave and pension entitlements.

Enhanced contract and your pension

Q. My colleagues and I are looking at signing the enhanced practice contract and we are concerned that our pension will be affected by doing this as we are all paying Class D PRSI. We have heard that if we sign this contract, we may break our service and will be transferred over to the Single Public Service Pension Scheme or change to Class A PRSI?

Signing the enhanced practice contract is not regarded as a promotional post for pension purposes nor is it a break in service. Therefore your pension and your Class D PRSI will not be affected by signing this contract. The only way your pension would be affected is if you were to break your service for more than six months.

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

CPC Section webinar hears from experts in reflective practice and mental health

REFLECTIVE practice was the focus of a presentation by Prof Fiona Timmins and Paul Horan at the recent Clinical Placement Co-ordinators (CPC) Section webinar.

Prof Timmins, dean of the School of Nursing and Midwifery and Health Systems, UCD, and Mr Horan, assistant professor of the School of Nursing and Midwifery, TCD, discussed how to facilitate structured reflective practice and how to examine the challenges of facilitating reflective practice programmes with larger numbers of students. Their presentation also looked at the difficulties associated with creating safe reflective spaces, how to facilitate reflective practice effectively and how to develop the skills that make a good facilitator.

The second part of the seminar looked at mental health first aider (MHFA) training, with a specific focus on anxiety. This session was facilitated by Angela Killion, health promotion and improvement officer, HSE, who spoke about how we think and feel about ourselves and how this affects our ability to reach our potential. Early intervention is often the key, according to Ms Killion, who described the 'Algee' step-by-step action plan of the MHFA response:

A: Approach the person, assess and assist with any crisis
L: Listen and communicate non-judgementally
G: Give support and information
E: Encourage the person to get appropriate professional help
E: Encourage other supports.

More information can be found by contacting Mental Health First Aid Training Ireland at **www.mhfaireland.ie**

The section would like to thank national section officers Jennifer Phelan, Rachael Dolan and Eileen Fallon for organising the webinar, which was attended by 45 members.

The importance of hosting section meetings and the networking opportunities they offer, was further highlighted by Tony Fitzpatrick, INMO director of professional services, in his welcome address.

Third-Level student health nurses meet at INMO HQ

MORE than 20 members of the INMO Third-Level Student Health Nurses Section met in the INMO head office in early September, just ahead of the universities and colleges starting the next academic year.

The meeting was a great networking opportunity and a chance to host an education session on writing policies and procedures, delivered by Nursing Matters and Associates.

Keep an eye out in the Diary pages of *WIN* for details of future meetings of this section.

Third-Level Student Health Nurses Section officers (l-r) Orlagh Flemming, vice chairperson; Jennifer Scott, chairperson; Elaine Dawson, treasurer; Michelle Cresswell, education officer and Eilish Corley, secretary

Advanced Practice Section publishes member survey

THE Advanced Practice Section met in the Richmond Education and Event Centre in September.

The two main focuses of the meeting were the launch of a section survey and an educational talk on cardiac failure from advanced nurse practitioner Melissa Hammond.

Feedback from the survey will be used to bring about changes to advanced practice in the Irish health service, according to the section.

Scan this QR code inset to complete the survey – it just takes around 12 minutes.

Pictured at the meeting were Oliver Allen, vice chairperson; Jean Carroll, INMO section development officer and Niamh Adams, INMO head of library services. Fifteen section members attended the meeting online.

INMO Professional

Continuing professional development for nurses and midwives

INMO EDUCATION PROGRAMMES

In the pull-out this month…

Complaints management for healthcare staff (acute or residential healthcare setting)

Oct 10

This programme is most relevant to senior nurse managers in the acute or residential healthcare settings. It will provide them with the key skills and communication tools to minimize the negative impact that 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.

Change management – valuable tools for nurses and midwives

Oct 10

The aim of this course is to enhance participants' understanding of change management and strategies to improve the potential for successful change initiatives in the workplace. Participants will gain valuable tools in how to understand the nature and process of change within the healthcare setting; appreciate the importance of managing stakeholders as part of the change process; apply change concepts with their clinical and managerial practice and reflect on their previous experience of change. They will leave with knowledge of how to best support their work colleagues in approaching change positively.

Type 1 diabetes management for nurses and midwives

Oct 12

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

INMO Professional

Embracing times of change

Steve Pitman
Head of Education and Professional Development

Over the next year, there will be significant changes across the health service. The structural changes within the HSE will impact acute and community services. The introduction of the regional health areas will result in a health service that integrates the hospital groups and the community healthcare organisations. It is hoped that this change will enable the vision of Sláintecare to be achieved.

Nursing and midwifery professionals are currently going through a process of review following the publication of the *Expert Review Body Report 2022*. The work is examining four key areas: nursing and midwifery workforce, education and professional development, digital health and governance and leadership structures.

In parallel the NMBI is carrying out a fundamental review of the undergraduate programmes, developing and implementing the Professional Competence Scheme, and reviewing the Code and Scope of Practice. The INMO is the collective voice of nurses and midwives and will continue to represent the views of members during this time of change.

INMO section conferences and webinars

The INMO will be hosting several conferences and webinars from October until December, the details of which are listed on *page 19*.

NMBI Monitoring the Maintenance of Professional Competence (MMPC)

Now referred to as the Professional Competence Scheme (PCS), the first meeting of the PCS Steering Group took place in September. The current proposal is for the introduction of an employer process and an individual process. The employer process (eg. the HSE PDP) could be used as a basis to indicate PCS compliance for all nurses and midwives employed in the organisation. This would require the employer to have robust systems in place that meet NMBI requirements. The individual process would be designed for registrants not employed by an organisation participating in the employer scheme. The work of the group is expected to be completed by December 2024. Look out for updates in future issues of *WIN* and the NMBI ezine.

Policy for pronouncement of expected death

The updated draft National Policy for Pronouncement of Expected Death by Registered Nurses is currently being reviewed by the PDRN Expert Reference Network which includes HIQA, the NMBI, the Coroner Society, patient advocates, the Irish College of General Practitioners and the Funeral Directors Association. This policy is an update of the 2017 national policy and covers designated centres for older persons, nurse-led intellectual disability (ID) services registered by HIQA, and specialist palliative care services. It is anticipated that this policy will be available in early 2024.

Midwifery

The INMO and RCM Northern Ireland All-Ireland Midwifery Conference will take place November 16 in the Hillgrove Hotel, Monaghan. This will be an excellent opportunity to network and meet other midwives from across the island to share ideas and experiences. The conference will cover a wide range of issues including continuity of care, inclusion health, supporting birth choices, and advanced midwifery practice.

Menopause and menstrual health at work

The INMO has joined with other trade unions in calling for measures to support workers and stop the stigma surrounding menstruation and menopause. This is an important step towards equality and dignity in the workplace. The 'Stop the Stigma' campaign will be launched in October to coincide with International Menopause Day. Trade unions have been advocating for comprehensive workplace policies that address challenges posed by menopause and menstrual health.

Research across the unions, including the results of the INMO menopause survey, highlights the urgency for implementing practical menstrual health and menopause workplace policies, focusing on accommodations, training, privacy and equality. Watch out for and support the #StopTheStigma campaign in your workplace and on social media.

The campaign is calling for the implementation of practical workplace solutions, including:

- Flexible work arrangements
- Enhanced managerial training
- Free menstrual and menopause products
- Physical accommodations
- Access to risk assessments
- Promoting a supportive culture
- Confidentiality and privacy
- Paid time off.

On-site education

INMO Professional offers extensive on-site programmes facilitated by expert practitioners. If you are interested in booking CPD courses for your organisation, please contact education@inmo.ie or 01 6640642.

Delivering courses for INMO Professional and writing for *WIN*

We are eager to offer members the opportunity to work with us in delivering education courses. If you are an AN/MP, CN/MS, or a nurse/midwife with expertise in clinical or management practice, we would like to hear from you. Contact education@inmo.ie or 01 6640642.

We are also interested in hearing from you if you would like to write professional and clinical articles for *WIN*. Please email 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: €30 members; €65 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

Oct 6 **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-today basis. The programme will assist participants in gaining an understanding of the clinical evidence underpinning the diagnosis and ongoing care and management of the child with asthma utilising current best practice.

Oct 10 **Introduction to change management for nurses and midwives**

The aim of this course is to enhance the understanding of nurses and midwives of change management and strategies to improve the potential for successful change initiatives.

Oct 10 **Complaints management for healthcare staff (acute or residential healthcare setting)**

This programme is aimed at senior nurse managers within the acute or residential healthcare settings to provide them with the key skills and communication tools to minimize 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.

Oct 11 **Phlebotomy** *(in person)*

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

Oct 11 **Leg ulcer assessment and management**

This short online course will advise participants on leg ulcer management. Topics covered on the day include; pathophysiology, assessment and management of leg ulcers.

Oct 12 **Master your communication skills**

When good communication is practiced, it improves client care, staff morale and working relationships. It also decreases workplace conflict caused by gaps in communication, inactive listening or cultural differences. This online training will help you develop your interpersonal and communication skills at all levels in the organisation. It focuses on your key competencies for face-to-face and written communications to ensure you can understand what is being communicated to you; how to respond and how to communicate clearly and with purpose. Learn these practical skills to ensure more effective and impactful communications.

Oct 12 **Type 1 Diabetes management for nurses and midwives**

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

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.

Oct 19 **Introduction to management and leadership skills for nurses and midwives**

The aim of this short online programme is to identify key managerial and leadership competencies for front line nursing/midwifery managers and to explore how these are applied in practice. The programme will include management theory, effective leadership and team working as well as delegation and clinical supervision.

Oct 24 **PEG feeding caring for adults and paediatrics who have a PEG tube in the hospital/community setting**

This short online introductory programme is aimed at all nurses working within the hospital and community setting caring for adults and paediatrics who have a percutaneous endoscopic gastrostomy (PEG) tube. It will address the clinical indications and requirements for PEG feeding in the home and hospital setting. It will provide guidance on medication administration and nutrition with a focus on hospital policies and government guidance. It will also discuss the complications of PEG feeding that can occur and how these can be clinically managed.

Nov 8 **Introduction to treating and preventing pressure ulcers**

This short online course will advise participants on pressure ulcer prevention. Topics covered on the day include; causes of pressure ulcers, risk assessment, and prevention of pressure ulcers.

Nov 9 **Diabetes: a general overview**

This course will give an insight into Type 1 and Type 2 diabetes. It will provide a general overview of the definition of diabetes, management and treatment of it. It will look at complications of diabetes and the need for screening and prevention of diabetes related co-morbidities. It gives an insight into medication management, structured education programmes and the benefits of using technology to manage glycaemic control.

Nov 13 **Positive behaviour support** *(in person)*

This programme explores the key components of compassion and their application in the care setting. It is an internationally recognised evidence-based approach to supporting individuals with behaviours that challenge. It introduces participants to the model of Positive Behaviour Support and outlines the benefits of its use. It is designed for management and frontline staff, supporting and improving the quality of care of individuals with behaviours that may challenge the services which support them. Fee: €125 INMO members; €195 non members.

Nov 14 **Navigating your way through conflict**

The key learning outcome for this online interactive short course will be to help participants develop the insights and skills necessary to successfully navigate their way through conflict situations and reach satisfactory solutions. In many ways, workplaces are perfect breeding grounds for conflict. As well as our skills, we bring our individual needs, goals, ambitions, personalities, perspectives, backgrounds and vulnerabilities with us into work.

Nov 15 **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. Fee: €90 INMO members; €145 non members.

Nov 16 **Dementia care and Communication**

This short course will review knowledge of the brain, memory and brain health. Participants will gain an understanding of dementia including types, symptoms, risk factors, treatments and supports available to people living with dementia. Participants will gain an understanding of best practice techniques when communicating with people living with dementia. This course will expand knowledge of non-cognitive symptoms of dementia, identify triggers and solutions. It will also gain an understanding of delirium, recognising symptoms, treating causes and providing non-pharmacological support to patients.

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

ONLINE

PEG Feeding

Caring for Adults and Paediatrics who have a PEG tube in the hospital/ community setting

3 CEUs

Tuesday, 24 October 2023

Time: 10.00am - 1.00pm
Fee: €30.00 INMO members; €65.00 Non members

This short online introductory programme is aimed at all nurses working within the hospital and community setting caring for adults and paediatrics who have a percutaneous endoscopic gastronomy (PEG) tube. It will address the clinical indications and requirements for PEG feeding in the home and hospital setting. It will provide guidance on medication administration and nutrition with a focus on hospital policies and government guidance. It will also discuss the complications of PEG feeding that can occur and how these can be clinically managed.

SCAN HERE

Early booking is advisable
To book a place call 01 6640618/41
For more information www.inmoprofessional.ie/course

BOOK NOW

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IN PERSON

Retirement Planning Seminar

Thursday, 16 November 2023

Venue: The Richmond Education and Event Centre, Dublin
Time: 9.30am - 2.30pm (registration 9.15am)
Fee: €10.00 INMO members; €65.00 Non members

INMO Professional in partnership with Cornmarket Financial Services have developed an in person seminar to help support members planning for retirement. Topics covered on the day will be: Superannuation, calculation of the lump sum, options for increasing benefits, AVCs, planning your finances in retirement, investment goals, personal taxation and budgeting and money saving tips.

SCAN HERE

Early booking is advisable
To book a place call 01 6640618/41
For more information www.inmoprofessional.ie/course

BOOK NOW

INMO Professional

INMO Irish Nurses and Midwives Organisation Working Together

IN PERSON

Nursing records under the spotlight

Wednesday, 15 November 2023

5 CEUs

Venue: The Richmond Education and Event Centre, Dublin
Time: 10.00am - 4.00pm (registration 9.45am)
Fee: €90.00 INMO members; €145.00 Non members

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

SCAN HERE

Early booking is advisable
To book a place call 01 6640618/41
For more information www.inmoprofessional.ie/course

BOOK NOW

INMO Professional

INMO Irish Nurses and Midwives Organisation Working Together

IN PERSON

Introduction to **Positive behaviour support**

Monday, 13 November 2023

6 CEUs

Venue: The Richmond Education and Event Centre, Dublin
Time: 9.15am - 4.30pm (registration 9.00am)
Fee: €125.00 INMO members; €195.00 Non members

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

SCAN HERE

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For more information www.inmoprofessional.ie/course

BOOK NOW

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.

Nov 16 **Retirement planning seminar** *(in person)*

INMO Professional in partnership with Cornmarket Financial Services have developed an in person seminar to help support members planning for retirement. Topics covered on the day will be: superannuation explained, when a full pension is available, the calculation of the lump sum, options for increasing your retirement benefits, AVCs, personal retirement savings accounts (PRSAs), savings plans, planning your finances in retirement, what to do about any surplus income you may have in retirement, individual requirements such as your investment goals, investment time frame, attitude to investment 'risk/reward' and personal taxation budgeting and money saving tips.

Nov 20 **Restrictive practice thematic inspections**

In June 2023 HIQA identified guidance to meet thematic programme regarding restrictive practices with facilities in care of the older person. The guide provides the right to live as independently as possible without unnecessary restriction. This can be achieved by providers and staff taking a positive and proactive approach in reducing and eliminating restrictive practices. In light of the new thematic inspection occurring from June 2023 and requests to support staff this programme will enhance knowledge and support the organisation in meeting best practice from June 2023 guidance framework.

Nov 22 **Adult asthma – getting the basics right**

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

Nov 22 **Assessment and care planning**

This short programme provides nurses caring for older persons with the most up-to-date information regarding policy and standards. It will focus on the need for comprehensive assessment, including risk assessment and care planning for older people in residential care settings. Participants will be provided with practical tips on how to prepare for and carry out a comprehensive assessment of a new resident in a nursing home, enabling them to develop a person-centred care plan. The programme will outline the appropriate steps for writing a person-centred care plan, how to conduct a review of an individual's care plan, and how to update it in accordance with changing needs.

Nov 23 **Competency-based interview skills**

This programme assists participants to prepare for a competency-based interview, which is based on the premise that past experience can predict future behaviour. This is an increasingly common style of interviewing 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. The programme will provide an overview of curriculum vitae development and will outline the steps in the interview process. Role play will be used to ensure that participants are able to communicate their knowledge and experience effectively for any future interviews.

Nov 28 **Introduction to effective library search skills**

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

Nov 29 **Become more assertive**

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

Dec 13 **Wound care management**

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

INMO Professional

Journal collections

An overview of the *Nursing Times* and RCN journal collections available to members

NURSING professionals play a critical role in the healthcare industry, providing essential care and support to patients across a wide range of settings. To stay current with the latest research, best practices and developments in the field, nurses often turn to professional journals for valuable insights and knowledge. Among the most esteemed publications in the nursing community are the *Nursing Times* journal and the Royal College of Nursing (RCN) Journal Collection. These journals offer an extensive array of specialisms and a diverse range of articles, making them indispensable resources for nurses worldwide. These are available for members through the online INMO library.

Nursing Times

The *Nursing Times* journal, founded in 1905, is one of the oldest and most respected nursing publications globally. It has established itself as a cornerstone in the nursing community, serving as a vital resource for nurses, nurse educators and healthcare practitioners seeking to expand their knowledge and expertise. One of the key strengths of the *Nursing Times* is its commitment to providing evidence-based information and research to guide nursing practice. The journal publishes peer-reviewed articles that delve into the latest developments in nursing research, clinical practice and healthcare policy. These articles are essential for nurses to stay up to date in their field and incorporate the best available evidence into their patient care. The journal offers a platform for nurses to share their own experiences and features articles and case studies written by practicing nurses, allowing readers to gain valuable perspectives from their peers in various clinical and educational settings. This emphasis on real-world experiences adds a practical dimension to the journal's content, making it relevant to nurses on the front lines. The specialisms covered by the *Nursing Times* include:

- Clinical nursing: articles in this category focus on the latest clinical practices, patient care techniques and innovative approaches to nursing care in various healthcare settings
- Nurse education: nurse educators will find valuable resources in this section, which explores effective teaching strategies, curriculum development and the use of technology in nursing education
- Leadership and management: nurse leaders and administrators can benefit from articles that address leadership skills, management strategies, and healthcare policy changes affecting nursing practice
- Mental health nursing: with the growing importance of mental health care, this specialism covers topics related to psychiatric nursing, psychotherapy, and the management of mental health disorders
- Primary care nursing: this section explores the unique challenges and opportunities faced by primary care nurses, including topics like preventive care and patient education
- Specialist nursing: articles within this category cater to specialized nursing roles such as paediatric nursing, gerontology, oncology, and critical care nursing, providing in-depth insights and updates.

Contact the library

If you would like further information on accessing these resources or any library services, please call: 01 6640614/25 or email: library@inmo.ie

Access the library via OpenAthens

We are currently rolling out Open Athens as a method for our members to access the online library. Although only in the early stages of implementation, if you are interested in registering for Open Athens access, please contact niamh.adams@inmo.ie

Visit the library

If you wish to visit the library, please make an appointment in advance so we can ensure that there will be a staff member available to assist you. The library opening hours are Monday to Thursday: 9.00am-5.00pm, Friday: 8.30am-4.30pm

RCN Journal Collection

The Royal College of Nursing (RCN) Journal Collection is a valuable resource specifically tailored for nurses, midwives and healthcare support workers. The collection includes journals, each specialising in different areas of nursing and healthcare, making it a comprehensive resource for professionals looking to deepen their knowledge in specific domains. The RCN Journal Collection includes:

- Nursing research: the collection includes journals that focus exclusively on nursing research, featuring original studies, systematic reviews, and meta-analyses. These articles contribute to the evidence base for nursing practice
- Clinical updates: practising nurses benefit from articles that provide timely clinical updates, such as guidelines for managing specific conditions or the latest pharmacological advancements
- Professional development: the RCN Journal Collection supports nurses' professional development with articles on leadership, continuing education, career advancement, and improving nursing skills.
- Policy and advocacy: nurses interested in healthcare policy and advocacy can access journals that delve into the political and social aspects of nursing practice, equipping them to influence change within the profession and healthcare system
- International perspectives: for nurses seeking global insights, the collection includes journals that feature international perspectives on nursing and healthcare.

Online – Introduction to Effective Library Search Skills

Next course date: Tuesday, November 28, 2023

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.

i-learn Royal College of Midwives

Raising awareness of cytomegalovirus

CYTOMEGALOVIRUS (CMV) is a common virus that is harmless to most people but can be dangerous to unborn babies. This RCM i-Learn module has been developed by the UK charity CMV Action in response to requests from midwives for more information about congenital CMV. It sets out the facts about CMV and four key areas where midwives can play a role in the forefront of reducing the impact of this virus.

This module will take approximately one hour to complete.

Why it matters

Cytomegalovirus (CMV) is a member of the herpes virus family. It is a common virus that can infect people of all ages. Most healthy adults and children will have no signs or symptoms and no long-term effects. However, it can pose serious problems if a woman catches CMV during pregnancy, and passes it on to her unborn baby, particularly in early pregnancy.

Congenital cytomegalovirus is the most commonly occurring congenital infection worldwide, affecting more neonates and children than many other widely recognised congenital conditions. However, the available evidence suggests that there is a lack of awareness among populations concerning congenital cytomegalovirus. Furthermore, to date, congenital cytomegalovirus has received inadequate attention from healthcare professionals and policy commissioners.

Congenital CMV (when the infection is passed from mother to baby across the placenta) is the leading preventable cause of hearing loss and a major cause of childhood disability. Despite this, there is very little awareness of CMV and the facts are often misunderstood. A diagnosis of CMV infection in pregnancy can be stressful and confusing.

CMV causes a wide range of disabilities and different children can be affected in very different ways. Some babies are obviously ill at birth (15% of those affected by CMV). Most will not show obvious symptoms yet account for two thirds of disease burden.

Role of the midwife

Currently there are no screening programmes in the UK and Ireland for either maternal or neonatal cytomegalovirus. Midwives have a significant role in the prevention of maternal and foetal complications that can result from exposure to infectious agents during pregnancy.

Pregnant women are warned about the dangers of toxoplasmosis (from cat litter trays, which affects around 20 babies a year) and listeriosis (from unpasteurised foods, affecting around 30 babies a year), but not about cytomegalovirus, which affects more babies than both of these combined.

The new NICE guidelines for antenatal care now recommend that women should be told about CMV. Midwives can play an important role in providing antenatal education about CMV risk reduction and in initiating a diagnostic evaluation when there is clinical suspicion. Identification of CMV during pregnancy may help ensure the neonate receives timely treatment after birth.

The four key areas where midwives can play a part in reducing the impact of CMV are:

- Give advice on reducing risks
- Reduce their own risk if planning a pregnancy

- Know what to do if infection in pregnancy is suspected
- Understand what would happen if a newborn baby was diagnosed with CMV.

Learning outcome

Having completed this module you will understand:

- How CMV can affect babies
- What CMV is and the symptoms it can cause
- How CMV is spread
- How risks of CMV infection in pregnancy can be reduced.

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

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Attention nurse and midwife student graduates

Congratulations on completing your Internship!

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INMO

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- Advances in CRC and robotic surgery
- Nursing management of patients in the robotic theatre
- Infection prevention and control
- The Trendelburg Position
- Living with chronic anxiety
- Considerations for the diabetic patient in theatre
- Quality Initiative presentations
- Keynote address: Confessions of a Party Animal

Fee: €90 INMO members, €140 non-members

INMO Professional

For further details go to www.inmoprofessional.ie/conference or contact: jean.carroll@inmo.ie

Welcoming our new students

The INMO is here to support you through college and beyond, **Róisín O'Connell** tells new nursing and midwifery students

I WOULD like to welcome all the incoming first-year nursing and midwifery students as they begin their journey to become nurses and midwives. You are entering an exciting stage of your life. Although nursing and midwifery is a challenging profession and career, it is also extremely rewarding and is valued across the globe.

The INMO is here to support you through your studies and after as you progress through your career. The INMO promotes the interests of our members and as a student member of the union, it is free for you to contact us for information, support, advice, representation and many other services.

I am your student and new graduate officer. I am here to answer any questions that you have. No question is a silly question, except perhaps the one that you don't ask. The questions I am most regularly asked are about clinical placements, allowances and your rights and entitlements as a student nurse or midwife.

Every month you will receive email updates from me including the *Student Link* E-zine that will update you on the matters affecting students.

Over the coming weeks and months, I will be visiting the 13 different universities that facilitate the nursing and midwifery degree programmes across the country. Here I will be offering students the opportunity to sign up for our free INMO student membership. Students can also sign up for free membership online on our website.

If you would like to learn more about how our union works and how you can get involved as a representative for your class, please contact me.

When I started out on my nursing career, I was nervous, unsure and excited all at the same time and I wasn't always sure who to call for advice. If you ever find yourself in this situation and you are unsure who to turn to, you should contact the INMO. We have lots of different services available to you to help make this transition period easier.

Watch out for the INMO 'Student Link' E-zine which will keep you up to date

To the new and existing student nurses and midwives, there are so many things that I would like to say to encourage you as you start out on this new path. One of the most important pieces of advice that was given to me when I started out as a student nurse was to always ask questions. It may seem like something small or to some it may even seem like the question has an obvious answer, but it is always better to ask and receive an answer rather than trying to figure it out on your own. Remember that you are a student and you are there to learn. You cannot be expected to know everything.

Another great piece of advice is to always look out for your fellow students. Over the course of your degree, you will be paired with numerous different students. It is important to look out for each other and to support each other as your fellow students will become your support network. Placements can be very rewarding, but they can also be very challenging, and it is important that you have someone that you trust, whom you can share your experiences with.

Lastly, I would like to wish you the best of luck and welcome to the team.

Class photos

Many final-year students will be graduating from college soon. It would be great to get a collection of graduation or last-day photos of newly qualified nurses and midwives. If you have a few photos, please email them to: roisin.oconnell@inmo.ie along with a caption. We will publish a selection in *WIN* in the near future.

Get involved as a rep

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

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

Róisín O'Connell is the INMO's student and new graduate officer. If you have a question for her please email her at: roisin.oconnell@inmo.ie.

Louise May and **Jean Rooney** discuss how new booklets summarising key information are proving invaluable to midwifery students at the Rotunda

Developing new support pathways for students

CLINICAL practice experience is an integral component of the midwife registration education programme. Clinical placements complement theoretical input to ensure safe, quality midwifery care for women, their babies and their families.[1] The aim of clinical practice learning is to facilitate midwifery students to become safe, competent, kind, compassionate, respectful and reflective midwife practitioners who develop the prescribed competencies over the four-year programme.[1]

An undergraduate programme, awarding a bachelor of science in midwifery, was introduced in Ireland in 2007, prior to which midwifery training was only available as a post-nursing qualification. This change introduced a whole new cohort of student midwives to the maternity care system – a cohort requiring different support in the clinical area to the higher diploma midwifery students who were already qualified nurses.

With the introduction of the undergraduate degree, maternity units throughout Ireland adapted into clinical learning environments catering for a four-year degree programme, including a 36-week clinical internship.

Student support in Ireland

The role of the clinical placement co-ordinator (CPC) is defined as an experienced midwife who provides dedicated support to student midwives or nurses in a variety of clinical settings. The CPC facilitates learning through the identification of learning opportunities in the clinical area and imparting their knowledge as well as creating an environment that is conducive to learning and quality.

Facilitation is achieved through the CPC acting as a link between the student and the various groups that support students in the education and clinical setting.[2] Named clinical placement co-ordinators monitor the quality of clinical learning environments on an ongoing basis and guide and support students to ensure that clinical practice placements provide an optimum learning environment.[1]

The post of CPC is unique to Ireland. It was created on an experimental basis in the late 1990s to support nursing students and to co-ordinate and assist nurse tutors, ward managers and staff nurses in relation to learning for students.[3] In the UK, mentorship on clinical placements is provided by ward-based staff, alongside the support of the higher education institution. Students have reported in the research that the clinical learning environment is a sociocultural setting with a hierarchy, power structure and supervisory relationships that affect the overall atmosphere and their perceptions of the value of learning experiences.[4] For effective clinical learning to occur, students must be integrated into ward activities and staff must be engaged with teaching and learning.

Support factors

A recent systematic qualitative review aimed to identify factors that enhance midwifery students' learning and development of self-efficacy in clinical placement.[5] The analysis revealed two themes: 'a nurturing relationship' and 'predictability in the learning process'. The first theme is particularly relevant when reflecting on the role of the CPC and how it facilitates optimum learning experiences for student midwives. Collaboration and building relationships with midwives, education staff and other students, all added to the learning experience of student midwives on clinical placements.[5]

Another systematic review, conducted in 2021 in Trinity College Dublin by Panda et al identified that 'the support structure' is an important factor in students' experience of the clinical learning environment (CLE). This study also discusses how lacking a sense of 'belongingness' was a major demotivating factor in the CLE.[6] Therefore,

excellent support in the clinical learning environment must encompass developing not only the skills of the students, but fostering a sense of "belongingness" to the organisation and the profession of midwifery.

Covid-19

The cessation of face-to-face education during the Covid-19 pandemic had a huge impact on education and training, with an estimated 90% of the 1.5 billion students enrolled in education worldwide unable to continue their studies during restrictions.

In Ireland many midwifery students were banned from clinical placements and faced a theory-only route, with rapid adaptation by higher education institutions to provide online learning. Synchronous and asynchronous methods of live online tutorials, recorded material, podcasts and videos were used to address the learning needs of the students.

Students who were on paid internships continued on placement in hospitals all over Ireland throughout the lockdowns of 2020 and 2021. Challenges were faced by the students and those in student support roles as there were unprecedented activity levels of staffing shortages, preceptorship issues as well as the general personal stress experienced by hospital staff at this time.

Two whole-time members of the clinical placement co-ordinator team in the Rotunda Hospital were redeployed to frontline clinical roles, leading to reduced support on the ground for students. One full-time CPC remained in her role, also helping on the emergency Covid-19 phone line. Anecdotally, the students did report a feeling of "all being in it together" and were very supportive and receptive to the remaining CPC. The team was incredibly impressed with how well the remaining students managed on placement.

New support pathways

Following return from redeployment, but with the situation of Covid-19 being uncertain and rapidly changing, the clinical placement co-ordinators sought to develop additional resources for the students during this time, to support and encourage them and also to provide scope for peer-to-peer support. Practical orientation and guidance during a time where preceptors were either absent, stressed or exhausted was seen as an additional support mechanism to students' learning during this challenging period.

A booklet, later to be named a 'cheat sheet' was decided on, initially for the delivery suite placement area. The CPC team met and discussed at length what 'golden nuggets' of information would be most valuable to students navigating their delivery suite placement. For example, how to check a room before a woman in labour arrives, how to set up a delivery trolley, care when a woman is labouring in water, the normal cord blood gas range etc. The value of peer-to-peer support was researched and the customisable format was chosen. Students are encouraged to fill in their own notes, even passing their books on to other students, but many keep them for their newly qualified career.

Developing the cheat sheets

The booklets were designed and the content tested with an audience of students at three online skills sessions delivered via Zoom over three weeks. Students gave their feedback and their input was incorporated into the final draft.

Students surveyed after their placements using the delivery suite cheat sheet described having the resource as:

- Useful
- Lifesaver
- Helpful
- Informative
- Amazing.

When asked would the students change any elements of the cheat sheets, some of the responses included:

- *"They are fantastic and have been of huge benefit to me. Thanks so much"*
- *"I like being able to add my own notes relating to patient care – when you see it it's easier to remember. Very handy to recap before starting in an area"*
- *"The drugs part of the cheat sheet was really helpful; maybe adding a few more drugs would be great."*

Following the positive feedback from the students, amendments were made and a further booklet for the antenatal ward was developed. This was launched and was followed by booklets for the postnatal wards, outpatients department, community midwifery team and the neonatal intensive care unit (NICU), with the gynaecology ward cheat sheet launching most recently.

Students were surveyed and asked if they felt the use of their cheat sheets enhanced their clinical performance and patient care. Responses were overwhelmingly positive. Preceptors were also asked for their feedback and have reported students having enhanced knowledge levels and are more proactive in the clinical area.

Student midwives have long been recognised in literature as playing an important

role in caring for women during all points in pregnancy and the relationship is mutually beneficial in terms of learning and support.[7] Parents valued the presence of students during labour and childbirth, especially as they felt that it further empowered the women.[8]

In order for students to develop into the highest standard of midwife, they should be well-supported, informed and integrated into the organisation and profession. Their learning needs and feedback should be incorporated into provision of support in the clinical learning environment.

Louise May and Jean Rooney are clinical placement co-ordinators at the Rotunda Hospital in Dublin

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INMO

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INMO Professional

When menopause comes early

Patients with premature ovarian insufficiency need to be supported by a co-ordinated approach to care, writes **Kate Pleace**

PREMATURE ovarian insufficiency (POI) is not the same as menopause that occurs at the expected life stage. POI, or premature menopause as it is also known, affects women/those with ovaries before they reach the age of 40. The term POI was coined in 1942 by Fuller Allbright et al[1] who first reported that the cessation of menstrual periods in a small percentage of younger women was caused by impaired ovarian function.

While symptoms are often similar, the condition differs from menopause not only because of the age of those affected but also because there is often unpredictable ovarian function associated with the condition.

Possible causes of POI include ovarian surgery, chemotherapy, genetic, chromosomal abnormalities, infection and autoimmune disorders. However, in the majority of cases the cause of POI is often idiopathic or unknown. Currently the prevalence of POI is estimated at around 1-3% of the general population. POI affects around one in 100 women under the age of 40, one in 1,000 women under the age of 30 and one in 10,000 women under the age of 20. Recent research suggests that this number may increase as more women have treatment for conditions such as cancer or endometriosis.

Diagnosis

While absent or irregular periods may often be the first symptom experienced, it is important to be aware that some patients may still present with a regular menstrual cycle. Other symptoms of POI can include infertility, vasomotor symptoms, genitourinary syndrome of menopause, joint pain and cognitive symptoms such as mood changes and anxiety. Many factors will influence how and where a person may present in the healthcare setting and often a diagnosis may occur when they are trying to conceive.

How the diagnosis is delivered to the patient is key, as several studies have highlighted that how we tell a patient they have POI can have a significant impact on their psychological adaptation. POI is also often an invisible condition and many patients may have been told they are too young for menopause or may have seen several healthcare professionals before a diagnosis of POI is made.

A diagnosis of POI is based on the presence of possible irregular or absent periods and a full clinical history. It is also important to consider family history as those with a mother, sister or family member with POI are more likely to also have the condition.

Hormone blood tests can also provide more information and diagnosis can include an elevated follicle-stimulating hormone

(FSH) blood test of more than 25IU/l. This is usually taken on two occasions – either at the beginning of the menstrual cycle or around four to six weeks apart if the patient is not experiencing regular periods.

Often a diagnosis of POI can be a shock or a life-changing event, and most commonly the diagnosis may be made alongside other investigations such as treatment for infertility. While a natural pregnancy is possible because the ovaries may not completely fail, this is rare and only occurs in around 5% of cases.

Treatment

POI is a chronic disorder that disrupts the lives and reproductive trajectories of people who are diagnosed with the condition, with the best chance of a pregnancy being via fertility treatment using egg donation.

The emotional impact of POI cannot be underestimated; those with POI often feel isolated, out of step with their friends and peers, and often may experience anxiety and depression. Those with the condition often describe multiple losses, including health, fertility, confidence, youth and vitality.

For many women or individuals with POI, there are a variety of treatment options that can help with symptoms. These include hormone therapies such as the oral contraceptive pill or hormone replacement therapy (HRT), the goal of which is to top up or replace the hormones that are no longer produced by the ovaries. For this patient group, HRT is recommended as gold standard because of the age of the patient. Most POI patients will take hormone therapy until the average age of menopause, which is around 52 years.

It is important to be aware that younger women using HRT may need a different treatment plan or regime than those who have reached menopause at the expected age. This is why a specialist referral or further advice may be needed. For patients who may also experience genitourinary syndrome of menopause or vaginal dryness and reduced libido, medical options such as local vaginal oestrogen or testosterone may also be considered alongside hormone therapy.

While medication can often help with the symptoms of POI, it is important that patients with the condition are also aware of its long-term impact. The early loss of oestrogen may negatively affect bone, cardiovascular and cognitive health. Lifestyle changes such as maintaining a healthy weight, exercising, stopping smoking, reducing alcohol intake and eating a healthy diet can also help to reduce the impact of POI on the patient's heart, bones and brain.

Many healthcare professionals have only a basic knowledge of menopause and there is a significant knowledge gap when considering more unusual related conditions such as POI. Healthcare professionals may also have a varying knowledge and experience of the prescribing and management of hormone therapy, which can lead to variations in the practice and management of POI. This in turn can have a negative impact on the journey of care for the patient.

> "Those with POI often feel isolated, out of step with their friends and may experience anxiety and depression"

Management

Due to the complexities of the condition, the optimal follow-up for women or those with POI must be lifelong, with effective management likely to be a collaborative care model with a variety of members of the multidisciplinary team. Currently in Ireland, this approach is only offered to a small number of people living with the condition. This highlights a need for further awareness, training and support for healthcare professionals, both within the area of women's health and in other areas of practice.

Part of my role at Dublin City University (DCU) is lecturing on the master's specialist women's health pathway for nurses and the soon-to-be-agreed stand-alone women's health modules. This gives me the privilege of educating nurses in the area of women's health and I am able to ensure that conditions such as POI and different types of menopause are taught to nurses so that they can help women with POI and make a positive difference in the care they receive.

It is important to signpost patients with POI to further support. The Daisy Network is a charity that provides support for those with POI. The group's representative in Ireland is Catherine O'Keeffe. Other useful resources for patients include *The Complete Guide to POI and Early Menopause* by Dr Hannah Short and Dr Mandy Leonhardt, which gives an excellent overview of the condition and treatment options. Another resource is *My Life on Pause* by Siobhan O'Sullivan, which gives a good account of a patient's journey and experience of POI. Further support and guidelines for healthcare professionals include the ESHRE guidelines on the management of premature ovarian insufficiency.

Co-ordinated approach

Despite significant progress in the area of reproductive endocrinology, our understanding of POI remains limited, and the area is greatly under researched. Conditions like POI present a unique challenge to research and patient care because of the likely smaller number of patients affected compared to menopause at the expected age, which may limit the opportunity for research.

Change is needed in POI research, patient care and support, and a co-ordinated approach to care is also required. My own PhD research with the Centre for Reproductive Research at De Montfort University in the UK will focus on women's lived experiences of POI. While the research is still in the early stages, it will centre around the patient's experience of the POI journey.

Without further ongoing research and education for healthcare professionals, we are left advising and treating women and those with POI using menopausal practice and guidelines, which may not be appropriate and are based on a different patient population.

Kate Pleace is assistant professor in women's health in the School of Nursing, Psychotherapy and Community Health at Dublin City University. Ms Pleace is also undertaking PhD research at De Montfort University in Leicester, UK

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Further reading

- *The Daisy Network* – **www.daisynetwork.org/**
- *Catherine O'Keeffe, Daisy Network Representative Ireland* – **www.wellnesswarrier.ie**
- *The Complete Guide to POI and Early Menopause by Dr Hannah Short and Dr Mandy Leonhardt*
- *My Life on Pause by Dr Siobhan O'Sullivan*
- *ESHRE POI Guidelines* – **www.eshre.eu**
- *DCU Women's Health Pathway* – **www.dcu.ie**

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For more information contact: jean.carroll@inmo.ie or visit www.inmoprofessional.ie

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Focus on liver cancer

A specialist multidisciplinary team should provide management recommendations for those with liver cancer, writes **Michèle Bourke**

PRIMARY liver cancer is among the top five causes of cancer-related death worldwide. Some 905,700 people were diagnosed with liver cancer worldwide in 2020, with 830,200 people dying with liver cancer globally in the same year. It is estimated there will be a 55% rise in the number of new diagnoses and deaths from liver cancer by 2040.[1]

October is Liver Cancer Awareness Month. Raising public awareness is vital in improving outcomes for patients with liver cancer. Not only because it is a major health problem itself, but also because it is associated with liver disease and cirrhosis. Prevention and early detection of primary liver cancer through public health measures, surveillance programmes, education and health promotion are key in the battle against this disease.

Background

There are two main types of primary liver cancer: hepatocellular carcinoma (HCC) originating in hepatocytes, and cholangiocarcinoma (CCA) forming in the cells of the biliary tree. HCC is the most prominent type, accounting for approximately 90% of cases worldwide. HCC generally occurs with a background of liver cirrhosis, therefore the most common risk factor is chronic liver disease. This article focuses on HCC.

Liver cirrhosis is a chronic disease due to constant liver damage from recurring insult, eg. excess fat in the liver, viral hepatitis, alcohol abuse, haemochromatosis, plus other aetiologies. Over time, as hepatocytes are in a constant state of injury and repair, mutations develop in the cells leading to carcinogenesis and the formation of HCC.

Patients with liver cirrhosis have a 1-8% cumulative annual risk of developing HCC, therefore liver cirrhosis and HCC tend to be managed simultaneously by hepatologists, in conjunction with hepatopancreaticobiliary surgeons, interventional radiologists, oncologists and specialist nurses.

Diagnosis and staging

HCC is one of the few cancers that can be diagnosed radiologically if the patient has liver cirrhosis or chronic hepatitis B virus (HBV) in the absence of cirrhosis. The Liver Imaging Reporting and Data System (LI-RADS) classification is widely used to guide non-invasive diagnosis of HCC. LI-RADS category LR-1 is considered a definitely benign lesion, whereas LR-5 is consistent with definite HCC.[2] If a patient does not have cirrhosis or chronic HBV, or a LI-RADS classification of LR-M (definite or probable malignancy, not specific for HCC), a histopathological diagnosis is required.

Liver cancer can be staged with various systems. The staging of HCC and its treatment algorithm differ from that of other cancers, as the background liver disease and level of liver function is a major determining factor in treatment selection. A patient may have a small cancer that would ordinarily be considered for curative resection in an organ without a synchronous pathology, eg. breast. However, when a patient has dual pathologies such as HCC and liver cirrhosis, the level of liver dysfunction from the chronic liver disease will increase the mortality risk from interventions like surgery. Conservative management with a life prolonging treatment plan may then become the clinical pathway of choice, regardless of the small cancer size.

Validated scores are available in the literature to assess the level of liver dysfunction and risk of mortality for patients with cirrhosis based on their clinical data. These include the Model for End Stage Liver Disease (MELD) score, which predicts the three-month mortality risk for patients with liver cirrhosis, as well as the Child Turcotte Pugh (CTP) score, which stratifies the severity of liver disease and predicts surgical mortality for patients with liver cirrhosis.

For HCC management, the Barcelona Clinic Liver Cancer (BCLC) Staging Classification is a widely accepted treatment algorithm which stages the cancer and guides clinicians to appropriate treatment modalities considering both HCC burden and extent of the background liver disease determined by the CTP score.[3] The MELD, CTP and BCLC are internationally recognised and recommended for use in the management of HCC and can provide prognostic information for these patients.

Treatment

All patients with a new diagnosis of liver cancer should have their case discussed at a specialist liver cancer multidisciplinary team meeting (MDM) with an expert consensus decision made regarding recommended treatment.[4,5] The specialist liver cancer MDM in St Vincent's University Hospital (SVUH) is an example of this.

Treatment for HCC can be divided into two categories, those with curative intent and those which are life prolonging.

Surgical options include liver resection and liver transplantation. Surgical resection removes the part of the liver affected by the cancer. Factors affecting consideration for resection include tumour size, location, vascular invasion, presence of metastases and level of background liver function.

Liver transplant involves the removal of the patient's native liver and replacing it with a new healthy donor liver. Strict criteria must be met before a patient is considered for a liver transplant. If deemed appropriate, they then undergo a period of assessment to ensure their suitability for this type of major surgery. Both surgical treatments are curative in nature, however liver transplantation is considered superior as it not only removes the existing liver cancer, but also the background liver cirrhosis which caused it and would be a continued risk factor for further HCC development.

Non-surgical options include thermal ablation (curative intent), transarterial chemoembolisation (TACE),

selective internal radiation therapy (SIRT) and systemic therapy, all of which are non-curative in nature. Thermal ablation uses extreme temperature (heat or cold) to ablate the liver cancer and is used to treat lesions ≤ 3cm in size. TACE works by injecting chemotherapy directly into the blood supply feeding the HCC as well as blocking off the arterial blood supply to it. SIRT is similar to TACE, however radiation is injected into the liver this time, which damages the cancer cells internally. Systemic therapy is used for patients who have advanced liver cancer with preserved liver function. Immunotherapy (IV) and tyrosine kinase inhibitors (oral) are used for this type of treatment.

For patients with deranged liver function and/or poor performance status, best supportive care and palliation is the treatment of choice regardless of the liver cancer burden.

SVUH is the only centre nationally equipped to offer the full array of approved treatment modalities here in Ireland.

Health promotion

The National Cancer Registry of Ireland described a 300% increase in the number of liver cancer cases in Ireland in the past decade.[6] In 2018, it reported 285 new cases of primary liver cancer per year in Ireland, with 290 deaths from primary liver cancer here per year.[7]

While primary liver cancer is a major burden globally, awareness of liver cancer is limited in this country. When I ask members of the general public about liver cancer, they describe secondary liver cancer or metastases to the liver from another primary cancer originating elsewhere in the body. Their knowledge is lacking about primary liver cancer, its causes, surveillance options, treatments and outcomes. This liver cancer awareness month we hope to shine a light on liver disease and its associated cancer here in Ireland.

Primary prevention

While improvements in cancer care are always welcome, prevention is better than cure. Prevention of primary liver cancer requires awareness of the risk factors for its development, mainly chronic liver disease. Globally viral hepatitis is the leading cause of liver cirrhosis, however fatty liver and alcohol excess are the leading risk factors in the western world.

A fibroscan is a quick and easy, non-invasive test used to identify the presence of fat and inflammation or scarring in the liver. Liver specific blood tests can be used to calculate scores to predict liver dysfunction. These tests, coupled with a comprehensive health history and physical assessment can make a diagnosis of liver disease and cirrhosis, prompting a surveillance protocol for liver cancer.

Viral hepatitis

Strategies to tackle viral hepatitis associated HCC include vaccination against HBV. Universal vaccination programmes for newborn babies in Asia are associated with significant decreases in HCC incidence there. In Ireland, the HBV vaccine is now given to children under the Childhood Immunisation Schedule as part of the 6-in-1 vaccine at two, four and six months of age.

Additional strategies involve antiviral therapy for those with HBV and hepatitis C virus (HCV). Treatment for HBV will keep the virus under control. New treatments for HCV can eradicate the virus altogether. Both treatments aim to prevent the development of significant fibrosis or cirrhosis in the liver. Antiviral therapies have shown to significantly reduce HCC risk. However, patients who have already developed cirrhosis will have a persistent risk for HCC development.

Non-alcoholic fatty liver disease

The HSE recently reported that Ireland has one of the highest levels of obesity in Europe.[8] Obesity is linked with many chronic illnesses including non-alcoholic fatty liver disease (NAFLD) and liver cirrhosis. It is associated with a 1.5-4.5 times higher risk of HCC, contributing to nearly 10% of all HCC incidence worldwide. NAFLD is currently the fastest growing cause of HCC in liver transplant candidates and is the leading cause of HCC in the absence of liver cirrhosis.[4] Weight loss and increased physical activity improves outcomes for patients with NAFLD, reducing the progression to cirrhosis.

Alcohol

Alcohol Action Ireland and the UCC School of Public Health attribute the number one cause of alcohol-related deaths in Ireland to liver cancer and liver cirrhosis. The International Agency for Research on Cancer classify alcohol as a group one carcinogen. There is a proven link between alcohol and several types of cancer. While it is important to note that there is no safe level of alcohol consumption, low risk drinking guidelines are available recommending fewer than 11 standard drinks per week for women and 17 standard drinks per week for men. It is hoped that the Public Health (Alcohol) Act 2018 will help to reduce alcohol use and subsequent harms in Ireland.

Smoking

Smoking is associated with risk for many cancers, but specifically a 20-86% increased risk for HCC.[4] Giving up smoking can return this risk to almost baseline after 30 years of cessation. The HSE provides resources and programmes to assist in smoking cessation.

Surveillance

Once a diagnosis of liver cirrhosis has been made or a patient has chronic HBV in the absence of cirrhosis, regular surveillance for primary liver cancer is recommended the world over, in the form of a liver ultrasound every six months, to assess for the development of primary liver cancer.[4,5] Although the evidence is not strong for the use of tumour markers as part of the surveillance protocol, the measurement of alphafetoprotein (AFP) level in blood may assist in early detection of primary liver cancer.

Conclusion

Primary liver cancer rates are increasing in Ireland. HCC is the most common type of primary liver cancer and usually occurs on a background of liver cirrhosis. Surveillance for HCC should be offered to all patients who qualify for it. A specialist multidisciplinary team should provide recommendations for management of anyone diagnosed with liver cancer. However, prevention is better than cure and steps need to be taken in at-risk groups to prevent the development of significant liver fibrosis, cirrhosis and primary liver cancer.

If you would like any further information, the Irish Liver Foundation: **www.liverfoundation.ie** and the Irish Cancer Society: **www.cancer.ie** have excellent information pages dedicated to primary liver cancer.

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Focus on: Chronic kidney disease

WIN looks at the management of a patient with diabetes whose blood results show a concerning change in eGFR levels

CHRONIC kidney disease (CKD) is a structural or functional abnormality of the kidney, present for more than three months. This includes patients with a sustained estimated glomerular filtration rate (eGFR) < 60ml/min, significant albuminuria, microscopic haematuria and structural abnormalities identified on imaging.

Anyone with diabetes, hypertension, heart disease, vascular disease, stroke, multisystem diseases such as systemic lupus erythematosus (SLE) or a family history of end-stage kidney disease or known genetic kidney disease should be screened for CKD. Screening tests required include:

- Urine dipstick for albumin:creatinine ratio (ACR)
- Urea and electrolytes (U/E) blood tests
- Blood pressure check.

Classification and staging

Once a diagnosis of CKD has been made, the next step is to determine staging, which is based on GFR, albuminuria and the cause of CKD.[1,2,3]

Nephrology referral

Criteria for referral to a nephrologist include:

- Estimated glomerular filtration rate (eGFR) < 30ml/min/1.73m2
- ACR > 70mg/g
- ACR > 30mg/g with microscopic haematuria
- A sustained decrease in eGFR by > 15ml/min/1.73m2 in a year
- A suspected genetic cause of chronic kidney disease.

Management strategies for CKD

Management of CKD includes reducing cardiovascular risk (eg. statins and blood pressure management), treatment of albuminuria (eg. angiotensin-converting enzyme inhibitors or angiotensin II receptor blockers), avoidance of potential nephrotoxins (eg. nonsteroidal anti-inflammatory drugs), and adjustments to drug dosing (eg. antibiotics and oral hypoglycaemic agents). Patients also require monitoring for complications of CKD, such as hyperkalaemia, metabolic acidosis, hyperphosphataemia, vitamin D deficiency, secondary hyperparathyroidism and anaemia.[1]

Table 1. The four strategies for management of CKD

• **Slow kidney disease progression:** Treat underlying disease, RAAS (renin-angiotensin-aldosterone system) blockade, SGLT2 inhibition
• **Reduce cardiovascular risk:** Blood pressure (general target < 130/< 80mmHg), lipid control, stop smoking
• **Dose drugs according to GFR**: For example, DOACs, metformin, digoxin
• **Reduce risk of acute kidney injury:** Implement 'sick day rules' for diuretics and RAAS blockade

Case study

A 62-year-old woman with a background of type 2 diabetes, hypertension and peripheral vascular disease attends her general practice for follow up of recent blood tests.

A year ago her eGFR had been 54ml/min and now it is found to be 46ml/min. Her medications included metformin, ramipril and atorvastatin, and she had dapagliflozin added to her regime four months ago by her endocrinologist. Urinalysis identifies 1+ proteinuria no haematuria. The primary care provider is concerned about the change in eGFR.

Management

SGLT2 inhibitors (SGLT2i) have been shown to slow the progression of both diabetic and non-diabetic kidney disease. They are believed to reduce intraglomerular hypertension, and therefore reduce proteinuria and GFR decline.

Alongside glycaemic control, blood pressure management and ACE inhibition, they are now a cornerstone of type 2 diabetes-related kidney disease management.

Due to the mechanism of action, changes in eGFR are common and expected after commencing a SGLT2i. The typical dip in eGFR is about 5ml/min or ≤ 20% increase in creatinine, usually apparent one to two weeks after starting the medication. Unless the decline is greater than this, the temptation to discontinue the drug should be resisted as it is expected. For patients such as in this case where there is evidence of proteinuria, it is particularly important that they are on medications that reduce their risk of end-stage kidney disease.

Sick-day rules

Patients started on an SGLT2i should be counselled on sick day rules (stopping the drug during a bout of vomiting or diarrhoea and restarting it when these symptoms cease), in a similar fashion to those starting metformin or ACE inhibitors.

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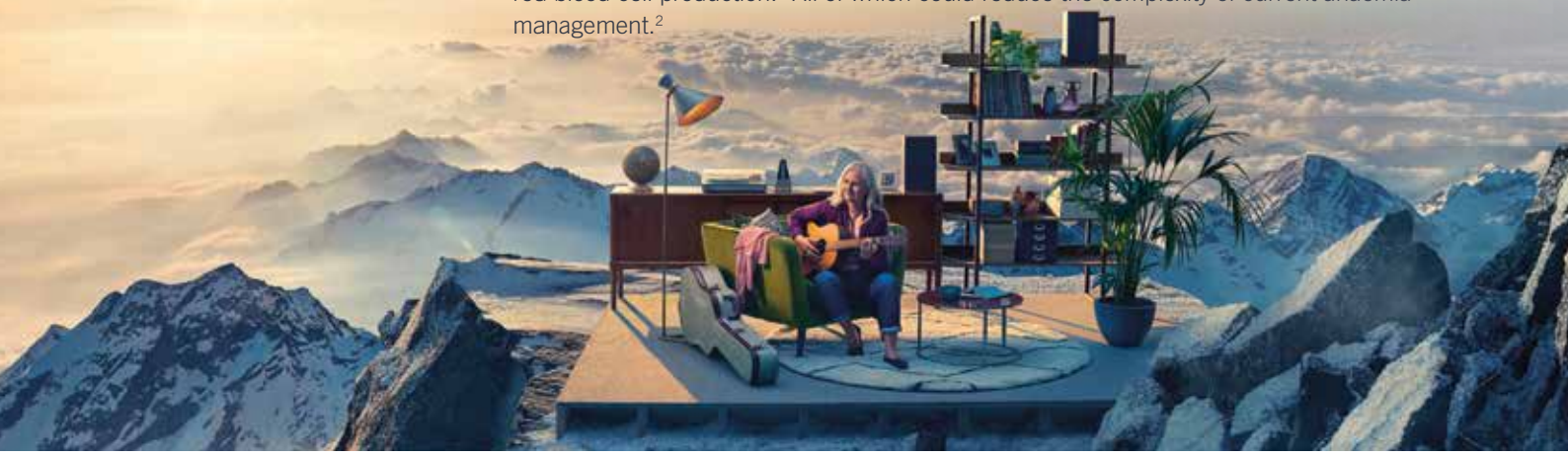
EVRENZO™ is like a breath of fresh air, in symptomatic anaemia of CKD

EVRENZO mimics the body's natural response to low oxygen conditions, such as those experienced at high altitude.[1] By stimulating a coordinated erythropoietic response, oral EVRENZO increases endogenous production of erythropoietin and improves iron bioavailability – ultimately leading to increased haemoglobin production and increased red blood cell production.[1] All of which could reduce the complexity of current anaemia management.[2]



EVRENZO is indicated for treatment of adult patients with symptomatic anaemia associated with chronic kidney disease (CKD)[1]

Evrenzo™ roxadustat

Prescribing Information
EVRENZO™▼ (roxadustat) film-coated tablets
Name: EVRENZO 20 mg film-coated tablets, EVRENZO 50 mg film-coated tablets, EVRENZO 70 mg film-coated tablets, EVRENZO 100 mg film-coated tablets, EVRENZO 150 mg film-coated tablets.
Presentation: Film-coated tablets containing 20 mg, 50 mg, 70 mg, 100 mg or 150 mg roxadustat. **Indications:** Treatment of adult patients with symptomatic anaemia associated with chronic kidney disease (CKD). **Posology and Administration:**Treatment should be initiated by a physician experienced in the management of anaemia. All other causes of anaemia should be evaluated prior to initiating therapy with EVRENZO and when increasing the dose. EVRENZO must be taken orally three times per week and not on consecutive days. The tablets are taken orally with/without food, swallowed whole and should not be chewed, broken or crushed. EVRENZO can be taken before or after dialysis (see SPC section 5.2). Individualise dose to achieve and maintain target haemoglobin (Hb) levels of 10–12 g/dL. Treatment should not continue beyond 24 weeks if a clinically meaningful increase in Hb levels is not achieved. Starting dose: Ensure adequate iron stores prior to initiation. Patients not currently/previously treated with an erythropoiesis-stimulating agent (ESA): Recommended starting dose: Patients <100kg: 70 mg three times weekly. Patients ≥100kg: 100mg three times weekly. Patients converting from an ESA: : Patients on ESA treatment can be converted to roxadustat. *Dialysis patients stable on ESA:* only consider conversion if clinically valid reasons exist. *Non-dialysis patients stable on ESA:* conversion not studied, only consider on benefit-risk to patient. The recommended starting dose is based on the average prescribed ESA dose in the 4 weeks before conversion. The first roxadustat dose should replace the next scheduled ESA dose. See Table 1. in the SPC. Maximum recommended dose: Patients not on dialysis do not exceed a roxadustat dose of 3 mg/kg body weight or 300 mg three times weekly, whichever is lower. Patients on dialysis do not exceed a roxadustat dose of 3 mg/kg body weight or 400 mg three times weekly, whichever is lower. Dose adjustments and Hb monitoring: The individualised maintenance dose ranges from 20 mg to 400 mg three times per week (400 mg only for CKD patients on dialysis). Monitor Hb every 2 weeks until a level of 10-12 g/dL is reached and stabilised, then every 4 weeks or as clinically indicated. The dose of roxadustat can be adjusted stepwise up or down from the starting dose 4 weeks after treatment start, then every 4 weeks except if the Hb increases by >2 g/dL, in which case the dose should be reduced by one step immediately. When adjusting the dose, consider the current Hb level and the recent rate of change in Hb level over the past 4 weeks, and follow the dose adjustment steps in Table 2 in SPC section 4.2. If dose reduction is required for a patient on the lowest dose, reduce the dose frequency to twice a week. If further dose reduction is needed, the frequency may be reduced to once weekly. Maintenance dose: After stabilisation of target Hb levels, monitor Hb levels regularly and follow dose adjustment rules. Consider alternative explanations in patients with inadequate Hb response (see SPC section 4.2). Patients starting dialysis while on roxadustat treatment: No specific dose adjustments required. Follow normal dose adjustment rules. Concomitant roxadustat treatment with inducers or inhibitors: When initiating/discontinuing concomitant treatment with strong inhibitors or inducers of CYP2C8, or inhibitors of UGT1A9, monitor Hb levels routinely and follow dose adjustment rules. Missed dose: If there is >1 day until the next dose, the missed dose must be taken as soon as possible. If ≤ one day remains before the next dose, skip the missed dose. Then resume the regular dosing schedule. Elderly: No adjustment of starting dose (see SPC section 5.2). Patients with hepatic impairment: Mild hepatic impairment: No adjustment of starting dose. Moderate hepatic impairment: Caution is recommended. Reduce starting dose by half or to the level closest to half the starting dose. Severe hepatic impairment: Not recommended (see SPC sections 4.4 & 5.2). Paediatric population: No data are available in patients < 18 years of age. **Contraindications:** EVRENZO is contraindicated in the following conditions: Hypersensitivity to the active substance, peanut, soya, or to any of the excipients listed in section 6.1 of the SPC; Third trimester of pregnancy (see sections 4.4 & 4.6 of the SPC); Breastfeeding (see section 4.6 of the SPC). **Warnings and precautions:** Cardiovascular and mortality risk: Overall, the cardiovascular and mortality risk for treatment with roxadustat has been estimated to be comparable to the cardiovascular and mortality risk for ESA therapy based on data from direct comparison of both therapies (see SPC section 5.1). Since, for patients with anaemia associated with CKD and not on dialysis, this risk could not be estimated with sufficient confidence versus placebo, a decision to treat these patients with roxadustat should be based on similar considerations that would be applied before treating with an ESA. Further, several contributing factors have been identified that may impose this risk, including treatment non responsiveness, and converting stable ESA treated dialysis patients (see SPC sections 4.2 and 5.1). In the case of non-responsiveness, treatment with roxadustat should not be continued beyond 24 weeks after the start of treatment (see SPC section 4.2). Conversion of dialysis patients otherwise stable on ESA treatment is only to be considered when there is a valid clinical reason (see SPC section 4.2). For stable ESA treated patients with anaemia associated with CKD and not on dialysis, this risk could not be estimated as these patients have not been studied. A decision to treat these patients with roxadustat should be based on a benefit risk consideration for the individual patient. Thrombotic vascular events: The reported risk of thrombotic vascular events (TVEs) should be carefully weighed against the benefits to be derived from treatment with roxadustat particularly in patients with pre existing risk factors for TVE, including obesity and prior history of TVEs (e.g., deep vein thrombosis [DVT] and pulmonary embolism [PE]). Deep vein thrombosis was reported as common and pulmonary embolism as uncommon amongst the patients in clinical studies. The majority of DVT and PE events were serious. Vascular access thrombosis (VAT) was reported as very common amongst the CKD patients on dialysis in clinical studies (see SPC section 4.8). In CKD patients on dialysis, rates of VAT in roxadustat treated patients were highest in the first 12 weeks following initiation of treatment, at Hb values more than 12 g/dL and in the setting of Hb rise of more than 2 g/dL over 4 weeks. It is recommended to monitor Hb levels and adjust the dose using the dose adjustment rules (see Table 2) to avoid Hb levels of more than 12 g/dL and Hb rise of more than 2 g/dL over 4 weeks. Patients with signs and symptoms of TVEs should be promptly evaluated and treated according to standard of care. The decision to interrupt or discontinue treatment should be based on a benefit risk consideration for the individual patient. Seizures: Seizures were reported as common amongst the patients in clinical studies receiving roxadustat (see SPC section 4.8). Roxadustat should be used with caution in patients with a history of seizures (convulsions or fits), epilepsy or medical conditions associated with a predisposition to seizure activity such as central nervous system (CNS) infections. The decision to interrupt or discontinue treatment should be based on a benefit risk consideration of the individual patient. Serious infections: The most commonly reported serious infections were pneumonia and urinary tract infections. Patients with signs and symptoms of an infection should be promptly evaluated and treated according to standard of care. Sepsis: Sepsis was one of the most commonly reported serious infections and included fatal events. Patients with signs and symptoms of sepsis (e.g., an infection that spreads throughout the body with low blood pressure and the potential for organ failure) should be promptly evaluated and treated according to standard of care. Secondary hypothyroidism: Cases of secondary hypothyroidism have been reported with the use of roxadustat (see SPC section 4.8). These reactions were reversible upon roxadustat withdrawal. Monitoring of thyroid function is recommended as clinically indicated. Inadequate response to therapy: Inadequate response to therapy with roxadustat should prompt a search for causative factors. Nutrient deficiencies should be corrected. Intercurrent infections, occult blood loss, haemolysis, severe aluminium toxicity, underlying haematologic diseases or bone marrow fibrosis may also compromise the erythropoietic response. A reticulocyte count should be considered as part of the evaluation. If typical causes of non-response are excluded, and the patient has reticulocytopenia, an examination of the bone marrow should be considered. In the absence of an addressable cause for an inadequate response to therapy, Evrenzo should not be continued beyond 24 weeks of therapy. Hepatic impairment: Caution is warranted when roxadustat is administered to patients with moderate hepatic impairment (Child Pugh class B). Evrenzo is not recommended for use in patients with severe hepatic impairment (Child Pugh class C) (see SPC section 5.2). Pregnancy and contraception: Roxadustat should not be initiated in women planning on becoming pregnant, during pregnancy or when anaemia associated with CKD is diagnosed during pregnancy. In such cases, alternative therapy should be started, if appropriate. If pregnancy occurs while roxadustat is being administered, treatment should be discontinued and alternative treatment started, if appropriate. Women of childbearing potential must use highly effective contraception during treatment and for at least one week after the last dose of EVRENZO (see SPC sections 4.3 and 4.6). Misuse: Misuse may lead to an excessive increase in packed cell volume. This may be associated with life threatening complications of the cardiovascular system. Excipients: EVRENZO contains lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose galactose malabsorption should not take this medicinal product. EVRENZO contains Allura Red AC aluminium lake (see SPC section 6.1) which may cause allergic reactions. EVRENZO contains traces of soya lecithin. Patients who are allergic to peanut or soya, should not use this medicinal product. Effects on ability to drive and use machines: Roxadustat has minor influence on the ability to drive and use machines. Caution should be exercised when driving or using machines. **Interactions:** Effect of other medicinal products on roxadustat: *Phosphate binders and other products containing multivalent cations:* Roxadustat should be taken >1 hour after administration of phosphate binders or other medicinal products or supplements containing multivalent cations (not lanthanum carbonate) (see SPC section 4.2). *Modifiers of CYP2C8 or UGT1A9 activity:* Monitor Hb levels when initiating/ discontinuing concomitant treatment with gemfibrozil, probenecid, other strong inhibitors/inducers of CYP2C8 or other strong inhibitors of UGT1A9. Adjust the dose of roxadustat following dose adjustment rules based on Hb monitoring. (see SPC section 4.2). Effect of roxadustat on other medicinal products *OATP1B1 or BCRP Substrates:* Co administration of roxadustat with simvastatin in healthy subjects increased the AUC and C_{max} of simvastatin and simvastatin acid. The concentrations of simvastatin and simvastatin acid also increased when simvastatin was administered 2 hours before or 4 or 10 hours after roxadustat. Co administration of roxadustat with rosuvastatin increased the AUC and C_{max} of rosuvastatin. Co administration of 200 mg of roxadustat with atorvastatin increased the AUC and C_{max} of atorvastatin. Interactions are also expected with other statins. Monitor for adverse reactions associated with statins and for the need of statin dose reduction. Roxadustat may increase the plasma exposure of other medicinal products that are substrates of BCRP or OATP1B1. Monitor for possible adverse reactions of co administered medicinal products and adjust dose accordingly. See SPC. Roxadustat and ESAs: It is not recommended to combine administration. **Pregnancy and lactation:** There are no data on the use of roxadustat in pregnant women. Roxadustat is contraindicated in the third trimester of pregnancy and is not recommended during the first and second trimester. If pregnancy occurs during EVRENZO treatment, discontinue EVRENZO and switch to an alternative if appropriate. EVRENZO is contraindicated during breast-feeding. Fertility: The potential effects of roxadustat on male fertility in humans are unknown. At a maternally toxic dose, increased embryonic loss was observed. Women of childbearing potential must use highly effective contraception during treatment and for at least one week after the last dose. **Undesirable effects:** Summary of the safety profile: The safety of EVRENZO was evaluated in 3542 non dialysis dependent (NDD) and 3353 dialysis dependent (DD) patients with anaemia and CKD who have received at least one dose of roxadustat. The most frequent (≥10%) adverse reactions associated with roxadustat are hypertension (13.9%), vascular access thrombosis (12.8%), diarrhoea (11.8%), peripheral oedema (11.7%), hyperkalaemia (10.9%) and nausea (10.2%). The most frequent (≥1%) serious adverse reactions associated with roxadustat were sepsis (3.4%), hyperkalaemia (2.5%), hypertension (1.4%) and deep vein thrombosis (1.2%). List of adverse reactions: Adverse reactions observed during clinical studies and/or in post-marketing experience are listed in this section by frequency category and MedDRA system organ class. Frequency categories are 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); not known (cannot be estimated from the available data). *Infections and infestations:* : Common: Sepsis. *Endocrine disorders:* Not known: Secondary hypothyroidism. *Metabolism and nutrition disorders:* Very common: Hyperkalaemia. *Psychiatric disorders:* Common: Insomnia. *Nervous system disorders:* Common: Seizures, headache. *Vascular disorders:* Very common: Hypertension, vascular access thrombosis (VAT)[1], Common: Deep vein thrombosis (DVT). *Gastrointestinal disorders:* Very common: Nausea, diarrhoea, Common: Constipation, vomiting. *Skin and subcutaneous tissue disorders:* Not known: Dermatitis Exfoliative Generalised (DEG). *Hepatobiliary disorders:* Uncommon: Hyperbilirubinaemia. *Respiratory, thoracic, mediastinal disorders:* Uncommon: Pulmonary embolism. *General disorders and administration site conditions:* Very common: Peripheral oedema. *Investigations:* Not known: Blood thyroid stimulating hormone (TSH) decreased.[1]This adverse reaction is associated with CKD patients who were on dialysis while receiving roxadustat. Description of selected adverse reactions. *Thrombotic vascular events:* In CKD patients not on dialysis, DVT events were uncommon, occurring in 1.0% (0.6 patients with events per 100 patient years of exposure) in the roxadustat group, and 0.2% (0.2 patients with events per 100 patient years of exposure) in the placebo group. In CKD patients on dialysis, DVT events occurred in 1.3% (0.8 patients with events per 100 patient years of exposure) in the roxadustat group and 0.3% (0.1 patients with events per 100 patient years of exposure) in the ESA group (see SPC section 4.4). In CKD patients not on dialysis, pulmonary embolism was observed in 0.4% (0.2 patients with events per 100 patient years of exposure) in the roxadustat group, compared to 0.2% (0.1 patients with events per 100 patient years of exposure) in the placebo group. In CKD patients on dialysis, pulmonary embolism was observed in 0.6% (0.3 patients with events per 100 patient years of exposure) in the roxadustat group, compared to 0.5% (0.3 patients with events per 100 patient years of exposure) in the ESA group (see SPC section 4.4). In CKD patients on dialysis, vascular access thrombosis was observed in 12.8% (7.6 patients with events per 100 patient years of exposure) in the roxadustat group, compared to 10.2% (5.4 patients with events per 100 patient years of exposure) in the ESA group (see SPC section 4.4). *Seizures:* : In CKD patients not on dialysis, seizures occurred in 1.1% (0.6 patients with events per 100 patient years of exposure) in the roxadustat group, and 0.2% (0.2 patients with events per 100 patient years of exposure) in the placebo group (see SPC section 4.4). In CKD patients on dialysis, seizures occurred in 2.0% (1.2 patients with events per 100 patient years of exposure) in the roxadustat group, and 1.6% (0.8 patients with events per 100 patient years of exposure) in the ESA group (see SPC section 4.4). *Sepsis:* In CKD patients not on dialysis, sepsis was observed in 2.1% (1.3 patients with events per 100 patient years of exposure) in the roxadustat group, compared to 0.4% (0.3 patients with events per 100 patient years of exposure) in the placebo group. In patients on dialysis, sepsis was observed in 3.4% (2.0 patients with events per 100 patient years of exposure) in the roxadustat group, compared to 3.4% (1.8 patients with events per 100 patient years of exposure) in the ESA group (see SPC section 4.4). *Skin reactions:* : Dermatitis exfoliative generalised, part of severe cutaneous adverse reactions (SCARs), has been reported during postmarketing surveillance and has shown an association with roxadustat treatment (frequency not known). Prescribers should consult the full summary of product characteristics in relation to other adverse reactions. **Overdose:** Single supratherapeutic doses of roxadustat 5 mg/kg (up to 510 mg) in healthy subjects were associated with a transient increase in heart rate, an increased frequency of mild to moderate musculoskeletal pain, headaches, sinus tachycardia, and less commonly, low blood pressure (all non serious). Roxadustat overdose can elevate Hb levels above the desired level; manage with discontinuation or reduction of roxadustat dosage and careful monitoring and treatment as clinically indicated. Roxadustat and its metabolites are not significantly removed by haemodialysis. **Package Quantities, Basic NHS cost:** EVRENZO (12 pack tablets): United Kingdom (UK): 20 mg = £59.24, 50 mg = £148.11, 70 mg = £207.35, 100 mg = £296.21, 150 mg = £444.32. Ireland (IE): POA. **Legal Classification:** UK: POM. Ireland POM/S1A **Product licence numbers:** Great Britain (GB): PLGB 00166/0427-0431. Northern Ireland (NI)/ IE: EU/1/21/1574/001-005. **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:** February 2023. **Document number:** MAT-IE-EVZ-2023-00002 **Further information available from:** UK: 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 SPCs which may be found at: GB: www.medicines.org.uk; NI: https://www.emcmedicines.com/en-gb/northernireland/; IE: www.medicines.ie.

United Kingdom **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.**

▼ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions.

CKD, chronic kidney disease. 1.EVRENZO SMPC. 2. Sanghani NS, Haase VH. Adv Chronic Kidney Dis 2019; 26:253–266.
MAT-IE-EVZ-2023-00007 I March 2023

astellas

Urge to Act

New European Association of Urology campaign aims for substantial transformation in EU-wide incontinence policies

INCONTINENCE is a major health issue that affects a large part of Europe's population, but is currently not receiving the focus and attention it should. It does not only have a significant impact on patients and their loved ones, but also national health systems, the economy, the environment and society.

The European Association of Urology's (EAU) policy office has initiated a new Europe-wide campaign, called 'An Urge to Act', which is aiming to achieve substantial change in EU policies relating to incontinence.

Urology week, which was recently celebrated at the end of September, also aims to bring attention to the issue.

Continence problems are a prevalent issue with consequences that are felt across all genders, regardless of age or socio-economic background. They are often the result of another condition or a side effect of treatment, are debilitating and often chronic, and can result in a serious negative impact on the patient's quality of life. Physical, psychosocial and economic consequences for patients and their carers are common.

While optimal continence health should be a reality for everybody, we must acknowledge that risk often correlates with age, and the burden of long-term care for people suffering from continence problems still falls disproportionately on women.

Speaking about the campaign Prof Philip Van Kerrebroeck, vice-chairman of the EAU's EU policy office, professor of urology at University of Maastricht and a clinical urologist at Maastricht University Medical Centre, Netherlands, said:"While interventions to prevent, manage and even cure incontinence exist, these interventions are not currently being implemented to their full potentiality."

The good news is that there are many ways to improve continence health, and a lot more can be done to reduce the burden on patients, their carers and society. The EAU's 'An Urge to Act' campaign calls for policymakers to recognise the burden of continence health problems, improve diagnosis and optimise patient outcomes in Europe through increased prevention, better care and access to supportive interventions, including treatment.

The campaign ties into European health initiatives such as collaborative programmes on non-communicable diseases and research, as well as European legislation on waste management, green policies and the classification of continence-related products. With the upcoming European elections this is the moment to act and to get continence health on the agenda.

European Association of Urology

The EAU represents the leading authority within Europe on urological practice, research and education. Over 19,000 medical professionals have joined its ranks and contributed to its mission to raise the level of urological care throughout Europe and beyond

Aims and objectives

- To act as the representative body for European urologists and facilitate the continued development of urology and all its supraspecialties
- To foster the highest standards of urological care throughout Europe
- To encourage urological research and enable the broadcasting of its results
- To promote contributions to the medical and scientific literature by its members
- To promote European urological achievements worldwide
- To establish European standards for training and urological practice
- To contribute to the determination of European urological healthcare policies
- To disseminate high quality urological information to patients and public

www.uroweb.org

Key issues

While interventions to prevent, manage, and even cure incontinence exist, these interventions are not currently being implemented to their full potential. Thus, many patients endure unnecessary suffering. On top of this, the associated healthcare costs, productivity losses, reduced quality of life, and ecological problems due to incontinence product waste impose substantial burdens on individuals, families and society. Healthcare professionals and informal carers are putting in a strong effort within the existing constraints of Europe's various healthcare systems.

According to the EAU, the current systems have not yet fully adapted to support continence care. The association says that policies and laws across Europe and in individual EU member states need to prioritise continence care, especially because of its prevalence and the vast availability of solutions. "If no action is taken to support continence health, continence problems will become one of the leading health issues in Europe. It is time to take urgent action and address the continence health challenge head on," it stated.

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

Your story matters.

Share it with us

The INMO's storytelling tool is now open to nurses and midwives across the country.

The tool is designed to capture stories from the working lives of nurses and midwives, to help us advocate and organise on the issues that matter most to our members.

Just scan the code and go to the website to tell us your story today.

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

Public Health Nurses Section Conference

Saturday, 11 November 2023

From 11am

Topics will include, amongst others:

- Human Trafficking and the role of nurses and midwives
- Expert review group - national updates
- Clinical updates to include wound management / Psychological and social development of children / Transgender children / Inclusion health

For more information contact: jean.carroll@inmo.ie
or visit www.inmoprofessional.ie

SCAN HERE

Take a break with WIN CROSSWORD Competition

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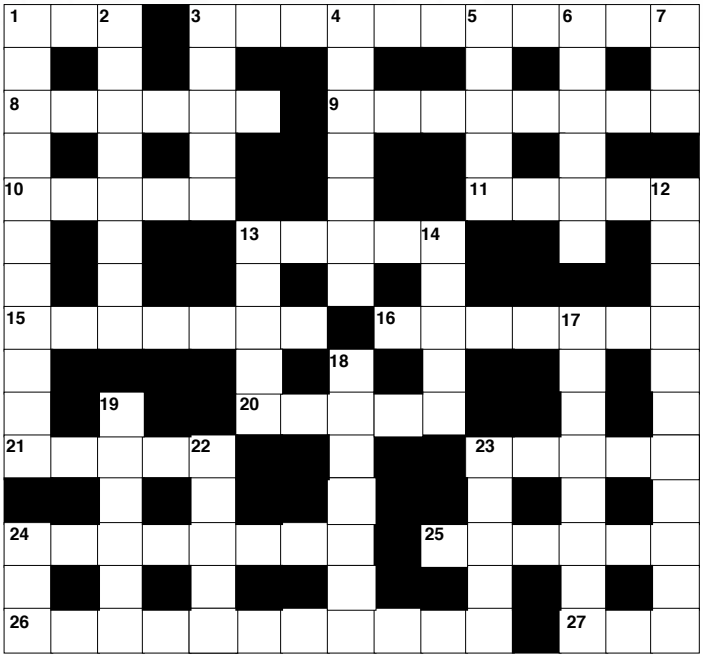
Across

1 A parish priest can use it on the phone (3)
3 Revealing nothing in conversation (5-6)
8 Swiss-style breakfast food (6)
9 In Gulliver's Travels, the Land of the Little People (8)
10 Ms Boyle has taken part in the census, annoyingly (5)
11 Chucked (5)
13 Nasal tone, or the sound of a plucked string (5)
15 The later part of the day (7)
16 A very welcome piece of good fortune (7)
20 Unclean, disorganized study (5)
21 Traditional dish with mashed potatoes (5)
23 Items of luggage, or histories of patients' conditions (5)
24 Soft drink (8)
25 See 22 down
26 Deadly condition put into tipsier form (11)
27 Number represented by the Roman Numeral X (3)



Down

1 & 2 A barometer measures it (11,8)
3 The claw of a bird of prey (5)
4 Vacation (7)
5 Cove, bay (5)
6 Italian river with a section Andy Warhol and others produced (3,3)
7 Morse code symbol (3)
12 Traditional prize for last place (6,5)
13 Having firm, well-defined muscles (5)
14 Great honour and acclaim (5)
17 Ability to see (8)
18 It's a Middle-eastern mixture of ale, Iris (7)
19 Tool, or the malleus (6)
22 & 25a Rooting pig I divert with some wine (5,6)
23 Ringlets (5)
24 Circuit of an athletics track (3)

Name:
Address:

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: **November 13, 2023.** Alternatively post your entry to: WIN Crossword, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Dublin A96E096

September crossword solution

Across: 1 Retrievers 6 Coma 10 Omega 11 Cormorant 12 Vehicle 15 Norms 17 Yard 18 Hoof 19 Recap 21 Robbery 23 Queue 24 Asti 25 Veto 26 Exile 28 Wrecked 33 Orchestra 34 Ernie 35 King Lear 36 Anemometer

Down: 1 Root 2 Therefore 3 Iraqi 4 Vocal 5 Rare 7 On air 8 Antiseptic cream 9 Foundry 13 Coco 14 Eyebrow 16 Chequebook 20 Cashew nut 21 Revered 22 Rake 27 Incan 29 Rearm 31 Stan

The winner of the September crossword sponsored by MedMedia is Anne McTigue O'Connor, Tuam, Co Galway

Older first-time mothers have higher breast cancer risk, study suggests

A STUDY observing changes in healthy breast cells may explain why women who have their first child later in life appear to have an elevated risk of breast cancer.

Researchers from Imperial College London examined healthy breast cells from 29 women who had given birth at different ages and women who did not have any children, to look at genetic mutations and how cells divide.

The researchers believe this is the first study of its kind to examine the entire genome of healthy, non-cancerous breast cells in women who have given birth at different ages. Key questions remain including whether breastfeeding, age at first period and menopause affect breast cancer risk.

Lead author of the study, Dr Biancastella Cereser, Department of Surgery and Cancer, Imperial College London, said: "In recent decades, women have begun having children later because of societal changes and personal preferences. Previous research has found that this is associated with a heightened breast cancer risk."

A woman's risk of developing breast cancer is influenced by pregnancy – but the relationship is complex. Several studies report that young first-time mothers have around a 20-35% lower risk of developing breast cancer in the long-term when compared with women who do not have any children. However, the risk of breast cancer then progressively increases for mothers who have their first child after the age of 24 – with a 5% increase in risk for every five years.

In the latest study, the researchers examined the cellular and genetic changes that take place in normal, healthy breast tissue in different groups of women: first-time mothers under 25 years; first-time mothers between 35 and 55; and women with no children (aged 25-53).

The research is published in the journal *Nature Communications*.

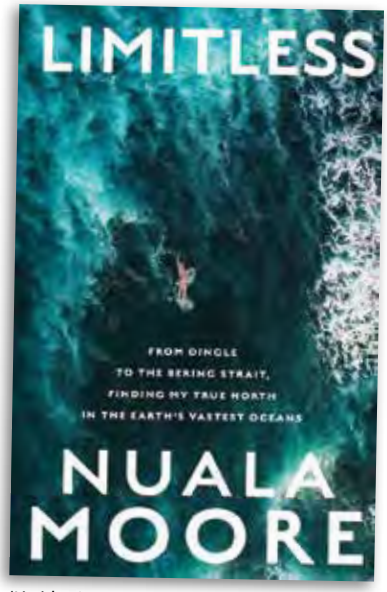
A breathtaking tale of life without limits

NUALA Moore is an Irish open water swimmer and adventurer who presented to the INMO Executive Council in March 2022 and the INMO Operating Department Section in October 2022 on strength and perseverance. She believes that everyone is capable of greatness, whatever shape that might take, and her presentations were well received by INMO members.

Limitless is her breathtaking new memoir, detailing what goes through her mind when she's in the water and how, when she returns home, she processes the fallout of pushing herself to the brink.

After years of marathon swimming, Ms Moore struggled to balance sacrifice and achievement. Her work-life balance, coupled with caring for her father, forced a change in her pathway. She turned to ice swimming. She has swum in some of the coldest, most remote and dangerous waters in the world, from the Bering Strait to the Drake Passage. These extreme situations offered her freedom and a chance to find her true north.

Ms Moore has spent decades as a scuba-diving professional and has been involved in developing standards and procedures both in ice and channel swimming. She holds two Guinness World Records for extreme cold-water swimming. She is a pioneer, a cold-water safety specialist, a coach, a mentor, an event organiser and an endurance swimmer who has pushed the boundaries for women in extreme sports. She is the first swimmer in the world to swim a mile from the Pacific Ocean to the Atlantic Ocean, in the Drake Passage.



'Limitless' is available from Gill Books at bookshops across Ireland

Ms Moore was awarded the Frank Golden scholarship for her work on cold water safety education. She founded Ocean's Triple 'R' (remote, recovery, rescue), a water safety initiative for sharing information around messaging.

She has been listed three times in the World Open Water Swimming Association's list of top 50 most adventurous women in open water swimming.

National youth mental health office established

A NEW HSE National Youth Mental Health Office has been announced by Minister for Mental Health and Older People Mary Butler.

The new national office will focus on delivering strengthened and more integrated supports for child and youth mental health care across Ireland.

The new office will provide for co-ordinated input across service, legislative and policy developments for all child and youth mental health areas, according to the Department of Health, from prevention and early intervention to the specialised Child and Adolescent Mental Health Service (CAMHS).

In addition, a new HSE national clinical lead for youth mental health has taken up post – Dr Amanda Burke – with a new assistant national director for child and youth mental health starting later this month. They will be supported by additional and dedicated staff for the national office.

The HSE says a key focus of the new office will be improved and centralised data collection and analysis to help inform new service responses for child and youth mental health.

Minister Butler described the new office as a "significant new initiative that will drive actual progress on the ground".

Reading initiative offers support for families of babies in neonatal ICU

THE Babies with Books Read-a-thon, an initiative to support families with a loved one in neonatal ICU, took place in September at more than 150 hospitals across the world, including at Children's Health Ireland (CHI) at Crumlin and Temple Street.

Bickay Lee-O'Reilly, neonatal clinical nurse specialist at CHI, said: "For families navigating the emotional journey of having a child in hospital, the experience can be overwhelming. The sight of wires, incubators and other medical equipment can create feelings of separation and helplessness.

"The simple yet powerful act of reading can help bring families closer together and support the developing brains of our youngest patients at CHI. The soothing rhythm of a parent's voice and colourful illustrations in children's books stimulate neural pathways, setting the stage for future learning and cognitive growth," Ms Lee-O'Reilly continued.

Esther Akhile with her newborn twins as the Coombe Hospital hosts its first Babies With Books Read-A-Thon, with support from Friends of the Coombe and Children's Books Ireland

The initiative is designed to help families feel more involved in their child's care and give them a sense of empowerment.

Olga, the mother of an eight-month-old patient at Crumlin's transitional care unit, said her son Conor, who has spent the past five months in CHI at Crumlin, enjoys following the pictures in his favourite book. Conor has had a tracheostomy procedure to help air and oxygen reach his lungs.

October

Wed 11
RNID Section meeting online from 11am on assisted decision making

Saturday 14
ODN Section annual conference. See *page 19* for further details

Monday 16
National Children's Nurses Section meeting. 11am online

Thursday 19
SALO meeting. 12.30pm. The Richmond and online

Saturday 21
PHN Section meeting. From 10.30am online

November

Saturday 4
Children's Nurses Section webinar from 11am

Saturday 11
PHN Section webinar from 11am

Monday 13
Nurse/Midwife Education Section meeting. 9am

Thursday 16
All Ireland Midwifery Conference
See *page 41* for further information

Wednesday 22
Assistant Directors Section masterclass. The Richmond from 11am

Wednesday 29
CPC Section meeting. 11am online

Thursday 30
OHN Section conference, Limerick. See *page 19* for further details

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

Condolences

- We offer our condolences to the family, friends and colleagues of Julian McCarthy on her untimely death. She was a long-serving member and nurse representative in Brothers of Charity, Upton, Cork. May she rest in peace.
- The North Tipperary Branch extends deepest sympathy to Ann Moore Dagg, CNM2, Nenagh Hospital, and her family following the recent loss of her father Joe Moore. May he rest in peace.

INMO Membership Fees 2023

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

Breastfeeding: The best start

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

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

WIN Recruitment & Training

Mailed directly to Irish nurses and midwives every month

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

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- Dublin based
- Night & Day Shifts part-time
- Reliable Staff/Continuity of Care
- Flexible Self Rostering (including midweek)
- 2 x Shadow Shifts
- Weekly payroll
- Free on-site parking
- NMBI/INMO or equivalent
- Excellent Interpersonal Skills
- English Language Fluency

Expressions of interest to:
recruitment@misneachhealthcare.ie

Night nurses needed

The Irish Cancer Society are seeking Registered General Nurses 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

Irish Nurses Rest Association

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

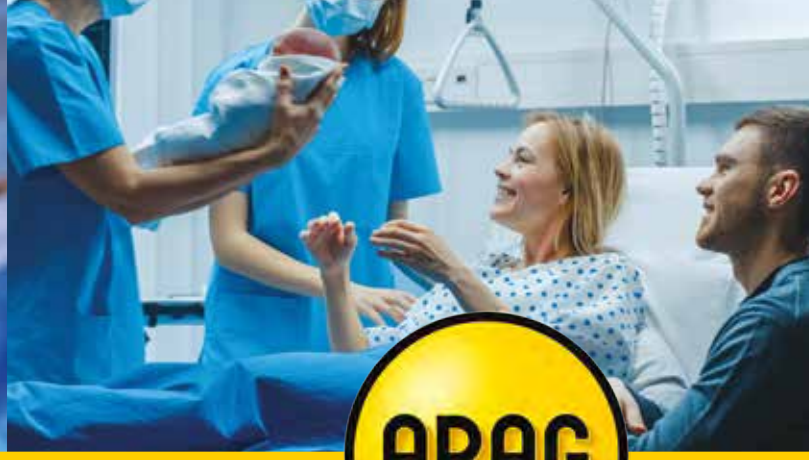
Please send applications to:
Ms Margaret Philbin, Rotunda Hospital, Dublin 1.
email: mphilbin@rotunda.ie

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

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

Submit your review to nursing@medmedia.ie

Word count: 400



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

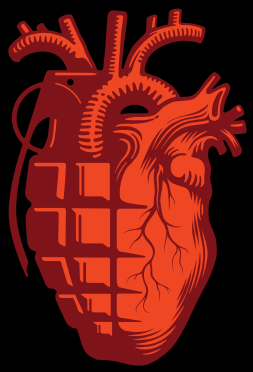
ATTR-CM

SUSPECT & DETECT

UNCOVER THE CLUES FOR DIAGNOSIS

SUSPECT ATTR-CM

(TRANSTHYRETIN AMYLOID CARDIOMYOPATHY)



A LIFE-THREATENING DISEASE THAT CAN GO UNDETECTED

Life-threatening, underrecognized, and underdiagnosed, ATTR-CM is a rare condition found in mostly older patients in which misfolded transthyretin proteins deposit in the heart.[1-7] It is vital to recognize the diagnostic clues so you can identify this disease.

CONSIDER THE FOLLOWING CLINICAL CLUES, ESPECIALLY IN COMBINATION, TO RAISE SUSPICION FOR ATTR-CM AND THE NEED FOR FURTHER TESTING

HFpEF — heart failure with preserved ejection fraction in patients typically over 60 years old[5-7]

INTOLERANCE — to standard heart failure therapies (ACEi, ARBs, and beta blockers)[8-10]

DISCORDANCE — between QRS voltage and left ventricular (LV) wall thickness[11-13]

DIAGNOSIS — of carpal tunnel syndrome or lumbar spinal stenosis[3,8,14-20]

ECHO — showing increased LV wall thickness[6,13,16,21,22]

NERVOUS SYSTEM — —autonomic nervous system dysfunction-including gastrointestinal complaints or unexplained weight loss[6,16,23,24]

LEARN HOW TO RECOGNIZE THE CLUES OF ATTR-CM AT:

SUSPECTANDDETECT.IE

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Date of Preparation: February 2021 GCMA code: PP-RDP-IRL-0105

Pfizer Rare Disease