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# WIN

Journal of the Irish Nurses and Midwives Organisation

World of Irish Nursing & Midwifery

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# ED overcrowding

Acute hospital nurses won't be taken for granted this winter

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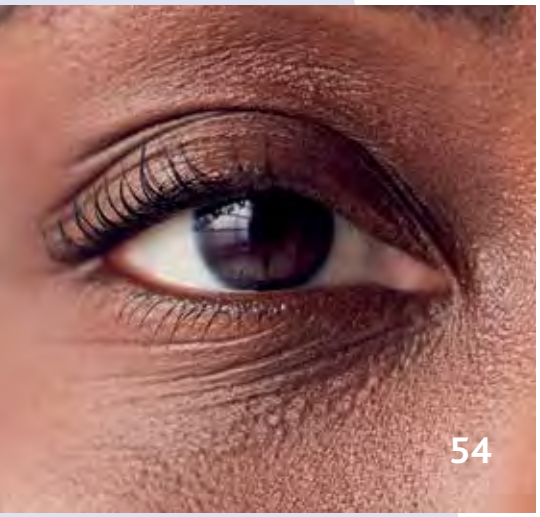


***On the cover this month:***
*Front to back: Dianne Lopez, Mary Dunne, Jan Hailey Reyes, Ralph Brennan, Isabel Redulla and Emma Morake*

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## JOBS & TRAINING



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# Breastfeeding: The best start

## Health benefits for infants

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

## Long-term benefits for children

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

## Benefits for mothers

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

## Support for mothers is essential

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

## Work and breastfeeding

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

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

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# Hiring freeze is breach of agreement

ON NOVEMBER 10 the HSE announced that the recruitment moratorium in place for clerical grades until the end of the year would now be extended across all grades, including nursing and midwifery posts, with the exception of 2023 nursing and midwifery graduates and consultants. The Framework for Safe Staffing and Skill Mix, which is government policy, sets out minimum numbers of nursing and healthcare assistant staff required across the health service, and it clearly shows that the reduced staffing levels that will result from this moratorium will make healthcare facilities less safe for patients and staff.

Those who experienced recruitment freezes in the past will understand the long-term effect this has on staffing. In December 2007, there were 39,000 full-time/whole-time equivalent (WTE) nursing and midwifery posts in the health service, but following the 2007 moratorium this number dropped to approximately 34,000 and it was mid-2020 before nursing and midwifery WTEs recovered to the 2007 level.

Today, following a massive campaign to recruit nurses from other countries, amid fierce global competition for nursing and midwifery staff, there are 44,893 WTE posts, including 900 students completing their training. In addition, there are approximately 2,800 unfilled funded nursing and midwifery positions – positions that are urgently required to ensure the safe provision of care over the coming months.

Furthermore, in response to questions about positions for 2024, HSE chief executive Bernard Gloster stated there would be an additional allocation of 2,268 WTE healthcare posts. However, this is neither adequate nor is it even equivalent to the 2,800 already-funded posts in nursing and midwifery alone that the HSE now says will not be filled.

As part of our response to this decision, the INMO will be asking the HSE what has been done with the money allocated to these funded nursing and midwifery positions and what the HSE's staffing plan will be for 2024 in order to meet its own commitments and implement its own safe staffing policy.

The INMO estimates there is currently a need for approximately 600 additional posts in maternity care and 600 additional posts in public health nursing and we would like to know how the HSE plans to recruit adequate staff in the coming months to ensure this necessary growth.

It is simply not safe to impose a recruitment ban in nursing and midwifery and expect the existing staff to proceed to open new, much needed, services while providing care in an increasingly overcrowded health service.

Health inflation is well documented, as are the post-Covid costs. The health budget covers many areas that need to be more appropriately allocated to other government departments, such as social welfare, all of which means that increases in health budget allocation are well justified. However, those tasked with making the necessary arguments around health spend at the national level failed to make clear the consequences of turning off the recruitment tap. Instead, they have taken the fallback position of employment control, with consequences borne by healthcare staff and their patients.

It is imperative that we retain the nursing and midwifery staff currently in Ireland and encourage those working away to return home, but this decision sends a clear message to Irish nurses and midwives abroad not to bother returning. In the current global competition for nursing and midwifery resources, sending this message is the very definition of an own goal.

Given the serious impact of this recruitment freeze, the Executive Council has deemed it to be a breach of the 2019 strike settlement agreement and has instructed that engagement take place with members to consult on potential industrial action. I urge all members to attend all meetings when they are notified to you, to demonstrate your objection to using existing staff to pay the price for poor financial management within the HSE.

**Phil Ní Sheaghdha**
**General Secretary, INMO**

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# EXECUTIVE COUNCIL ELECTION 2024

All members are asked to note that 2024 is an election year for election, to the Executive Council, for a two year period (2024-2026). Elections will be conducted under the revised new Rule Book (Rule 8) adopted at the ADC in May 2021.

## ELIGIBILITY FOR NOMINATION TO EXECUTIVE COUNCIL (RULE 8)

Nominations for the Executive Council shall be submitted, on the appropriate form, to the General Secretary, on, or before, 5pm on Wednesday, **February 14, 2024.** To be eligible for membership of the Executive Council a member must:

**i)** have been a paid-up member of the Organisation, for not less than two years prior to the date of her/his nomination, and be on the Live Register of the Nursing and Midwifery Board of Ireland (NMBI); and

**ii)** be proposed and seconded by Officers of their Branch or Section following endorsement of the candidate by that Branch or Section.

**To be eligible for election as an undergraduate student nurse/midwife member of the Executive Council an undergraduate student must:**

**i)** have been a member of the Organisation for not less than six months prior to the date of her/his nomination; and

**ii)** be proposed and seconded by undergraduate student nurses/midwives who have themselves been members of the Organisation for not less than six months or be proposed and seconded by Officers from their Branch.

## COMPOSITION OF THE EXECUTIVE COUNCIL

### Clinical: 16 seats

Includes all grades of Registered Nurse and Midwife (other than those eligible to go forward under the Education and Management Categories below), to be filled as follows:

**i)** Registered General Nurse - at least two seats
Registered Midwife - at least one seat
Registered Nurse Intellectual Disability - at least one seat
Registered Sick Children's Nurse - at least one seat
Registered Public Health Nurse - at least one seat;

**Please note persons elected, to these reserved seats, must be on that register and engaged in clinical practice in that discipline.**

**ii)** If these reserved seats are not filled, via the 16 candidates with the most votes, then they must be filled with reference to the next highest candidate, from that discipline, who is engaged in clinical practice in that discipline.

**iii)** If there are no candidates meeting any of the six reserved seats (clinical) then the seats shall be filled by the candidate with the highest vote in the clinical category.

### Education: 2 seats

**i) One seat to be filled by members from all grades of Nurse/Midwifery Teachers, Clinical Teacher, and/or others with a Nurse/Midwifery Teaching qualification who are actively engaged in nurse/midwifery education.**

**ii) One seat to be filled from members who are working in the wider field of nurse/ midwife education and its management including Clinical Placement Co-Ordinators/Clinical Placement Facilitators/Specialist Co-Ordinators and Nurse/Midwife Practice Development Co-Ordinators.**

### Management: 3 seats

**Includes all members at, or above, Clinical Nurse Midwife Manager 3 who are actively engaged in management.**

### Undergraduate Student Nurses/Midwives: 1 reserved seat

**Includes all undergraduate Student Nurses/Midwives/New Graduates up to 24 months qualified.**

- Provided always that only those grades for whom the Organisation has negotiation rights shall be a member of the Executive Council
- In the event of any of the seats allocated to the Education and Management categories not being contested, then those seats shall be filled by the candidates, in the **Clinical Category,** who receive the next highest vote, or votes, after the initial filling of the 16 seats taking into account the six reserved clinical seats.
- In the event of any dispute, as to the category for which a member may be eligible for election, then the Executive Council shall determine the category under which a member is eligible to contest the election.

## ELIGIBILITY FOR OFFICE OF PRESIDENT AND VICE PRESIDENTS (RULE 9)

**9.1.1** The President, first Vice-President (Honorary Treasurer) and second Vice-President shall be elected at the **2024** Annual Delegate Conference at which elections are scheduled.

**9.1.2** A separate election shall be held for President, first Vice-President and second Vice-President, and such elections shall be by secret ballot of all voting delegates at the Annual Delegate Conference.

**9.1.3** The elected candidate must secure an overall majority by exceeding 50% of the eligible votes cast. If no candidate has achieved an overall majority, as aforesaid, then the candidate, or candidates, receiving the lowest vote or votes, if their combined vote is less than the total vote of the highest candidate, shall be eliminated and a further ballot shall take place immediately.

**9.1.4** If there shall be a tie, another vote shall be taken, and if the result is still a tie, the outcome shall be decided by lot (drawing the name of the successful candidate) by the chairperson of the Standing Orders Committee.

**9.2** To be eligible for election to the office of President or Vice-Presidents she/he shall have been an elected member of the incoming Executive Council and shall have been a member of the outgoing Executive Council for the term immediately preceding her/his election.

**9.3 Nominations for the office of President, first and second Vice Presidents, together with their written consent must be submitted in writing to the General Secretary not later than 21 clear days before the Annual Delegate Conference for notification to delegates to that meeting at which the election will take place. (Closing date for receipt of nominations is 5pm on Tuesday, April 9, 2024).**

**9.4** The President shall preside at the Annual Delegate Conference and Special Delegate Conferences held during the year and at all Executive Council Meetings. In the absence of the President the first Vice-President shall take the Chair; in the absence of the first Vice-President the second Vice-President shall take the Chair.

**9.5** The office of President shall not be held by the same person for more than two consecutive terms.

# A positive focus with the president

Karen McGowan, INMO president

## Season's greetings

IT IS that time of year again where on behalf of the INMO I would like to wish you all a peaceful Christmas and happy new year. I hope that you will all have some time to rest and be with friends and family over the coming weeks. It has been another challenging year and the HSE's planned recruitment moratorium will only exacerbate existing issues. Rest assured that the INMO will continue to fight on your behalf and I urge you to attend the upcoming information meetings in relation to potential industrial action.

## Changing the narrative on women's health

I AM a firm believer that if you give people the skills and information required it can assist them to make informed decisions. Nursing and midwifery have a 93% female workforce and the INMO is working with ICTU on a campaign to stop the stigma in relation to women's health in the workplace *(see page 15)*. As women we are still battling against our health being a taboo subject so it is absolutely necessary to change this narrative ourselves.

*Karen McGowan and attendees pictured at the first Ladies Lounge event held at Beaumont Hospital, Dublin*

I recently hosted the first 'Ladies Lounge' at Beaumont Hospital. The idea came to me from looking after women in the gynaecology department and working in a predominantly female workforce. It became clear that there was a need for women to voice questions about issues that affect them in a safe and comfortable environment. From the results of the INMO survey on menopause in the workplace, it is evident that better support is required so this became the topic of our first meeting.

Our first session was on perimenopause and menopause and was delivered by Dr Shayi Dezayi, gynaecology registrar and menopause specialist at Beaumont Hospital. Dr Yvonne Hartnett, senior registrar in perinatal health at the Coombe Hospital, covered mood disturbance in perimenopause and menopause. Women's health physiotherapist at Beaumont Hospital, Lisa Ringwood, delivered a practical session on pelvic floor health. We finished with a restorative yoga session delivered by nurse and menopause coach, Shaunna Nolan. After each speaker there was an opportunity to ask questions which enabled a lot of people to engage further. There was a relaxed atmosphere and attendees really engaged with the topics. These conversations further support staff with the information needed to make their own decisions.

By dedicating the Ladies Lounge to open discussions on health issues that affect women we hope to foster a positive culture within the hospital that normalises menopause and other women's health issues. The future vision for the lounge is to cover all aspects of women's health, from menstrual bleeding to menopause.

The Ladies Lounge is open to everyone in Beaumont Hospital. Menopause was topical this time as it affects everyone at some stage and each individual differently, but how we deal with it has changed over the years. The Ladies Lounge is a safe and confidential space to open the conversation and support each other. This is an opportunity to be inclusive and empowering to fellow colleagues. We had fantastic attendance on the day and a great atmosphere. The next Ladies Lounge is being planned following suggestions made by attendees. I am proud of this initiative and I'm further motivated by the feedback from the women who attended. We plan to spread the word further among our colleagues in order to open this opportunity up to more people in the workplace.

# Executive Council update

THE Executive Council met virtually and in person a number of times over the past month. There are a number of issues ongoing nationally but none as pertinent as the recent recruitment embargo announced by the HSE. The Executive met on November 10 in emergency session to consider potential industrial action in response to this. It was decided that we would immediately engage with members with a view to consulting on a ballot for industrial action to protect nursing and midwifery practice and patient safety. It is shocking that this announcement was made in this manner and we will not stand for it.

Section 39 industrial action was also discussed at this meeting. A proposal was negotiated under the auspices of the Workplace Relations Commission which includes pay adjustments of 8% and a mechanism for determining future pay for workers in these organisations. Information sessions were organised and members were balloting as *WIN* went to print.

The European Federation of Nurses (EFN) held its General Assembly in Madrid in October. This was a great opportunity to raise issues and share knowledge and to progress issues by lobbying at European level. The General Assembly was attended by INMO general secretary Phil Ní Sheaghdha and INMO head of professional services Tony Fitzpatrick, who was elected to the EFN Executive Council. I want to pay tribute to outgoing EFN president Elizabeth Adams who led so well during her tenure in office. Her professionalism and leadership have been exceptional and has made us so proud to have an Irish EFN president.

The INMO's planning committee for ADC 2024 met recently and plans for the conference are going well. This is an election year so if you are interested in joining our Executive Council please put your name forward for election at your next Branch or Section meeting.

## Get in touch

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

# Legislation to underpin safe staffing framework urgently needed

LEGISLATION to underpin safe staffing is urgently needed in order to protect patients, the INMO Executive Council stressed last month. .

The Executive is calling on members to resist any instances where they feel compelled to deviate from safe practice. Members must ensure they are not being asked to provide ever increasing services with a reduced workforce.

INMO general secretary, Phil Ní Sheaghdha said: "The INMO Executive Council has reinforced the position that safe staffing underpinned by legislation is urgently required in order to protect patients no matter where they are in the system.

"The INMO will now commence a process of engagement with its members to ensure any instances where they are compelled to deviate from safe practice are resisted to ensure they are not being asked to provide ever increasing services with a reduced workforce.

"Behind the trolley figures that the INMO publishes every day are extremely vulnerable patients being treated in undignified and dangerous conditions. It is shocking that the necessary measures have not been taken by the HSE and individual hospital groups to alleviate gross overcrowding."

***Emergency response:*** *As overcrowding continues unabated in acute hospitals across the country, INMO acute hospital representatives met to discuss how they can ensure safe practice*

The INMO has been calling for a solid plan to deal with hospital overcrowding with a strong emphasis on infection control since early summer. The Organisation is urgently looking to meet each individual hospital group to hear how they plan to deal with the overcrowding crisis that is materialising in the vast majority of Irish hospitals and how they will protect staff and the patients in their care.

"Our members are concerned about the spread of infections such as Strep A, Norovirus and indeed Covid-19. It is clear that the spread of viruses is going to have a detrimental impact on patient flow throughout our hospitals over the coming weeks.

## October overcrowding

Over 10,538 patients including 273 children went without a bed in October 2023. The top five most overcrowded hospitals were:

- University Hospital Limerick, 2,043
- Cork University Hospital, 1,034
- Sligo University Hospital, 730
- University Hospital Galway, 662
- Mater University Hospital, 609.

Ms Ní Sheaghdha said: "We know that there are less staff to deal with the growing demand in our health system and that it has a knock on impact on both patient and staff safety.

"Unsafe staffing levels are going to be a feature of this winter unless we see targeted recruitment and retention plans in each hospital and community care area to allow for more nurses and midwives to be recruited at the pace at which we need them.

"Again this winter, our members are not assured that their safety and that of their patients is a priority. The HSE and government must outline what steps are being taken both at national and local level to dramatically reduce the number of patients on trolleys."

# Overcrowding record broken in UH Limerick

A RECORD-BREAKING 130 admitted patients were on trolleys in University Hospital Limerick on Monday, October 23, 2023 – almost a quarter of the shocking total of 563 patients nationwide without a bed that day.

INMO assistant director for industrial relations for the Midwest, Mary Fogarty said: "These record-breaking trolley figures in UHL come as no surprise to INMO members who have been working in overcrowded and understaffed wards with no reprieve for years on end. The fact that there are more patients on trolleys across the hospital than in the emergency department itself is making the provision of safe and timely care impossible. Patient flow out of ED is proving difficult because of the sheer volume of trolleys across the hospital.

"Our members are burned out and demoralised as a direct result of their working conditions. It is impossible for them to provide safe care in a working environment that is persistently dangerous. INMO members in the hospital met to discuss their grave concerns about their safety and that of their patients. They feel that none of the interventions directed by hospital management have had any positive impact to date. Hospital management and the HSE must outline what targeted interventions they intend to carry out to take the pressure off our members for the sake of patient safety."

# Recruitment freeze compels INMO to consult on industrial action ballot

## HSE decision will send Irish health service into free fall

IN IMMEDIATE response to the HSE's recruitment freeze being extended to nursing and midwifery staff, the INMO Executive Council held an emergency meeting on Friday, November 10, 2023 to discuss potential industrial action.

The announcement that the HSE was extending its recruitment freeze to almost all nursing and midwifery grades until the end of the year, with the exception of 2023 graduates, is a "serious error" by the employer, which will have a "disastrous" impact on the provision of care, according to the INMO.

The HSE's announcement came without documentation and without consultation with the union. Furthermore,the HSE declined a request for a meeting.

The INMO Executive Council issued a statement that it would immediately engage with members with a view to a ballot for industrial action to protect nursing and midwifery practice and patient safety.

The INMO also stated it calculated there are currently approximately 2,800 nursing and midwifery funded vacancies in the health service, which urgently need to be filled.

INMO general secretary Phil Ní Sheaghdha said: "This recruitment freeze represents a serious error on the part of the employer, and the impact on the provision of care is going to be disastrous.

"While we welcome all increases in bed capacity that have been made in the past year, increases in beds must mean increases in staffing. Anything other than this means our members are being set up for an unacceptable level of risk to their practice and their wellbeing.

"In the years that we have been surveying our members on their intention to leave the health service, the numbers keep increasing. This is due to the inordinate amount of stress being placed on them in overcrowded and understaffed environments.

"This measure has the potential to force even more nurses and midwives out of their jobs and out of the country, and that itself poses a long-term risk to the health service and to the people who depend on it.

"We have been raising the alarm since late summer that we are on track for a winter of severe overcrowding. What is urgently needed is a meaningful implementation of the safe staffing framework that guarantees a minimum number of nurses and healthcare assistants per patient, based on dependency and environment. This framework, which is government policy, must be underpinned by legislation to protect patient care delivery from unsafe decisions like this announcement by the HSE, which takes us in completely the wrong direction."

*See also page 5 & 12*

# Donation to Irish Red Cross efforts in Gaza

THE INMO Executive Council took the decision in October to make a substantial donation on behalf of INMO members to the Irish Red Cross humanitarian effort in Gaza.

INMO general secretary Phil Ní Sheaghdha said: "The INMO unequivocally condemns the scenes in Israel and Palestine that have occurred in recent weeks. Our thoughts and sympathies are with all those who are suffering because of the ongoing conflict in Israel and Palestine.

"Our fellow healthcare workers in Gaza need immediate international intervention and assistance as they desperately try to provide life-saving care in an impossible situation.

"We are urging the Irish government to use its influence to ensure that the key asks of the World Health Organization are listened to."

INMO president Karen McGowan said: "We echo the WHO's call for hostages to be released and for them to receive medical treatment. Life-saving supplies should be provided to healthcare workers urgently.

"The support to those that provide care in a humanitarian crisis should never be conditional."

# NMBI annual registration renewal now underway

THE facility to renew your registration and pay the annual retention fee for 2024 opened on October 25 this year.

The Nursing and Midwifery Board of Ireland (NMBI), as the independent regulator, requires that nurses and midwives update their relevant information with it annually and also pay the annual retention fee.

This is a process the NMBI undertakes independently, however, it is a process that the INMO monitors carefully, as non-payment of the fee results in loss of registration in accordance with the Nurses and Midwives Act 2011.

The process will remain open until January 31, 2024. The extension in time to complete the process was previously secured following representations from the INMO. The INMO will continue to monitor the experience of our members carefully. If you encounter difficulties, they should be raised with the NMBI, but do also let your union official know so that the Organisation can ensure issues of concern are addressed by the NMBI.

The NMBI sends renewal notices by email to all registrants with instructions on how to renew online. The renewal process should not be started without this notice. If you do not receive a renewal email, contact the NMBI customer care centre at Tel: 0818 200116 or email: regservices@nmbi.ie to request your notice.

**– Edward Mathews, INMO deputy general secretary**

## World news

*Nurses and midwives in action around the world*

**Canada**
- Amid crisis more than 7,300 internationally educated nurses waiting to be registered to work in Ontario
- Vote by the 80,000 members of FIQ – healthcare professionals to begin strike on November 8 and 9
- British Columbia's healthcare worker shortage is hurting patients

**France**
- Bonuses for caregivers at work during the 2024 Olympics: "The remuneration is not up to par", judges a nursing union

**India**
- Why India is facing a mass exodus of nurses

**New Zealand**
- Minimum ratio of nurses to patients should be set in law, says union

**Philippines**
- Healthcare workers stage protest to demand salary increase

**Portugal**
- Nurses go on overtime strike until the end of the year

**Spain**
- Union denounces "lack of interest" from the Ministry of Health to develop the categories of specialist nurse

**UK**
- Workforce data reveals rise in retired nurses returning to NHS

**US**
- Safe Patient Care Act: Michigan's proposed nursing laws part of national trend
- New Jersey nurses are on strike for better staffing
- Health worker burnout reaches 'crisis levels' as harassment doubles, says Centers for Disease Control

# Budget failed to address nurse/midwife retention

BUDGET 2024 failed to focus on the continuing major problem of retaining nurses and midwives in the Irish health service, the INMO said.

Responding to the Department of Health measures of Budget 2024, INMO general secretary Phil Ní Sheaghdha said: "Since December 2019, we have seen an insufficient amount of additional whole-time equivalent staff nurses recruited each year. Currently, we have over 400 vacancies in emergency departments alone, we have seen an exodus of midwives from the public health service and there is a recruitment crisis in public health nursing. The HSE has acknowledged that there is a higher than normal turnover in nursing and midwifery, but Budget 2024 clearly does not allocate sufficient resources needed to fund the numbers required to guarantee the safe staffing framework, which is the government's own policy.

"With an ageing population and record attendances at EDs, the need for a thriving nursing and midwifery workforce in both acute hospital and community settings has never been greater.

"At the departmental briefing on the Budget, the Health Minister announced the establishment of a 'productivity taskforce', what is really needed is a retention taskforce. There is a real crisis facing the health sector when it comes to retaining our highly trained nurses and midwives who are leaving in their droves for better opportunities abroad or outside of the public healthcare setting.

"Traditionally young nurses and midwives went abroad for a year or two, now they are leaving for much longer periods, or indeed for good, because safe nurse and midwifery staffing levels are taken as a given in other jurisdictions. Because of the conditions both in our hospitals and in the housing sector, we are fearful that safe staffing will not be a reality in our hospitals anytime soon.

"In order to ensure that young nurses and midwives see Ireland as a viable place to work and thrive on graduation, the government must do more to reduce the cost of living near the large hospitals in Dublin, Cork and Galway. The government will have to go further than a tax credit for renters to keep the future of our health service here.

"A laser-like focus on retaining nurses and midwives in the public health service is required now more than ever."

# HIQA inspection reports highlight urgent need for safe staffing

THE level of unfilled clinical posts as outlined in the latest hospital inspection reports from the Health and Information Quality Authority should be a cause of concern for the government, the INMO has commented.

INMO general secretary Phil Ní Sheaghdha said: "The INMO commends the work of HIQA in highlighting the often very dangerous conditions that patients are being treated in and Irish nurses and midwives are working in.

"The HIQA inspection reports published recently highlight the very serious staffing problems that exist in Irish hospitals. They report on inspections carried out in early spring and we know the staffing and overcrowding situation in acute hospitals has become much worse since then.

"In the most recent reports published referencing the situation in April, we know that there was 18% nursing deficit in the emergency departments in Mercy University Hospital and in Portiuncula University Hospital and a 13% nursing deficit in the EDs in St James's University Hospital.

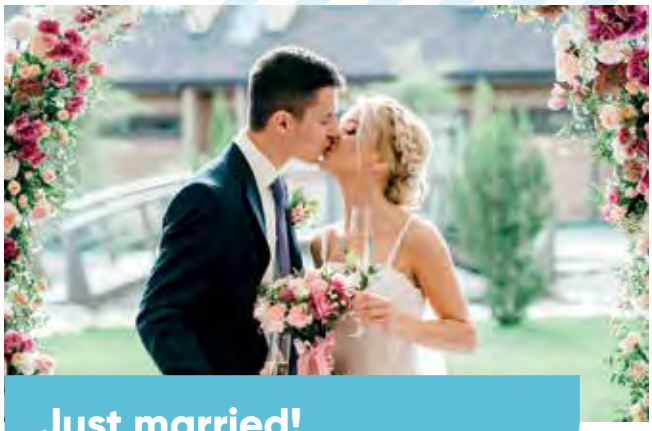
"With these most recent reports and a litany of others by HIQA, the government should not fathom allowing a recruitment freeze of patient-facing staff to happen at this time. With staffing now worse and overcrowding more extensive, not having full clinical staffing complements across all hospital sites will make it much more difficult for the staff who are working in hospitals to carry out their roles safely.

"Successive reports from HIQA highlighting the impact of unsafe staffing prove that safe-staffing underpinned by legislation is urgently needed. HIQA issue recommendations but have no legislative function to ensure they are adhered to. The reports by HIQA detail the stark reality of unsafe working and patient care but without a legislative basis, their recommendations seem to be falling on deaf ears."

The full HIQA inspection reports can be accessed on **www.hiqa.ie** under the 'reports and publications' tab.

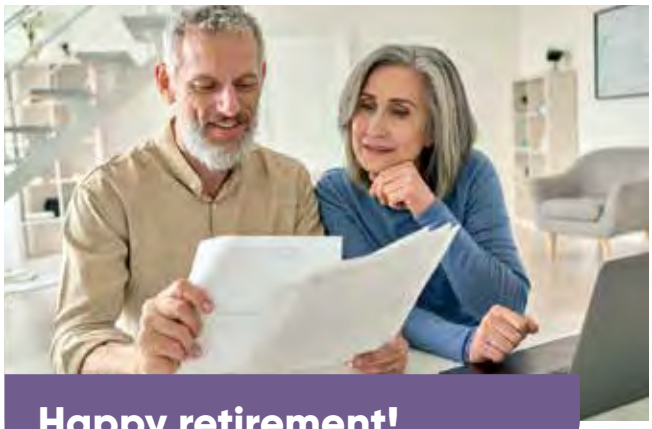
# Nurses, those exciting moments can mean changes to your **tax situation**

**New job!**



**Just married!**

**Sending kids to college**



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*Source: Cornmarket PAYE Tax Return client statistics, 2023.



18314 Tax Win Ad 11-23

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

# NJC and INMO vigorously oppose extension of recruitment freeze

THE staff panel group of unions of the National Joint Council (NJC) for the health service was informed on Friday, November 10, 2023 of the HSE chief executive's intention to announce the embargo on all staff appointments to be extended until the end of the year.

This extended the recruitment embargo announced in October for clerical and support grades, with the embargo now applying across all grades with the exception of 2023 graduate nurses/midwives and consultants.

The NJC staff panel was not consulted on this extension of the embargo, which is in breach of the requirement for proper consultation with the unions in relation to such matters. The staff panel immediately requested an urgent meeting with the HSE but the HSE declined to meet with the staff panel on this matter.

The unions have now begun consulting with their respective executive councils and members on their response to this announcement. The INMO Executive Council convened an emergency meeting on November 10 in response to the announcement and agreed to consult with members on the possibility of balloting for industrial action.

The NJC staff panel and the INMO will vigorously oppose this decision over the coming weeks and represent to the employer the very serious and long-term consequences for staffing and safety that will result from any pause in recruitment.

The INMO will also make it very clear that the effect of this embargo and the freezing of appointments will be to encourage healthcare staff to seek employment abroad, particularly in the UK and Australia, amid stark shortages and fierce global competition for nursing and midwifery resources *(see page 9)*.

# NJC talks continue on several national issues

DISCUSSIONS are ongoing on several issues at the National Joint Council (NJC). This is the primary forum for managing industrial relations in the health service, which involves joint talks between the unions and the HSE on changes to conditions of employment and other issues of concern.

### Covid-19 and long Covid

The Department of Health has confirmed that the INMO's request for an extension to the Special Leave With Pay for Covid-19 scheme has been approved by the Department of Public Expenditure. The temporary scheme was due to expire on October 31, 2023 and will now be extended until March 31, 2024. This arrangement will apply to those currently on this scheme only.

Meanwhile, a full Labour Court hearing took place on October 27, 2023 regarding the long Covid claim. Members will be updated on this shortly.

### Extended working week

Since the HSE began its recruitment pauses, the staff panel has been requesting an urgent meeting with HSE chief executive Bernard Gloster. Meanwhile, the INMO has advised members not to take on any additional duties that may be asked of them as a result of the recruitment pause.

This has impacted talks with the HSE in relation to the extended working week. The unions took the stance that continuing such talks were not appropriate given the HSE's extension of the recruitment embargo. The unions will consider re-engaging with the employer on an extended working week following a meeting on the recruitment pause with Mr Gloster.

### Vexatious complaints and serial offenders policy

The unions stated their concerns regarding sections of the HSE policy for dealing with vexatious complaints. The unions stated the sections in relation to vexatious complaints and serial complainers needed to be strengthened in order to protect staff from both internal and external complainants.

The HSE stated that there was an accompanying document of 120 pages which has been submitted to the senior management team at the HSE which is still awaiting sign off and this document would give support in relation to these matters. The employer agreed that these sections should be reviewed and the unions requested a copy of the full document. We will keep members informed of progress on this matter.

### National Investigations Unit

Prior to the announcement of the HSE recruitment embargo the HSE had been sanctioned to commence a new competition for the appointment of up to 10 investigators on a full-time fixed term basis to the National Investigation Unit. However, since the announcement of the recruitment embargo, it is understood that this competition cannot proceed unless a derogation is granted by the HSE chief executive.

Prior to the embargo, and with regard to the composition of investigating teams, the INMO had put forward a case for the inclusion of nursing/midwifery representatives in order to ensure adequate clinical and professional expertise in the investigations.

There were a number of meetings with the HSE on this matter but no agreement was reached. It was therefore decided to revert to Mr Kevin Duffy, former Labour Court chairman, whose report in 2018 recommended the establishment of a National Investigation Unit.

Following lengthy discussions in October it was agreed that where a complaint related to a clinical or professional matter and the investigator was not from that discipline, then an assessor would be appointed to review the entire evidence in conjunction with the investigator. It was agreed that a protocol would be developed to deal with this matter. This is a positive outcome which will assist in resolving this issue.

on recent national issues

# Round up of industrial action

## Strike notice served on Section 39 and 56 facilities

**Section 39, Section 56 and Section 10 organisations**

In a claim for implementation of terms under Building Momentum, the Executive Council approved the serving of strike notice on a number of Section 39 and 56 facilities employing INMO members, in coordination with colleagues in Fórsa and SIPTU. These facilities include Enable Ireland, Cheshire Ireland, Ability West, Co-Action and St Joseph's Foundation.

The Workplace Relations Commission intervened on October 16, 2023 and, following intense discussions at the WRC, a set of proposals emerged which it was agreed would be put to members in the various unions.

At an Extraordinary Meeting on October 17, the Executive Council endorsed the decision to suspend the industrial action in order that our members in these employments could consider the proposals.

In summary the proposals offer a pay increase of 8% including an element of back pay to April 1, 2023. Furthermore, the proposals provide a process for dealing with the issue of pay parity and, subject to acceptance of the proposals, there will be ongoing discussions on outstanding matters with the WRC no later than December 1, 2023. The government is fully committed to dealing with the issues of pay over the course of the next Public Service Agreement.

Information sessions were planned for members concerned with a view to conducting a further ballot on the proposals through November.

**CUH staff car park**

A communication was circulated to Cork University Hospital staff on October 19, 2023 that there were plans to close staff car parking spaces from October 23, despite management having made a firm commitment that there would be no changes to the current parking arrangements until there was further consultation with staff and the trade unions.

The issue was escalated following an email to staff and a demonstration was planned at which it was intended industrial action would be announced. However, following INMO engagement, management advised that the planned closure of the onsite car parking would not proceed and that they would engage with the union to resolve the matter.

**St John's Hospital, Limerick**

Despite numerous local engagements management at St John's Hospital, Limerick have failed to stabilise the nursing vacancies and the skill mix over several months. Members are calling for bed closures on each of the three inpatient wards, in order to reduce risks to patient safety in the context of staffing shortages and a 23% vacancy rate. However, due to the failure to resolve the high vacancy rate the union has no option but to pursue industrial action , which has been approved by the Executive Council *(see page 17)*.

# PHN/CNM2/CMM2 salary scales – change on way

FOLLOWING a lengthy process, the Labour Court has stated that recommendations 44-46 from the Expert Review Group into Nursing and Midwifery should be implemented. These are:

- (44) The public health nurse salary scale to be merged with that of the current clinical nurse/midwife manager 2 salary scale
- (45) Extend the revised PHN/CNM2/CMM2 salary scale by the addition of one further scale point and the introduction of a long service increment
- (46) The specialist/location allowance currently available to CNM2/CMM2 grades to also apply to the CNM3/CMM3 grades.

This is a significant outcome for the members involved.

The unions are now engaging with the employer to seek the immediate implementation of this recommendation.

The creation of a maximum point and long service increment for the CNM2/CMM2 salary scale will require immediate engagement with the employer.

Members will be updated as discussions progress.

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

# Nurse and Midwife Representative Training 2024

2023 has proved to be an extremely successful year for INMO Nurse and Midwife Representative Training and we would like to thank our members for making this possible. The INMO trained more than 100 new representatives.

The INMO will provide Representative Training again in 2024 for our members, dates are outlined below.

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

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

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

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

| Date | Location |
|---|---|
| 6 & 7 February 2024 | Limerick |
| 13 & 14 Feb 2024 | Cork |
| 5 & 6 March 2024 | Dublin Advanced Rep Training |
| 11 & 12 March 2024 | Dublin |
| 19 & 20 March 2024 | Louth/Cavan |
| 5 & 6 June 2024 | Waterford |
| 12 & 13 June 2024 | Galway |
| 19 & 20 June 2024 | Dublin |
| 16 & 17 July 2024 | Dublin |
| 10 & 11 September 2024 | Dublin |
| 3 & 4 October 2024 | Sligo |
| 8 & 9 October 2024 | Cork |
| 14 & 15 October 2024 | Dublin |

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

## CONTACT YOUR INMO OFFICIAL

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

# Joint call for long-overdue workplace menstruation and menopause policies

THE INMO has joined a coalition of Ireland's largest trade unions in a campaign calling for employers and the government to address issues related to menstruation and menopause in the workplace.

Through its 'Stop the Stigma' campaign launched last month, the union-led initiative aims to implement reforms that will enhance protection and supports for those experiencing menstruation and menopause in the workplace to align with the evolving workforce.

The Stop the Stigma campaign strives to adapt workplace protections and policies to modern needs and to eradicate workplace challenges like hardship, stress and stigma associated with menstruation and menopause.

The campaign launched a position paper in Leinster House on October 24, 2023. Backed by extensive research, the position paper includes a draft policy of recommended workplace policies in relation to menstruation and menopause. It also outlines the need to protect workers' rights in this context under the Safety, Health and Welfare at Work Act 2005 and the Employment Equality Acts 1998-2015.

The coalition states that the introduction of appropriate supports would also have a significant impact on sick leave absence rates in Ireland's workplaces, benefiting hundreds of thousands of workers.

As well as the INMO, the 'Stop the Stigma' coalition comprises Fórsa, the Financial Services Union (FSU), the Communication Workers Union (CWU), the Irish National Teachers Organisation (INTO), SIPTU, UNITE, Energy Services Union (ESU) and is backed by the Irish Congress of Trade Unions (ICTU).

The new campaign is advocating for improved workplace supports concerning menstruation and menopause to eliminate unnecessary stress from the workplace and people's working lives. The INMO joins the campaign as a forerunner in calling for such supports, having been the first union in Ireland to call for workplace policies to support staff experiencing menopause with a comprehensive position paper launched in 2019.

This paper noted the very high percentage of women among healthcare workers, and the specific role of the health service as an employer in providing appropriate supports for staff experiencing menopause.

Research and collective bargaining activity across the Stop the Stigma coalition has revealed a dire need for implementation and protection of workplace menstruation and menopause policies.

The unions' research has revealed:

- Menopause and menstruation have a negative impact on the working lives of people who menstruate
- These health concerns are treated as jokes in several workplaces
- Several workplaces are ill-equipped to deal with these health concerns
- A majority of respondents are in favour of implementing a workplace policy that offers a range of supports to help people stay in employment comfortably.

In response to these findings, the new position paper calls for:

- Flexible work arrangements to accommodate physical discomfort and fatigue due to periods and menopause
- Enhanced managerial training to facilitate open discussions about menstruation and menopause
- Free menstrual and menopause products
- Reasonable physical accommodations such as ergonomic workstations and temperature controls
- Access to risk assessments
- Promotion of a supportive culture
- Confidentiality and privacy regarding workers' menstrual and menopause symptoms and arrangements
- Feasible paid time off for symptoms without detriment.


***INMO general secretary Phil Ní Sheaghdha:*** *"The silence around women's health issues is damaging, and it impacts equality in society and at work"*

The Stop the Stigma coalition's position paper says that excluding, or neglecting, to address the specific needs of individuals experiencing menopause and menstruation perpetuates gender-based discrimination, and further creates an inequitable work environment. The Employment Equality Acts 1998-2015 mandate employer responsibility to implement protective policies for all employees.

Speaking at the launch of the position paper, INMO general secretary Phil Ní Sheaghdha said many INMO members were reporting the need to take early retirement from their roles, finding their professional lives curtailed because of the physical demands of their work.

"With more and more women participating in the workforce, having workable menopause and menstrual policies that protect women at work has never been more urgent. There is a huge need for education and awareness training for all staff in our workplaces and across society. The silence around women's health issues is damaging, and it impacts equality in society and at work.

"This is very serious. The potential for women's careers to be negatively impacted particularly by menopause needs to be eliminated, and education and awareness training are key to reducing stigma and facilitating the vital conversations women need to have at work," Ms Ní Sheaghdha said.

"The development of workplace policies is an employer's responsibility for fostering equality and is vital for retaining skilled staff in their professions."

The full position paper can be found on the ICTU website **ictu.ie**

**– Beibhinn Dunne**

# St Luke's ED rosters preserved following protracted dispute

FOLLOWING a protracted dispute on proposed roster changes in the emergency department of St Luke's Hospital, Kilkenny, members have voted overwhelmingly in favour of maintaining existing rosters.

Following a stalemate at local level over the introduction of a new rostering method, the dispute was referred to a joint review group, under the provisions of the Public Service Agreement. This group brought the INMO and the HSE together in an attempt to resolve the rostering issue.

Following engagement, it was agreed that the rosters would be maintained and certainty would now be given to both management and staff on rostering arrangements going forward.

*INMO IRO Liam Conway: "Current rosters will be maintained"*

INMO members had sought that existing rostering arrangements and local conditions would be maintained.

I would like to acknowledge the efforts of INMO local reps and the members of the joint review group for their assistance in resolving this dispute.

**– Liam Conway, INMO IRO**

# Two cases demonstrate importance of correct verification process when moving job

THE importance of ensuring all prior service is verified and counted on accepting new posts was emphasised by two recent cases in the south and southwest of the country.

A member working in the HSE South region contacted the INMO following promotion as they believed their increment had been calculated incorrectly. On review, the union discovered that the member had been placed incorrectly on the promotional point of the scale. Following representation, the union secured that they were placed on the correct point of scale, moving them two points from the original verified service provided by the HSE. The change to scale was worth over €3,000 per annum basic salary.

In a separate case, a nurse in the Southwest region recently received a new incremental point on the pay scale and payment of arrears from the original contracted start date after seeking assistance from the INMO regarding her verification of service.

On examining the matter, the INMO discovered that a period of the member's service was excluded in error under the HSE verification process. The INMO provided representation to the member and supported them in seeking that all relevant work experience, including that from overseas, be incorporated into the verification process. Due to a particular service not being able to provide verification, an affidavit was used to support the member's verification.

In both cases outlined above, the members were placed on the correct point of scale and received arrears from their contract date. This was achieved through local representation and collaborative engagement with service management and HR.

These cases highlight the importance of showing that you have provided the correct verification of service on appointment, whether at staff nurse or enhanced nurse grade or promotional post.

It is also important that you always review your contract terms and conditions and, if you have a query, that you engage with your employer or seek guidance and assistance from the INMO.

**– Liam Conway, INMO IRO**

## Transition talks for Milford

DISCUSSIONS are ongoing with Milford Care Centre, Limerick, which is transitioning from Section 39 status to a Section 38 publicly funded service. While some concerns around pensions remained, management informed the INMO that these are being dealt with. Members will be kept appraised of any further issues that emerge during the transition process.

**– Karen Liston, INMO IRE**

***Bantry General Hospital's MAU – an urgent care model to be emulated***

*INMO staff and Executive Council members met at Bantry General Hospital medical assessment unit (MAU) recently, alongside director of nursing Maureen Minihane and assistant directors of nursing Anne O'Sullivan, Catherine Harte and Mary Holland. The MAU demonstrates a very successful and replicable model for urgent care outside emergency departments and Mary Holland retires from the MAU this year after contributing to the success of this unit over many years. Pictured (l-r) were: Catherine Harte, Mary Holland, Phil Ní Sheaghdha, INMO general secretary, Maureen Minihane and Anne O'Sullivan*

# Members at St John's, Limerick plan work to rule due to staffing deficits

NURSES at St John's Hospital, Limerick have served notice of industrial action on their employer. This follows many months of seeking to address serious staffing deficits at the hospital and concerns about patient safety.

Additionally, to keep the system flowing, nurses have inadvertently taken on work that is not within their remit but is the responsibility of other grades.

These additional workloads can no longer be absorbed into the nurse's role as it is taking away from time for patients and families.

The further failure of the hospital to introduce the Safer Nurse Staffing and Skill Mix Framework, coupled with in the region of 30 full-time nursing posts currently vacant, is placing significant workload stress on our members as well as having implications for patient safety.

*INMO assistant director of IR Mary Fogarty: "Additional workloads can no longer be absorbed"*

Following the period of notice which expires on November 22, INMO members will commence a work to rule at the hospital.

**– Mary Fogarty, INMO assistant director of IR**

# Average premium payments due under Covid leave

THE INMO has successfully negotiated a review of all claims for special leave with pay for Covid-19 at Midland Regional Hospital Portlaoise, after highlighting miscalculations in respect of premium payments owed to staff.

According to HSE circular 064-2020, determination of this element of the special leave with pay scheme should be based on "an average of the employee's unsocial hours premium payments over the six-week period immediately prior to the commencement of the employee's absence".

Following negotiations with hospital management, the INMO can confirm that management had misinterpreted circular 064-2020 in relation to payment of the loss of premiums while eligible for special leave with pay for Covid-19. INMO members had been refused premium pay if they had availed of parental leave in the weeks prior to their Covid-19 related absence. Management has now accepted this misinterpretation and has committed to an examination of all claims for special leave with pay, with a view to paying premiums where owed.

All members who have been absent due to Covid-19 and who availed of the special leave with pay scheme, are advised to check they have received all premium payments due. If you require assistance with this matter, please contact the INMO.

**– Grainne Walsh, INMO IRE**

# Many nurses found to be still on legacy pay scale

A SUBSTANTIAL cohort of nurses working within CHO3 Older Persons Services have not moved to the enhanced practice pay scale, according to the local HR department.

On foot of this data, the INMO has had further engagement with directors of nursing in each site as the data shows some staff have many years of experience and are on the higher end of the outdated staff nurse pay scale. In some instances, staff on the outdated senior staff nurse scale would receive a higher rate of pay on the enhanced practice senior staff nurse scale.

Since meeting with the directors of nursing, the INMO Limerick Office has received many queries and hope that this will result in members moving to the enhanced scale immediately so that they can avail of the higher rate of pay.

Members in all areas, and in this area in particular, who are on the fourth point of the old pay scale or above are advised to apply for the enhanced practice contract without delay to avoid missing out a higher rate of pay. The higher rate will be processed and paid at your next increment once you have applied and received the new contract. Contact your local HR department or the INMO if you require assistance.

**– Karen Liston, INMO IRE**

# Member compensated in sick pay dispute

AN adjudicator at the Workplace Relations Commission concluded that the Brothers of Charity Service in the Mid West did not adhere to agreed procedures in relation to sick leave.

The WRC adjudicator awarded a nurse the full net sick pay due of €1,200 and a compensatory sum of €3,000 for the manner in which the employer dealt with the matter in their workplace.

The nurse had submitted a medical certificate to her employer however the employer took the decision not to pay her for the period of sick leave on the basis that they were exercising discretion. The employer failed to follow the Managing Attendance Policy and made serious allegations regarding the *bona fides* of the medical opinion in this case.

*INMO IRE Marian Spelman: "Agreed procedures not followed"*

The INMO welcomed the decision of the WRC as it clearly sets out that agreed procedures and policies must be followed by managers when an employee is to suffer a detriment.

**– Marian Spelman, INMO IRE**

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# Care-Connect

## The patient experience

Anna Roycroft is 41 years of age, and lives in Bandon, Co. Cork with her husband and 12 year old son. Anna was diagnosed with cardiomyopathy in 2012 at age 30.

Anna suffers from the usual symptoms of heart failure, such as tiredness, fatigue and breathlessness. As an Irish Life Health member, Anna heard about the Heart Care Programme in early 2023 and joined because she wanted to be more proactive in managing her condition and overall health.

It didn't take long for the programme to become part of Anna's weekly routine.

## Real-time clinical monitoring

Anna's measurements are sent to the Care-Connect clinical nurse team, who review the data and ensure it meets the thresholds set. Consultant Cardiologist Dr Matt Barrett works with Care-Connect to shape their model of care and develop up to date protocols to provide the best cardiology care to patients on the programme.

*"My mum has a similar condition, so we all got checked out as it's known to be passed on in the family.*

*It didn't come as a shock…. As a kid I tended to struggle with running and hill walking, and always found myself lagging behind and getting really breathless.*

*Since joining the Heart Care Programme, I've become more aware of the status of my condition. I started exercising more, and eating better. It's even had a knock-on effect on the family – we're all feeling healthier.*

*On a Monday and Thursday morning I measure my weight, blood pressure and heart rate. I input these into the easy to use Luscii app - I just click the notification and follow the instructions. It couldn't be easier!"*

**Anna Roycroft**


*"If the measurements are good and within the threshold, we'll just send Anna a message on the app to reassure her that everything is looking good. If anything is off, we'll either phone or message Anna to let her know and maybe advise that she sees her GP or Consultant. In some cases, we might advise the member to slightly alter their medication while they wait to follow-up with their treating clinician."*

**Olga Levis,** Connect-Care nurse

*"Ultimately our vision at Care-Connect is to achieve the best possible health outcomes as close to the patient's own home as possible. If we see something and the patient needs some attention, we'll try to work through it remotely and advise on the best next step. There's evidence to say that more virtual and remote contact models of care can reduce hospital admissions and help optimise medications."*

**Donal Bailey,** GP and CEO of Care-Connect

Hear from Dr Matt Barrett and Dr Donal Bailey: **Scan the QR code**

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# International Section celebrates 20 years

## The International Section is an integral and growing part of the INMO, representing nurses and midwives from around the world. *WIN* spoke to some of the section's members

THE INMO's International Nurses Section marks 20 years in existence this year. Initially established as the Overseas Nurses Section in 2003, the group was set up to provide an opportunity for nurses from abroad to discuss, reflect and solve problems that were unique to them.

That same year, the section chairperson, Fidel Tiguinod, received an INO research award to carry out a study exploring the experiences of overseas nurses working in the Irish health service. Within a year of its foundation, the section was awarded the prestigious Media and Multicultural Award, recognising the section's efforts to successfully integrate foreign-trained nurses and midwives into the Irish health service.

In 2006 the section collaborated with the Immigrant Council of Ireland on the Immigration and Residency Bill and the implementation of a green card system and employment permit. The following year it was heavily involved in an information and awareness campaign on the new Employment Permit Act 2006, along with the Migrants Rights Centre of Ireland, the Immigration Council of Ireland and the Honorary Philippine Consulate.

The section has gone from strength to strength over the years, often representing the INMO at international conferences and forums. Section members also began to be represented on the INMO's National Executive from 2008. At the 2012 annual delegate conference (ADC), the section was rebranded as the International Nurses/Midwives Section and began hosting its annual 'Culturefest' the following year.

### International perspective

Current section chairperson Jibin Soman became a nurse partly because he was aware it would open opportunities for him to work anywhere in the world. He came to Ireland in 2017 and soon joined the INMO as he had always been a union member in his home country. For him, being in a union is like taking out insurance on your professional life.

*Jibin Soman, section chairperson*

*Toyosi Atoyebi, section secretary, with Bolatito Aderemi and Ibukun Oyedele*

He told *WIN*: "Whenever I see an overseas nurse join my workplace, I go and talk to them and advise them to join the INMO. You may feel you are safe today, but you don't know what is going to happen tomorrow. I remind my colleagues not to try to tackle their problems alone and advise them to talk to their INMO representatives or industrial relational officers.

"It's great to have someone who knows how to support you. Our section tries to provide that access to the INMO for our colleagues from around the world. As part of the International Section, you meet a lot of new faces and a lot of experienced nurses from our own countries who have been working in Ireland for a long time. They too have lot of experience to share, which makes the adaptation process into this country smooth and easy."

Janet Baby Joseph is a qualified nurse and midwife who came to Ireland from Kerala in India in 2016. Now working as a midwife in Cork University Maternity Hospital, she initially worked in a private nursing home and found that she needed the support of the INMO. She advises her colleagues to join the INMO.

"Do you take out car insurance after having an accident? Do you take out life insurance after an accident? No, you do it before, in case something happens. Joining a union is the same thing. You take out INMO membership before you have issues, so that there's somebody there to support you when you need them," Ms Joseph said.

Bolatito Adiremi was an INMO rep for almost 10 years and an officer in the Dublin Southwest Branch, as well as being a member of the Section. In these roles she was able to avail of free professional development courses. "I seized the opportunity and I did well over 20 courses which greatly increased my joy in my profession," she said.

Elizabeth Allauigan sits on the INMO Executive Council and was chair of the International Section from 2017 to 2022. She moved from the Philippines in 2004 and works as a critical care nurse in St James's Hospital, Dublin. She has done a

huge amount of outreach work within the Filipino community in Ireland.

She told *WIN*: "I tried to reach out to every Filipino nurse and midwife and explained what the Organisation can do for them. Some people think it's just another outgoing payment from their salary, but I tell them it's worth it.

"I also told them to join the International Section because it's great fun and you meet a lot of different people. We speak of and learn about each other's culture and provide great peer support for each other," Ms Allauigan continued.

Also Filipino, Diana Malata, ANP in ophthalmology in the Royal Victoria Eye and Ear Hospital, was vice-chairperson of the Section from 2013 to 2016. She spoke of visiting several hospitals in different counties in Ireland to encourage people to join the Section.

"We also participated in different cultural celebrations with members from lots of different countries which was really great fun and informative too," she said.

Grace Oduwole is assistant director of nursing at Bellville Community Unit, Dublin and is also a member of the INMO Executive Council. Ms Oduwole joined the INMO as soon as she started working in Ireland and has been an active member of the section since its inception. She has held the roles of secretary and vice-chairperson.

Ms Oduwole told *WIN*: "I would love to see more international nurses attending conferences and taking roles on committees within the union. When I came to this country, we were introduced to INMO and it was a bit of solace to know that there is an organisation that will support us if we need it."

Ms Oduwole stresses that the International Section was created for all nurses who did not train in Ireland, including those from English-speaking countries. She feels that giving nurses and midwives greater involvement in decision-making nationally and locally greatly boosts morale and results in a more efficient health service.

### Retention

She said the priority for the section in 2024 will be to look at how to support retention of nurses and midwives in Ireland. "In 2024, I think our focus should be on retention. I know that the recruitment rate is very high, but the retention rate is very, very low. I want the section to look at what we can do to improve the welfare of international nurses in Ireland so that they want to stay here and work," she said.

Numerous section members mentioned the RCSI's aptitude test, which all overseas nurses and midwives must pass before receiving their NMBI pin and licence to work in Ireland.

Ms Joseph said: "One of the major factors is the lack of direction and guidance. A similar kind of examination is held in the UK, but candidates are well trained by the NHS before they go for the examination. If we could create something like that pre-exam training here in Ireland it would be a great help."

Mr Soman, in his role as section chairperson, expanded on how the section might go about this by providing targeted supports. "At present there are lots of issues in the adaptation process and aptitude test, so we are trying to engage with NMBI to streamline the process and make it less daunting. We are hoping to provide more targeted professional development programmes for overseas nurses and midwives in Ireland. We are also planning to try to meet with new nurses and midwives who arrive in the country every three to four months," he said.

### Housing crisis

Finding affordable accommodation is a significant issue for nurses and midwives. Reema Anthony, CNM3 in Cork University Hospital, said she gets calls from staff from Ireland and overseas who are struggling to find or retain accommodation, citing the lack of affordable housing as a major deterrent for overseas nurses and midwives moving here for work.

"I know accommodation is a huge challenge for everyone at the moment, but for those from outside of Ireland it can be really stressful as they don't know where to turn for help. I attend the INMO ADC and I am active with the section, so this gives me lots of insight into the issues the union is prioritising and I'm glad to see there is work on affordable accommodation for nurses and midwives ongoing."

International nurses and midwives are now represented throughout the INMO on various committees, as well as the National Executive. They campaign for their section's issues and the issues facing the wider Organisation.

### Representation

Section members have represented the INMO at conferences in Ireland and abroad. The section has also raised funds for multiple charities in its 20 years in existence. At the 2016 ADC the section put forth a motion calling on the INMO to back the urgent need for the government to enact the Criminal Law (Hate Crime) Bill to protect minorities in Ireland. The motion was overwhelmingly carried. The section also played a significant role in the INMO's centenary event 2019, where it honoured two pioneering members, Bolatito Aderemi and Lina Ducao, for their contribution to the health service in Ireland.

*Janet Baby Joseph presenting to the 2023 INMO ADC*

*Diana Malata in her workplace*

In 2010 the section helped to create the Philippine Nurses Association of Ireland, with which the section is now affiliated. In recent years the INMO launched a co-operation agreement with Migrant Nurses Ireland, which then held its first national conference in the Richmond Education and Event Centre in January 2023. The Organisation has also established links with the Cork Indian Nurses group in recent years.

Ireland's health service is heavily dependent on international nurses and midwives who bring their skills and expertise to this country. The INMO is proud of its thriving International Nurse/Midwife Section and all of the incredible work its members do to go above and beyond their nursing and midwifery duties.

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

# 20th Anniversary International Nurses & Midwives Section Conference

*Recognising the contribution of migrant nurses and midwives to the Irish health service*

**Wednesday, 6 December 2023**

The Richmond Education and Event Centre

## PROGRAMME

| | |
|---|---|
| 9.00am: | Welcome Tea/Coffee/Refreshments |
| 9.30am: | **Opening Ceremony**<br>Address from Karen McGowan, INMO President |
| 10.00am: | **Minister for Health Address**<br>Stephen Donnelly, Minister for Health |
| 10.15am: | **The contribution that international nurses and midwives are making to the Irish health system** |
| 10.45am: | Networking - coffee and photo opportunity |
| 11.15am: | **Address from Dr. Pamela Cipriano President of ICN** |
| 11.30am: | **Panel Discussion**<br>Chaired by Eamon Dunphy, Broadcaster on the issues faced by international nurses and midwives working in the Irish health system |
| 12.30pm: | **Address from Minister Roderic O'Gorman** |
| 12.45pm: | **Cultural Presentations** |
| 1.15pm: | Lunch |
| 2.30pm: | **Award for the Poster Competition** |
| 2.45pm: | **Extraordinary General Meeting of the International Nurses and Midwives Section** |
| 3.45pm: | **Members acknowledgments** |
| 4.00pm: | Close and Networking |

**Places are restricted and bookings are essential.**
To register your interest in attending, and to book a place
**please email your name** and **INMO Membership number** to **jude.maher@inmo.ie**

# Recognition for those who go the extra mile

## A PHN from Ballina and a midwife from Sligo announced as the winners of the fourth annual Pure Foundation Fund

THE fourth annual Pure Foundation Fund winners have been announced, with Maria Flannery O'Boyle, a public health nurse from Ballina, and Mary Meade, a midwife from Sligo, being named as the Irish winners. They received a bursary of €5,000 each for their departments so that they can continue to improve the care of parents and babies.

The Fund celebrates the achievements of healthcare professionals working in maternity, neonatal and postnatal care by encouraging parents and healthcare professionals to nominate individuals who played crucial roles in pregnancy, birth and postnatal care, and made a difference in the lives of parents and babies.

Some 395 nominations were received across the UK and Ireland and two winners from each country were selected by an expert panel, which included Steve Pitman, INMO head of education and professional development, Mandy Daly, founder of the Irish Neonatal Health Alliance, and representatives from the Neonatal Nurses Association and premature and sick baby charity Bliss.

Maria Flannery O'Boyle, a public health nurse from Ballina, Co Mayo, was nominated by an unprecedented 22 people. One nominator, mother of two Laura Murphy, praised her for the wealth of knowledge and amazing support she offers to breastfeeding mothers. Ms Murphy commented on Ms Flannery O'Boyle's practical advice and the fact that she goes above and beyond in her role, running a breastfeeding/mother and baby group in Ballina once a week and making time for every parent who needs her.

On receipt of the award, Ms Flannery O'Boyle said that she was "amazed, delighted and grateful".

"My experience as a mother, my professional knowledge as a public health nurse, lactation consultant and having a master's in motherhood/social support give me insight regarding the importance of good quality support and the creation of networks for mums and babies to support them in the transition to motherhood. The group creates awareness around mum's and baby's mental health and integrates the child's developmental milestones in the first year of life."

*Maria Flannery O'Boyle*

*Mary Meade*

Mary Meade, a midwife from Sligo, was nominated by Mary Keating, who was diagnosed with placenta previa while pregnant with her second baby last year, resulting in a four-week hospital stay prior to delivery.

Ms Keating highlighted how comfortable Ms Meade made her feel during her traumatic experience, remarking that she "would never have got through those four weeks without her".

She added: "I think of her often with such fondness and I will be forever thankful to her for the help, support, compassion and empathy that she gave me during that time."

Speaking about the award, Ms Meade said it was "an honour" to accept it.

"Nursing and midwifery have been my life since I was very young and I never lose sight of the fact that it could be me in the bed or a member of my family, so I always treat people like I would like to be treated at such a vulnerable time. Midwifery certainly isn't about individualised awards as I work as a part of a wonderful team of midwives, student midwives, healthcare assistants and a wider circle. So I'm delighted to accept this award on behalf of our team at Sligo University Hospital."

Mr Pitman said that the INMO was pleased to collaborate with the Water Wipes Pure Foundation Bursary Awards for another year.

"We are delighted with the standard of nominations received. These nominations reflect the high-quality care provided by nurses and midwives in Ireland. I would like to extend my congratulations to Mary Meade and Maria Flannery O'Boyle, winners of the Bursary Award 2023. Both women have shown compassionate care and an unwavering commitment to go the extra mile to support women, families and babies," he added.

WaterWipes launched the Pure Foundation Fund in 2020 to celebrate and recognise the incredible work of healthcare professionals involved in maternity, neonatal and postnatal care. The award is designed to support and promote individuals and departments that go above and beyond in their efforts to make a difference to the lives of the parents and babies in their care.

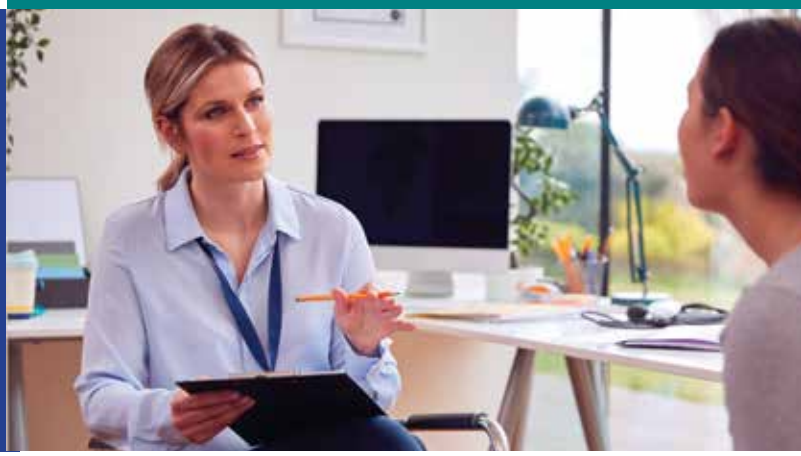
INMO Professional

Irish Nurses and Midwives Organisation
Working Together

**IN PERSON ONLY EVENT**

# Occupational Health Nurses Section Annual Conference

*'Enhancing occupational health performance in a changing world'*



## Thursday, 30 November 2023

Time:
9.00am - 4.00pm

Venue:
The Limerick Strand Hotel

Fee:
€100 INMO members
€150 Non members
€50 Students

| | |
|---|---|
| 8.15am: | Trade exhibition - registration tea coffee and scones |
| 9.00am: | **Welcome address, Tony Fitzpatrick Director of Professional Services** |
| 9.30am: | **Cardiology Updates**<br>Speaker: Prof Robert Kelly, Consultant Cardiologist and Lifestyle Medicine Physician |
| 10.15am: | **Nurse led coaching for individuals with complex chronic pain**<br>Speaker: Norma O'Keeffe, Advanced Nurse Practitioner in Pain |
| 10.45am: | Coffee / exhibitor break |
| 11.15am: | **Inclusivity**<br>Access UCC Employability Programme: A model of inclusive recruitment & training<br>Speakers: Shay Nolan , Access UCC, EmployAbility Project Manager |
| 11.45am: | **Managing Neurodiversity at work – how occupational therapy can make a difference**<br>Speaker: Sue Knight , Cork OT Services |
| 12.15pm: | **Advocating for Occupational Health - RCPI strategy**<br>Speaker: Prof Ken Addley, Consultant Occupational Physician and Faculty Advocacy Lead, RCPI |
| 1.00pm: | Lunch & trade exhibition |
| 2.15pm: | **Self Compassion**<br>Speaker: Fiona Brennan, Clinical Hypnotherapist, Best-Selling Author, Speaker |
| 3.00pm: | **DATA protection**<br>**Management of Occupational Health Records from a GDPR & compliance perspective**<br>Speaker: Dolores Martyn DATA Protection Consultant, XpertDPO |
| 3.45pm: | Formal Close of conference |

BOOK NOW

To book contact:
**016640641/18 or education@inmo.ie**
www.inmoprofessional.ie

# Q and A Bulletin Board

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

## Leave entitlements following an assault at work

*Q. I was assaulted by a patient while at work. I am now out on sick leave as a consequence of this assault. My employer advised I would be paid sick pay under the normal sick leave rules. I am now concerned that I will be using up most of my sick leave entitlement. Can you advise if there is any other scheme available if you are assaulted at work?*

If you work for the HSE, there is a scheme that covers physical assault in the workplace. This scheme allows for pay inclusive of premiums that you would have earned had you not been assaulted. In addition, the period of time spent absent from work is not considered as sick leave.

You should immediately make contact with your employer and request to be included in the 'Serious Physical Assault at Work Scheme' for nurses and midwives. If this is denied, you have the right of appeal to an appeals board and you should seek assistance with your appeal from your local industrial relations official. For information on the Serious Physical Assault at Work Scheme you can contact the INMO Information Office *(see contact details below)*. There is also a no fault compensation scheme for nurses working in emergency department and medical assessment units.

All nurses/midwives who are absent from work as a result of a serious physical assault by a patient/client incurred in the course of their duties are covered by this scheme. Payment is granted on the assault occurring in the actual discharge of the employee's duties and without his/her own default.

A serious physical assault is defined as: "The intention or reckless applications of force against the person by another without lawful justification or causing another to be subjected to such force without lawful justification, resulting in physical injury."

The Serious Physical Assault at Work Scheme provides as follows:

a) Full pay based on the earnings an employee would have earned if still at work and working the hospital/community approved roster
b) Such full pay which would include basic pay, allowances and premium earnings may be paid for a period of up to six months for public sector employees
c) Payment made under (b) above shall be reduced by the amount of social welfare benefit to which the employee is entitled arising from absence due to the injury
d) Salary paid to an employee in the circumstances outlined above will not affect an employee's entitlement under the sick pay scheme.

In the case of nurses/midwives, the following special extensions to the above scheme apply:

- A medical assessment to review the employee's progress should be carried out no later than six weeks into the period of absence. If it is unlikely that the employee will be fit to return to work within the six-month period covered by the scheme or immediately thereafter, but there remains a reasonable expectation that the employee will return to work, a first special extension may be granted up to a maximum period of three months.
- A medical assessment to review the employee's progress should be carried out no later than six weeks into the first special extension. If it is unlikely that the employee will be fit to return to work during the three-month period covered by the first special extension or immediately thereafter, but there still remains a reasonable expectation that the employee will return to work, a further final extension may be granted.
- The second special extension provides for basic pay only and is for a maximum period of three months.

Expenses incurred in respect of hospital/medical charges will be recouped as follows:

- A refund of expenditure incurred in respect of treatment provided by the Irish public health service
- General practitioner, casualty and consultant visits
- Prescription charges.

Nurses/midwives are obliged to claim under medical insurance schemes where appropriate (eg. VHI, Refund of Drug Schemes, etc) and any payments made in respect of hospital/medical expenses will be solely in respect of excess expenditure by the individual. Payments made under this scheme do not confer any admission of liability on the part of the employer.

You can seek the Serious Physical Assault Scheme Leave application form (HSE sHR 108[m]) from your HR department or line manager.

### Legal advice helpline

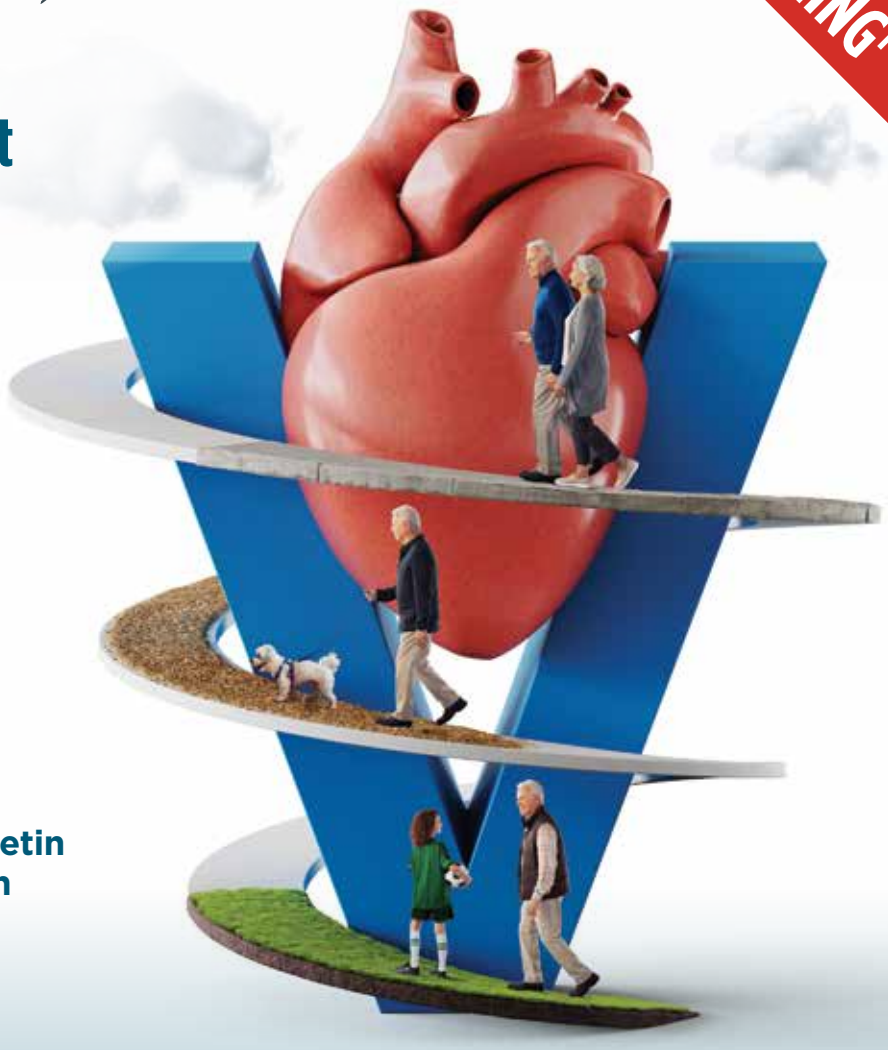
In addition to the above, every INMO member has access to a 24-hour legal advice helpline service. A team of legal experts is on call 24/7, ready to provide a member with practical legal advice over the phone. The service provides legal advice for those working in the Republic of Ireland and the UK if required. With lawyers in both jurisdictions, together with computerised legal research facilities, the helpline staff aim to sort out even the most complex legal problem faced by INMO members. However, the legal help line is not designed to deal with workplace issues that your local INMO industrial relations team can assist with. The helpline can be reached at Tel: 0818 670747 or 01 6707472.

INMO information officers Catherine Hopkins and Catherine O'Connor can be contacted at Tel: 01 6640610/19 or email: catherine.hopkins@inmo.ie and catherine.oconnor@inmo.ie. Office hours are Monday to Thursday 9am-5pm and Friday 8.30am-4.30pm.

# Vyndaqel® ▼ (tafamidis)

**61 mg for ATTR-CM**

**ATTR-CM IS LIFE-THREATENING[1]**



## The first and only treatment indicated to reduce:

- all-cause mortality
- frequency of CV-related hospitalisations

## in patients with wild-type or hereditary ATTR-CM.[1]

## ORAL VYNDAQEL
61MG SOFT CAPSULES

**Indicated for the treatment of wild-type or hereditary transthyretin amyloidosis in adult patients with cardiomyopathy (ATTR-CM).[2]**

**www.vyndaqel.ie**

ATTR-CM=transthyretin amyloid cardiomyopathy; CV=cardiovascular.

**References: 1.** Maurer MS, Schwartz JH, Gundapaneni B, et al. Tafamidis treatment for patients with transthyretin amyloid cardiomyopathy. N Engl J Med. 2018;379(11):1007-1016. **2.** VYNDAQEL Summary of Product Characteristics.

**Vyndaqel▼ 61 mg soft capsules (tafamidis) Prescribing Information:** Before prescribing Vyndaqel please refer to the full Summary of Product Characteristics.
**Presentation: Vyndaqel 61 mg soft capsules.** Each soft capsule contains 61 mg tafamidis. **Uses:** Vyndaqel is indicated for the treatment of wild-type or hereditary transthyretin amyloidosis in adult patients with cardiomyopathy (ATTR-CM). **Dosage:** Treatment should be initiated under the supervision of a physician knowledgeable in the management of patients with amyloidosis or cardiomyopathy. When there is a suspicion in patients presenting with specific medical history or signs of heart failure or cardiomyopathy, etiologic diagnosis must be done by a physician knowledgeable in the management of amyloidosis or cardiomyopathy to confirm ATTR-CM and exclude AL amyloidosis before starting Vyndaqel, using appropriate assessment tools such as: bone scintigraphy and blood/urine assessment, and/or histological assessment by biopsy, and transthyretin (TTR) genotyping to characterise as wild-type or hereditary. The recommended dose is one capsule of Vyndaqel 61 mg (tafamidis) orally once daily. Vyndaqel 61 mg (tafamidis) corresponds to 80 mg tafamidis meglumine, tafamidis and tafamidis meglumine are not interchangeable on a per mg basis. Vyndaqel should be started as early as possible in the disease course when the clinical benefit on disease progression could be more evident. Conversely, when amyloid-related cardiac damage is more advanced, such as in NYHA Class III, the decision to start or maintain treatment should be taken at the discretion of a physician knowledgeable in the management of patients with amyloidosis or cardiomyopathy. There are limited clinical data in patients with NYHA Class IV. If vomiting occurs after dosing, and the intact Vyndaqel capsule is identified, then an additional dose of Vyndaqel should be administered if possible. If no capsule is identified, then no additional dose is necessary, with resumption of dosing the next day as usual. There are no recommended dosage adjustments for elderly patients or patients with renal or mild and moderate hepatic impairment. Limited data are available in patients with severe renal impairment (creatinine clearance less than or equal to 30 mL/min). Tafamidis has not been studied in patients with severe hepatic impairment and caution is recommended. There is no relevant use of tafamidis in the paediatric population. **Method of Administration:** The soft capsules should be swallowed whole and not crushed or cut. Vyndaqel may be taken with or without food.**Contra-indications:** Hypersensitivity to the active substance or to any of the excipients as listed in section 6.1 of SPC. **Warnings and Precautions:** Contraceptive measures should be used by women of childbearing potential during treatment with tafamidis and for one month after stopping treatment. Tafamidis should be added to the standard of care for the treatment of patients with transthyretin amyloidosis. Physicians should monitor patients and continue to assess the need for other therapy, including the need for organ transplantation, as part of this standard of care. As there are no data available regarding the use of tafamidis in organ transplantation, tafamidis should be discontinued in patients who undergo organ transplantation. Increase in liver function tests and decrease in thyroxine may occur. This medicinal product contains no more than 44 mg sorbitol in each capsule. Sorbitol is a source of fructose. The additive effect of concomitantly administered products containing sorbitol (or fructose) and dietary intake of sorbitol (or fructose) should be taken into account. The content of sorbitol in medicinal products for oral use may affect the bioavailability of other medicinal products for oral use administered concomitantly. **Pregnancy and Lactation:** Tafamidis is not recommended during pregnancy and in women of childbearing potential not using contraception. Available data in animals have shown excretion of tafamidis in milk. A risk to the newborns/infants cannot be excluded. Vyndaqel should not be used during breastfeeding. **Interactions:** In a clinical study in healthy volunteers, 20 mg tafamidis meglumine did not induce or inhibit the cytochrome P450 enzyme CYP3A4. *In vitro* tafamidis inhibits the efflux transporter BCRP (breast cancer resistant protein) at the 61 mg/day tafamidis dose with IC50=1.16 µM and may cause drug-drug interactions at clinically relevant concentrations with substrates of this transporter (e.g. methotrexate, rosuvastatin, imatinib). In a clinical study in healthy participants, the exposure of the BCRP substrate rosuvastatin increased approximately 2-fold following multiple doses of 61 mg tafamidis daily dosing. Likewise, tafamidis inhibits the uptake transporters OAT1 and OAT3 (organic anion transporters) with IC50=2.9 µM and IC50=2.36 µM, respectively, and may cause drug-drug interactions at clinically relevant concentrations with substrates of these transporters (e.g. non-steroidal anti-inflammatory drugs, bumetanide, furosemide, lamivudine, methotrexate, oseltamivir, tenofovir, ganciclovir, adefovir, cidofovir, zidovudine, zalcitabine). Based on *in vitro* data, the maximal predicted changes in AUC of OAT1 and OAT3 substrates were determined to be less than 1.25 for the tafamidis 61 mg dose, therefore, inhibition of OAT1 or OAT3 transporters by tafamidis is not expected to result in clinically significant interactions. No interaction studies have been performed evaluating the effect of other medicinal products on tafamidis. **Undesirable Effects:** The following adverse events were reported more often in 176 ATTR-CM patients treated with tafamidis meglumine 80 mg compared to placebo: flatulence [8 patients (4.5%) versus 3 patients (1.7%)] and liver function test increased [6 patients (3.4%) versus 2 patients (1.1%)]. A causal relationship has not been established. Safety data for tafamidis 61 mg are available from its open-label long-term extension study. Adverse reactions from cumulative clinical data in ATTR-CM participants: *Common (≥ 1/100 to < 1/10)* Diarrhoea, rash, pruritus. **Legal category:** S1A. **Marketing Authorisation Numbers:** EU/1/11/717/003–61mg (30 capsules). **Marketing Authorisation Holder:** Pfizer Europe MA EEIG, Boulevard de la Plaine 17, 1050 Bruxelles, Belgium. For further information on this medicine please contact: Pfizer Medical Information on 1800 633 363 or at medical.information@pfizer.com. For queries regarding product availability please contact: Pfizer Healthcare Ireland, Pfizer Building 9, Riverwalk, National Digital Park, Citywest Business Campus, Dublin 24 + 353 1 4676500. **Last revised:** 02/2023
▼ 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. See section 4.8 of the SmPC for how to report adverse reactions.
Ref: VY 61MG 3_0

Further information available upon request.

PP-VYN-IRL-0206. Date of Preparation: May 2023.



Pfizer

# Preparing for clinical placement

**Róisín O'Connell** offers advice on how to get the most out of your clinical placement and how to avail of available support when needed

AS WE begin winter, many students will be heading out on clinical placement, with many first-year nursing and midwifery students preparing for their first-ever clinical placements. This can be a time filled with many different emotions, excitement, nervousness and an overall sense of stress. It can be daunting when you first embark on your clinical placements and the best way to avoid any unnecessary stress is to ensure that you are prepared.

## Before attending placement

Preparation is key. Always try to put your best foot forward and to ensure that you are well rested, that your uniform is clean and tidy, that your hair is neat and away from your face and, most importantly, that you are on time.

If you are not familiar with your placement site, make sure to plan your route to the location ahead of time. Become familiar with the bus schedule and if you are driving to placement it is good idea to do a practice run. Take a drive to the hospital prior to placement to ensure that you are familiar with where to park and how long the commute will take. Remember to factor in time for traffic, difficulty finding a parking space if spaces are limited, or a late bus.

If you are unsure what the canteen facilities are like, it is a good idea to bring a packed lunch and some water. You will need fuel to get you through the day.

Some essentials to have in your bag are a black pen, a little notebook and a highlighter. These are handy to have so that if you hear a new term or are introduced to something new you can jot it down and look it up later.

Finally, ensure that you have familiarised yourself with the local policy regarding sick leave in case you need to miss a day of placement.

## Learning on placement

You will have covered a large amount of information while in college and you will be exposed to even more while on placement. If you are ever unsure about something, do not be afraid to ask your preceptor questions. Showing interest and initiative is a huge element of being a student nurse or midwife.

When on clinical placement your ward will be allocated a clinical placement co-ordinator (CPC), who is also an excellent source of information. They are there to support you should you need any help while on placement.

Many students find that protected reflective time is the perfect opportunity to look up new information that you heard during handover, or to research diseases or disorders that your patients are admitted with. All students should have protected reflective time for four hours per week, as per the NMBI Nursing/Midwifery Registration Programmes Standards and Requirements. These hours may be structured or self-directed.

## Advice from a friend

When on clinical placement many students can feel overwhelmed. Managing placement, college work, a part-time job and your personal life, can be extremely difficult. There is always help there if you need it, you just have to ask.

When I was a student I sometimes found it difficult to manage placement and college work, but I sought help from my clinical placement co-ordinators and my lecturers. I also had the support of my friends and family. If you ever feel like you need help, go to those around you and ask for help. If you are ever unsure of something, ask questions.

Remember that you are a student and that you are not expected to know

everything. We all must learn and remember that everyone at some point was a student, just like you.

Finally, remember that the INMO is here to support you when you are on clinical placement. If you have questions or are experiencing issues while on placement, do not be afraid to get in touch. It is important that each class has an INMO rep who is linked in with me – if your group does not have one then please discuss this and nominate one person to get in touch.

I wish you all the best on your placement.

## 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 as full size or large files to: roisin.oconnell@inmo.ie along with a caption. We will publish a selection in *WIN* in the near future.

*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.*

# Section focus

INMO Professional

Jean Carroll, Section Development Officer

## Annual ODN Section conference hears from experts in infection prevention and self care

INFECTION prevention was the focus of a presentation by Jincy Jerry, assistant director of nursing in infection prevention and control at the Mater Hospital, at the recent Operating Department Nursing (ODN) Section conference.

The conference, which took place in the Knightsbrook Hotel in Trim, Co Meath in October and was attended by more than 70 theatre nurses, also heard from Dr Chris Luke on self care for health professionals.

Ms Jerry has expertise in clinical disinfection, environmental decontamination, surgical site infection surveillance, outbreak management and healthcare ventilation, and was named Hospital Manager of the Year 2020 at the Irish Healthcare Awards for outstanding leadership and innovation.

Dr Chris Luke spoke to attendees about the importance of joy and contentment to work performance, as well as the avoidance of burnout.

He recommended that healthcare professionals monitor metrics such as sleep, laughter and energy. He also discussed the importance of spending time with loved ones and friends.

*Members of the ODN Section at their recent conference in Co Meath. Back row (l-r): Mariamma Rajan, Patricia Lemass, Ber Brady, Patricia Keenan, Nicholas Hegarty and Lisa Hennessy. Front row (l-r): Sini Mathew, Teresa Herity, Julie George, Bernie Mee and Susan Abraham*

Dr Luke reminded attendees to arrange to seek professional help if they were struggling with their mental health.

Several members expressed an interest in getting more involved in the section, which is always welcoming of new members.

The AGM of the ODN Section will take place online in January *(see page 58)*.

## Networking at the TT Section conference

THE Telephone Triage Section held a conference in Portlaoise in September, which proved a great networking opportunity for nurses working in the out-of-hours setting.

This conference has run every year for more than 20 years, and members were delighted to have the opportunity to meet up in person given the nature of their roles.

It is hoped that a number of members from across various out-of-hours settings will join up with the committee to keep the section viable.

The section would like to express its gratitude to its industry partners for their financial support in hosting this event.

Please contact INMO section development officer jean.carroll@inmo.ie to get more involved in the section most relevant to your area of practice.


*Jean Carroll, INMO section development officer (left), with Fiona Kennedy from Caredoc*

*(l-r): TT Section officers Geraldine Byrne, Edwina Commerford and Hazel James, with Tony Fitzpatrick, INMO director of professional services*

## Advanced Practice Section survey

THE INMO's Advanced Practice Section requests your input in a research survey that aims to identify challenges faced by advanced nurse and midwife practitioners in the Irish health system.

Scan the QR code below to access the survey. It should take no longer than 10-15 minutes to complete.

### Get in touch

Contact: Jean Carroll
Section Development Officer
at HQ at Tel: 01 6640 600
or email: jean.carroll@inmo.ie

INMO Professional

*Continuing professional development for nurses and midwives*

# INMO EDUCATION PROGRAMMES

*In the pull-out this month…*

## Adult asthma – getting the basics right

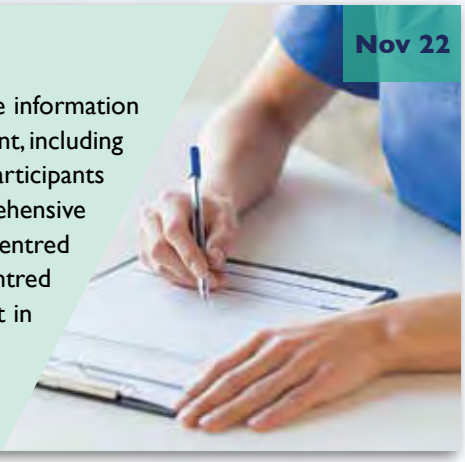
**Nov 22**

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-to-day basis. The programme will assist participants in gaining an understanding of the clinical evidence underpinning the diagnosis and ongoing care and management of the person with asthma utilising current best practice.

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

## Assessment and care planning

**Nov 22**

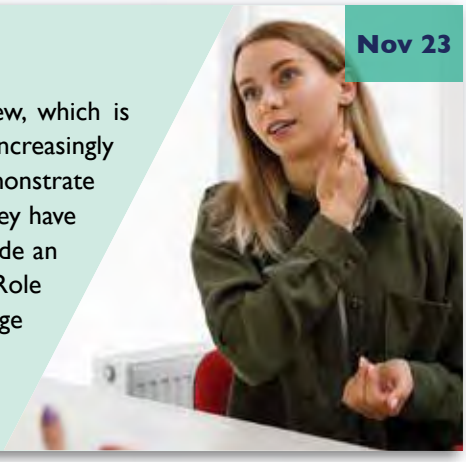


This programme provides nurses caring for older persons with the most up-to-date information regarding policy and standards. It will focus on the need for comprehensive assessment, including risk assessment and care planning for older people in residential care settings. Participants will be provided 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.

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

## Competency-based interview preparation

**Nov 23**



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 CV 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.

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

INMO Professional

# Season's greetings from INMO Professional

**Steve Pitman**
**Head of Education and Professional Development**

INMO Professional would like to wish all INMO members a Merry Christmas and a Happy New Year. We would also like to thank all members who contributed to the work of INMO Professional through their participation in education courses, section meetings and conferences and providing education courses in 2023.

### International Nurses and Midwives Section

The INMO International Section will be celebrating its 20th anniversary on December 6 in the Richmond Education and Event Centre. This will be a celebration that recognises the important contribution that internationally educated nurses and midwives have made to the Irish health system. The event will showcase some of the many achievements of these members as well as feature lively discussion and debates on some of the key issues for migrant nurses and midwives.

### Section conferences

November was a busy month for INMO section conferences and webinars. These included the All-Ireland Midwifery Conference that took place in Monaghan in November. The National Children's Nurses Section webinar also took place in November. This webinar included a presentation from Gráinne Bauer, chief director of nursing, Children's Health Ireland, who provided an update on the developments with the new Children's Hospital and children's nursing. The webinar also included a session on e-health and bereavement.

The INMO PHN Section webinar also took place in November and included presentations on: human trafficking from Annette Kennedy; technology in wound care monitoring by Prof Georgian Gethin; and digital health from Loretto Grogan. Recordings of webinars can be found at **www.inmoprofessional.ie**

The INMO ADON Section Masterclass featured a workshop led by Jane Salvage, a nursing policy activist, teacher and writer. Jane is the author of *The Politics of Nursing* and is a hugely influential nurse leader who has contributed to advancing nursing.

### National Digital Health Conference

Technology is becoming an increasing part of the delivery of healthcare. Nurses and midwives are at the heart of many of the innovations and changes that are being implemented across the country. Digital Health has been identified as one of the four key area of the *Report of the Expert Review Body* (2022). One of the key goals of Sláintecare is to digitally connect the health service and digitally connect the citizen to health. This will affect all HSE staff and will require the development of digital literacy skills and for significant investment in digital resources.

The National Digital Health Conference 'Better Together for Digital Healthcare 2023' will take place on December 1 in the Convention Centre, Dublin. This hybrid event is organised by the HSE Office of the Nursing and Midwifery Services Director, Digital Clinical Office and eHealth and Disruptive Technologies. Further information can be found at #Better2getherDH2023.

### Pure Foundation WaterWipes Bursary

Congratulations to the INMO members who were selected as the winners of the 2023 Pure Foundation WaterWipes Bursary Award: Mary Meade, a midwife at Sligo General Hospital, and Maria Flannery Boyle, a PHN in Ballina. Both winners have shown compassionate care and an unwavering commitment to going the extra mile to support women, families and babies. The INMO partnered with the WaterWipes Pure Foundation and were delighted with the high standard of nominations received this year. These nominations reflect the high-quality care provided by nurses and midwives in Ireland.

### CJ Coleman Award

INMO Professional is delighted to offer the CJ Coleman Research and Innovation Award again for 2024. The award is sponsored by CJ Coleman, insurance broker who have generously sponsored the INMO members' research award for over a decade. A bursary of €1,000 will be awarded for a completed research/change project, promoting and improving the quality of patient care and/or staff working conditions in an innovative way.

The closing date for completed applications is Friday, March 8, 2024. Further details and a link to the application form are available on the INMO website.

### On-site Education

INMO Professional offers an extensive range of on-site programmes facilitated by expert practitioners. If you are interested in booking, you can email: education@inmo.ie or Tel: 01 6640618/41.

### Delivering courses and writing for *WIN*

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

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

INMO Professional

# Education Programmes

Tel: 01 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**

**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.

**Feb 1** **Risk management and incident reporting**

This new online programme outlines the core principles of best practice in managing risk, underpinned by the philosophy and care needs. At the end of the session participants will be enabled to: understand key terms and definitions related to risk management in healthcare; outline the stages of the risk management process based on the international standard and framework for risk management; outline the five steps of risk assessment; understand the purpose and maintenance of a risk register and complete accurate records of incidents for incident reporting. Ultimately, this programme promotes best practice with risk management and patient safety.

**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.

Feb 7 **Chronic obstructive pulmonary disease – getting the basics right**

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

Feb 7 **Master your communication**

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.

Feb 8 **End of life care of the older person**

This programme offers nurses an opportunity to update their knowledge on caring for patients who have a life-threatening illness and are in need of palliative care. It identifies the main principles in end of life care for the older person. The concepts and philosophy of end of life care will be explored, as well as care planning. Advice will be provided on how to treat common symptoms experienced by older people at the end of life such as nausea, vomiting, breathlessness, delirium, moist respirations and constipation. It will improve knowledge and highlight the holistic care, inclusive of physical, spiritual, psychological, financial and emotional wellbeing, required by a patient and their family at end of life.

Feb 19 **Understanding and developing care plans for nurses**

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

Feb 21 **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. Learning outcomes: understand the anatomy and physiology of wound management; understand and identify the factors influencing wound healing; understand and identify the differences between acute and chronic wounds; understand and implement a holistic assessment of individuals with wounds; understand the current modalities of different types of dressing and their application.

Feb 22 **Type 1 diabetes management**

This short online education 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 continuous glucose monitoring (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 and midwives to try and formulate plans to look at issues that clients face.

Feb 22 **Mindfulness for midwives**

Are you a midwife/nurse/PHN working in a maternity hospital or community setting, and you are expected to support women during pregnancy, birth and beyond? Have you always desired more skills in teaching breathing and calming techniques to expectant parents? If your role involves taking antenatal classes or offering advice to women suffering unexpected outcomes, then this course is for you. Take this journey to the inner world and become aware of your breath, body, and emotions to offer your full presence to the mothers you serve.

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

# 2023/24 Education Programmes

Below are some of our online and in person courses scheduled for 2023/2024 for nurses and midwives.
Booking early is recomended, call 01 6640618/41 or email education@inmo.ie.

## Restrictive Practices
2023 Thematic support for your centres

**Mon, 20 November 2023**
**Thurs, 21 March 2024**

## Adult Asthma
Getting the basics right

**Wednesday,**
**22 November 2023**

## Assessment and Care Planning

**Wed, 22 November 2023**
**Mon, 19 February 2024**

## Competency based Interview preparation

**Thursday,**
**23 November 2023**

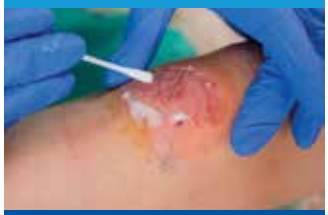
## Introduction to effective Library search skills

**Tuesday,**
**28 November 2023**

## Become more assertive

**Wednesday,**
**29 November**

## Wound care management

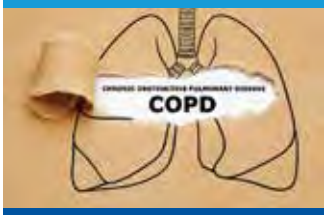


**Wed, 13 December 2023**
**Wed, 21 Feburary 2024**

## Risk Management & Incident reporting

**Thursday,**
**1 February 2024**

## COPD
Getting the basics right




**Wednesday,**
**7 February 2024**

## Master your communication

**Wednesday,**
**7 February 2024**

## End of life care for older people

**Thursday,**
**8 February**

## ONSITE EDUCATION
for Nurses and Midwives

Bringing education programmes to your workplace

SCAN HERE

**Call 01 6640618/41 or email education@inmo.ie**

For more information www.inmoprofessional.ie/course

INMOPROFESSIONAL

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Irish Nurses and Midwives Organisation
Working Together

# Mindfulness for Midwives

Thursday, 22 February 2024

ONLINE


Are you a midwife/nurse/PHN working in a maternity hospital or community setting, and you are expected to support women during pregnancy, birth and beyond? Have you always desired more skills in teaching breathing and calming techniques to expectant parents? If your role involves taking antenatal classes or offering advice to women suffering unexpected outcomes, then this course is for you.

Take this journey to the inner world and become aware of your breath, body, and emotions to offer your full presence to the mothers you serve.

The course will include; why Mindfulness matters; mindful breathing; breathing techniques for labour; mindfulness for breastfeeding mothers; mindful communication techniques for midwives and loving kindness meditation.

# Restrictive Practices

Monday, 20 November 2023;
Thursday, 21 March 2024

ONLINE


On 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 the June 2023 guidance framework.

SCAN HERE

**Call 01 6640618/41 or email education@inmo.ie**

For more information www.inmoprofessional.ie/course

INMOPROFESSIONAL

**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.

**Feb 27** **Telephone assessment for nurses and midwives**

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

**Feb 29** **Medication management best practice**

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

**Mar 6** **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.

**Mar 12** **Falls reduction, assessment and review**

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

**Mar 13** **Leg ulcer study session**

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

**Mar 21** **Restrictive practices – 2023 thematic support for your centres**

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 the June 2023 guidance framework.

**Apr 3** **Time management**

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

**Apr 17** **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. After completing this course, participants will be able to: discuss the causes of pressure ulcers; identify the factors that place a person at risk of developing pressure ulcers; have an understanding of the key principles of preventing ulcers and be able to take action to prevent pressure ulcers in the clinical environment; have an understanding of pressure ulcer classifications and grading; have an understanding of the key principles of the SSKIN Bundle and how to implement it in the clinical environment.

# Understanding the Harvard referencing system

## An overview of how and why you should reference your articles or research papers

PROPER referencing is an essential skill for nursing and midwifery students as it ensures the ethical use of information and demonstrates scholarly integrity. This article introduces the Harvard referencing system, emphasising its significance in academic writing, addressing plagiarism concerns, and providing a practical example for students to follow.

### Why reference?

Referencing is a fundamental aspect of academic writing. It not only acknowledges the sources of information but also plays a crucial role in upholding academic integrity. It is a location guide for your reader to be able to source the specific information to which you are referring or quoting. Along with the American Psychological Association (APA), the Harvard Referencing System is one of the most common styles in use for midwives and nurses engaged in education. For academic students, mastering their required referencing system is vital in demonstrating their ability to engage with academic literature and avoid plagiarism. Equally important in a world where misinformation is an increasing concern, understanding how to reference is a key skill which will be useful throughout your career as a midwife or nurse.

Referencing serves several essential purposes in academic writing:

- Avoiding plagiarism: this is the act of using someone else's work, ideas, or words without proper attribution. Referencing helps you avoid plagiarism by crediting the original authors. Plagiarism is a serious offense in academia and can lead to severe consequences
- Supporting your claims: Referencing allows you to support your arguments and claims with evidence from credible sources. This enhances the validity and credibility of your work
- Building on existing knowledge: Nursing and midwifery are dynamic disciplines with a wealth of research and knowledge. Referencing enables you to build on the existing knowledge by connecting your work to the broader body of literature
- Facilitating further research: Your references become a resource for other researchers and students who can explore the sources you've used for their own work.

### Understanding the Harvard referencing system

Originating at Harvard University, this referencing system is also known as the author-date system, distinguishing it from the more numerical systems.[1] It is one of the most widely used citation styles across academic settings. At its core, the system uses in-text citations which include the author's last name and the year of publication, while a full reference list is provided at the end of the document.

In-text citations are placed within the body of your text and refer to the full details in the reference list. Here's how they typically look:

- Single author: (Smith, 2019)
- Two authors: (Johnson & Williams, 2020)
- Multiple authors (more than two): (Brown et al., 2018)
- Direct quotations: (Smith, 2019, p. 45)

The reference list is a comprehensive list of all the sources cited in your work. It provides enough information for the reader to locate the source. The format of a reference varies depending on the type of source. Initially, sources included books and journals. However, today, there are a huge range of sources including websites, blog posts, podcasts, datasets and social media posts to name but a few.

One issue to note regarding the use of Harvard, is that while this system has specific guidelines, very often, there are slight variations depending on the college or university you are attending and what discipline you are studying under. Therefore, it is essential that if studying you ensure you have access to the guidelines provided by the School of Nursing and Midwifery. Your college library will also provide you with guidance relating to the specific referencing system you should you use.

Mastering a referencing system, such as the Harvard referencing system is crucial for students, but also for nurses and midwives engaged in writing papers or policies during the course of their work. It not only ensures academic integrity but also helps in building strong and evidence-based arguments in your academic work. Always remember to avoid plagiarism, give credit to original authors, and build on existing knowledge to contribute to the field of midwifery and nursing.

If you are looking for guidance on how to reference, the INMO library staff are on hand to assist with any queries you may have.

*Reference*

*1. Dwyer M. A guide to the Harvard referencing system. British Journal of Nursing. 1995; 4(10): 599-602*

### 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

Professional DEVELOPMENT CENTRE

i-learn Royal College of Midwives

# Genetics and genomics for midwifery practice

GENETICS and genomics for midwifery practice was originally written for iLearn by the National Genetics Education and Development Centre in the UK to help midwives develop a better understanding of genetics and genomics.

Genomic information is increasingly being used to understand the underlying basis of disease, to refine diagnoses, target treatment and diagnose infections. Midwives may therefore see families where previously unknown genetic disease has been identified, or where the cause of multiple foetal anomalies has been shown to be due to problems with several genes.

This module will take approximately two hours to complete.

## Why it matters

Genetics and genomics play a crucial role in midwifery practice by providing valuable insights into the health and well-being of expectant mothers and their babies. Midwives are responsible for guiding women through the entire pregnancy, from conception to postpartum care.

Understanding the principles of genetics and genomics is essential as it allows midwives to assess and address genetic risks, provide personalised counselling and enable informed decision making regarding antenatal care. They can help to identify genetic conditions that may affect the mother or the baby, assess the risk of hereditary diseases as well as offering appropriate guidance and support to expectant families.

## Role of the midwife

It is important to identify individuals and families who have inherited conditions because their family members may be at an increased risk of developing the condition or of being a carrier.

Some conditions are caused by chromosome anomalies and modern techniques can help us to understand their clinical implications. Other conditions are due to a combination of genetic changes that predispose a person to a condition. A midwife's understanding of genetics and inheritance is therefore important for the foetus, the mother and the wider family.

The role of midwives in genetics and genomics encompasses conducting comprehensive family medical histories, facilitating genetic counselling and ensuring informed consent for genetic testing.

Midwives can also educate and empower expectant parents to make informed choices regarding prenatal screening and testing options, as well as assist in interpreting genetic information and obtaining referrals to genetic specialists when necessary. By staying updated on the latest developments, midwives can better advocate for the health and wellbeing of their patients.

## Learning outcomes

Having completed this module, you should be able to:

- Understand your role in genetics and genomics
- Consider the skills required to gain appropriate information from the families in your care
- Demonstrate a knowledge of how genetic conditions occur and how they may be inherited within a family
- Describe your role in identifying those with a higher probability of having a genetic condition and how you would refer to specialist genetic services
- Appreciate how genomic information is likely to impact on maternity care.

### 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

# Quality & Safety

*A column by Maureen Flynn*

## Quality Improvement Collaborative Handbook

NURSES and midwives across the country are involved in quality improvement (QI). QI is a well-established, evidenced based approach to understanding processes and systems, pinpointing improvement opportunities, and designing sustainable solutions. In this month's column we share a new resource – the *Improvement Collaborative Handbook*. This will be of interest to nurses and midwives wishing to improve practice and care provided to patients.

At its simplest, a QI collaborative is a systematic approach to quality improvement in which organisations test and measure practice innovations and then share their experiences to accelerate learning and widespread implementation of best practice

### How collaboratives work

Improvement collaboratives use a structured approach to support individuals, teams and systems all at the same time. The shared learning and mutual support that comes from participating in a collaborative motivates us to do things differently, which in turn becomes an effective vehicle for change to improve patient outcomes, service use and costs. It involves:

- Team based learning sessions
- Identifying and testing changes for improvement
- Continuous sharing of ideas, learning and best practice
- Identification of an important quality or safety goal.

Collaboratives typically take 10-12 months to complete, following a series of learning sessions, action periods, measurement and evaluation and summative reports. A collaborative brings teams from multiple sites together to learn and share experiences together.

### Key roles

*Collaborative lead:* The collaborative lead assumes overall responsibility for the collaborative design, co-ordination, delivery and evaluation across the organisation, supported by a collaborative advisory group.

*Clinical champion:* Most often a front-line clinician responsible for guiding the design and delivery of the collaborative from a clinical perspective.

*Collaborative advisory group*: Members provide specific clinical expertise and QI technical knowledge and skill sets to support the planning, development and delivery of the collaborative.

*Site leads:* Each participating service designates a site lead. The site lead may be a local quality and patient safety leader or a clinician with experience in QI. The site lead is crucial in facilitating and guiding improvement locally.

*Project teams:* Every site will have one or more project teams, each with a team lead and three to eight team members. The team lead provides leadership and direction to the team, while the members actively contribute to the project's activities and work collaboratively towards achieving the improvement goals.

### Improvement Collaborative Handbook

Nurses and midwives across Ireland have participated in collaboratives for example in reducing falls and pressure ulcers. The new handbook is useful for all sectors of healthcare, as the QI methods presented are versatile and applicable across all areas where nurses and midwives work – in both clinical and corporate settings.

The handbook contains:

- Step-by-step guidance for organising and leading Collaboratives
- Worked examples from previous successful Collaboratives
- Integration of toolkits, templates and resources for data-driven results
- Tried-and-tested methods to tackle challenges across healthcare sectors.

This handbook is your compass to successfully lead, plan, and implement an improvement collaborative. It brings together the experience of the National QPS Directorate as well as other subject matter experts who have delivered collaboratives for over a decade. It presents an Irish-specific adaptation of the successful Breakthrough Series Collaborative Model from the Institute for Healthcare Improvement.


### Get involved

Read the two page summary on the National Quality and Patient Safety (QPS) Directorate website or download the full handbook. At your next ward, unit, team for group meeting talk about quality improvement. Connect with your hospital, hospital group or community care QPS lead to find out if there is a collaborative running in your area.

The National QPS Directorate can offer coaching, mentoring, advice, and useful resources to support the use of this handbook in delivering your improvement collaborative

### Further information

You can find the summary and handbook on the HSE website at: **https://urlis.net/improvecollab** or by scanning the QR code on the right.

To find more information or talk to a member of the NQPSD team please contact the team by email at QPS.Improvement@hse.ie

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

*Acknowledgements: Thank you to the QPS Improvement team and a special thank you to Maria Lordan Dunphy, Roisin Egenton, Dervla Hogan and Alison Dwyer for assistance in preparing this column. Thank you in advance to the team in the Dublin Midlands Hospital Group, who will be testing the Improvement Collaborative Handbook with NQPSD in 2023 and 2024 as they implement collaboratives in acute hospital services*

**Aparna Shukla** says that learning to meditate can help to develop resilience and manage stress

# Meditation: a stress-reducing life skill

AS NURSES and midwives, we like to plan and implement patient care and know exactly what to do and when to do it, but when it comes to selfcare, we can feel lost. Christmas can be a busy time, but if we take care of our minds and bodies while doing all other preparations rather than postponing it until after the new year, we will experience a win-win situation for us personally and professionally. Try to make a strategy that can be helpful to reduce stress and increase happiness.

Stress can be defined as a "state of worry or mental tension caused by a problematic situation. Stress is a natural human response that prompts us to address challenges and threats".[1]

While Christmas is a festive period, we can nevertheless encounter demands and challenges. Cohen et al described stress as an umbrella term when the environmental demands of a situation are more than an individual's perceived ability to cope with it psychologically and physiologically effectively.[2]

## Classification of stress

It is well known that stress not only affects our health but also affects our mood, behaviour and wellbeing. Anything that seriously threatens homoeostasis is stress according to Selye, who also observed that tissue damage and disease result from prolonged stress.[3] The human body can effectively cope with short-term stress, but it is prolonged stress that results in diseases.

Stress can be classified as good stress, tolerable stress or toxic stress.[4] Good stress is also known as eustress, which often results in growth and positive outcomes and promotes resilience. Tolerable stress often requires the support of family or friends to cope with the adverse situation and may cause distress. The person may still experience growth and develop resilience. However, in the case of toxic stress, the degree and duration of stress may be greater than the individual's capability to cope, and the person may have limited support from others.[4]

## Reducing stress

A stressful situation may lead to health-promoting or health-damaging behaviour.[4] One proven method to reduce stress is through meditation. Eight weeks of 13-minute daily meditation resulted in decreased anxiety and fatigue scores, mood disturbance and enhanced attention and memory.[5]

Many times, the first step towards meditation is difficult, or if we start meditating, then it may be challenging to maintain a regular practice. Here is a list of suggested ways to meditate that may help establish and maintain a regular practice:

- Set aside time for meditation either first thing in the morning or end your day with meditation before going to sleep
- Do not be rigid on time, instead start with only five minutes in the beginning and aim for 15 to 20 minutes daily
- If you find sitting down in silence difficult, then learn walking meditation
- A good starting point can be your local yoga class, as most yoga classes include meditation at the end with Shavasana
- It would be helpful to have a teacher who can guide you if you experience an obstacle in your meditation practice
- The mindfulness-based stress reduction eight-week course is the gold standard for mindfulness-based intervention.

## How to meditate

Keeping your meditation routine and ritual simple will likely keep you disciplined.

There are just three things necessary for your meditation:

- Your time
- Your attention
- Your intention.

Once you have these three ingredients, you may use golden silence to bring your attention to breath, body, sound or thoughts. Every time the mind wanders, bringing it back to breath, body or sound can be helpful to stay in the present moment experience.

Whether it is a festive period or not, we all experience some stress occasionally. Not all stress is harmful. Sometimes, stress is necessary for our growth and developing resilience. As nurses and midwives, we are constantly challenged by demanding situations at work. If we learn meditation techniques as a tool to manage stress, it may support us in living a more peaceful, balanced life. Mindfulness-based stress reduction meditation has been found to change our brain's grey matter concentration in areas associated with emotion regulation and learning, memory and self-referential processing.[6] This is evidence-based information and not just ancient Eastern practice.

I hope meditation practice can help you navigate the stressful elements of your daily life through the winter.

*Aparna Shukla is a registered nurse and midwife and a certified yoga teacher. She regularly facilitates mindfulness and yoga sessions for nurses and midwives for the INMO*

*References on request by email to: nursing@medmedia.ie (Quote Shukla, A. WIN 31(8) 39)*

# TEST campaign: 'think diabetes'

With potential severe long-term effects of diabetic ketoacidosis, it is important for both parents and healthcare professionals to recognise the signs of diabetes at an early stage, writes **Edna Roche**

IRELAND HAS A high incidence rate of type 1 diabetes in children and adolescents. It is in the top 25% for diabetes incidence worldwide.[1] The number of new cases in children under 15 years in Ireland has increased substantially from 16.3 cases/100,000/year in 1997[2] to 27.1 cases/100,000/year in 2018.[3]

Ireland's rate of diabetes appears to be stabilising, albeit at a high incidence rate.[3,4] Annually there are on average 285 new cases of type 1 diabetes diagnosed in those under 15 years.

The symptoms of type 1 diabetes can be subtle and vague and thus we need to 'think diabetes' and work with our community to reduce the number of children and young people presenting with diabetic ketoacidosis (DKA). The acronym 'TEST' is a reminder of the key diabetes symptoms:

- T – increased thirst
- E – energy depleted
- S – sudden weight change (weight loss)
- T – toilet trips increased.

It can be difficult to recognise the classic symptoms of polyuria and polydipsia in an adolescent due to their increased independence and privacy, particularly relating to toileting. Children under two years are particularly vulnerable to delayed diagnosis where the symptoms are increasingly vague, including irritability and constipation. The classic symptoms of polyuria and polydipsia are more difficult for families to recognise until well advanced, with nappies persistently leaking or bursting.

Delayed diagnosis in childhood diabetes is often due to families waiting to seek help due to the vagueness of the symptoms. The time from parents recognising the onset of symptoms to seeking medical help is the 'appraisal interval' and this is often the longest part of the pathway from symptom onset to diagnosis.[5] Parents report delaying seeking medical help for diabetes symptoms because they hoped the symptoms would go away,[5] and because they perceived their child was 'well'.[6]

Childhood diabetes due to insulin deficiency is rapidly fatal without insulin therapy. In the early stages the signs of diabetes in young children and teenagers can be subtle, sometimes making early diagnosis challenging. Delayed diagnosis of type 1 diabetes can result in potentially fatal metabolic decompensation or DKA.

In addition to its immediate risks, there is increasing evidence that the presence of DKA at diagnosis sets children and young people on a path of poor metabolic control and increased risk of diabetes-related complications in young adult life.

Type 1 diabetes is a multifactorial disease. It is an autoimmune condition where those with a genetic predisposition interact with an environmental agent(s), and autoimmune pancreatic beta cell destruction ensues leading to insulin deficiency.[7] Despite great advances and much research, the cause is not yet fully understood.

While there is a genetic tendency towards the development and also protective haplotypes, we found that only 10% of newly diagnosed children in Ireland had a history of type 1 diabetes in a first-degree relative, this is similar to other populations.[8] A diagnosis is a bolt out of the blue for most families.

Type 1 diabetes has a number of stages in its development[7] and by the time clinical symptoms occur over 90% of the pancreas has been destroyed. The clinical history is short, at two to three weeks.[8,9] If associated with an infection causing insulin resistance, the effects of the insulin deficiency become more extreme and the symptom duration shortens. A co-existing pneumonia or other significant infection can result in rapid metabolic decompensation into life-threatening DKA.

## Classic presenting symptoms of type 1

The classic presenting symptoms of type 1 diabetes are polyuria, polydipsia, lethargy and weight loss.[5,8,10] There are other less common but important clues to childhood diabetes which include:

- Secondary enuresis – bed-wetting in the previously toilet-trained child is important and warrants checking the urine for glucose
- Constipation, particularly in younger non-ambulant children who cannot complain of thirst or access increased fluids
- Irritability or mood-swings
- Increased hunger and persisting weight loss despite increased food intake[8]
- Fatigue and weight loss are significantly more frequent symptoms in those aged under two years with DKA at diagnosis.[10]

## Missed opportunities

In a meta-analysis of over 24,000 children, almost 40% with DKA had been seen at least once by a doctor before diagnosis; these were missed opportunities.[9] It is important to look out for the subtle symptoms and 'think diabetes'. A simple check of blood and urine can help exclude or confirm the diagnosis.

In a child with symptoms suggestive of type 1 diabetes, a glucometer is sufficient to check for glucose and blood ketones. The urine can also be checked for glycosuria and ketonuria. If the blood glucose is elevated or there is glycosuria, the child should be immediately referred to the local paediatric emergency department for further management.

A random glucose above 11.1mmol/L in a child with symptoms is enough to suggest a diagnosis of diabetes. No additional investigations are required. Children with type 1 diabetes can deteriorate rapidly into DKA even over a matter of hours, so they should attend their local hospital the same day without delay.

As the symptoms tend to be subtle, there is a tendency for the symptoms to be attributed to more common conditions or explained away and minimised.

The majority of children and young people presenting to their doctors with symptoms of diabetes will be diagnosed that day. However, approximately one-fifth of children are not diagnosed at the initial visit,[5,10,11] with some delayed up to two weeks.[11]

A study in the UK found that almost a quarter of children had multiple contacts with healthcare professionals prior to diagnosis.[10] In almost half the cases of delayed diagnosis, the reason for the delay was waiting for additional unnecessary tests.[10,11] DKA was more frequent in those where diagnosis was delayed.[10,11]

## Medical emergency

DKA is a medical emergency. It is a life-threatening acute metabolic decompensation due to insulin deficiency characterised by hyperglycaemia, acidosis and ketonaemia/ketonuria.[12] The clinical signs of DKA (in association with the background symptoms of diabetes) are dehydration, vomiting, abdominal pain and sighing respirations (Kussmaul breathing) which if untreated can progress to coma and death.

DKA can still be fatal in children even in developed healthcare systems, with a mortality rate of 0.15% to 0.3%.[13] Cerebral oedema accounts for the majority of deaths. The risk of developing cerebral oedema in new onset diabetes is 11.9/1,000 DKA episodes or 1.2%.[14] Cerebral oedema is associated with a 24% mortality and morbidity in 35% of survivors.[14] Younger children, particularly those under two years, are most vulnerable to DKA and cerebral oedema.[10]

Apart from the immediate health risks of DKA, its medical management is challenging, requiring meticulous management and strict adherence to written protocols specific to children and adolescents. The required treatment is intensive with intravenous insulin, fluid and electrolytes.

Treatment of DKA is not without its dangers. Continuous clinical monitoring with hourly blood testing is required. The treatment and monitoring of DKA is very stressful and frightening for young children, adolescents and their parents.[6] The trauma is further exacerbated by the sudden onset where the child may have been perceived as 'well' by their parents only hours or days previously.

When a child presents with DKA at diabetes diagnosis, a period of stabilisation of 24-48 hours is required before meaningful education regarding diabetes and its management can happen, resulting in a prolonged hospitalisation.

In contrast, a child or adolescent with a new diagnosis of diabetes who does not have DKA has a very different course. Those diagnosed and referred early who have hyperglycaemia but not acidosis often do not even require intravenous fluids, can eat and commence insulin subcutaneously. They do not require ICU or HDU admission; monitoring is much less intense and less invasive. They and their families are less stressed, diabetes education and training can commence sooner and the duration of hospitalisation is shorter. Currently all children and young people with new onset diabetes are admitted to hospital in Ireland to commence treatment.

There is wide international variation in the occurrence of DKA at diabetes diagnosis in children, ranging from 16-67%.[15] The Irish Childhood Diabetes National Register prospectively monitors the rate of DKA at diagnosis and reported almost one-third (31.6%) of children had DKA at diagnosis in the period 2011 to 2015.[16]

More recent data would suggest the rate of DKA at diagnosis in Irish children has exceeded 40%.[17] This rate is too high. DKA at diagnosis is avoidable by earlier detection and prompt intervention. Reducing the incidence of DKA at diagnosis is a vital therapeutic target.

## Long-term adverse effects of DKA

Increasing evidence is emerging of the long-term adverse effects of DKA at diabetes diagnosis for children and adolescents.[18] Cameron et al found evidence of morphological and functional brain changes in children with DKA at diabetes diagnosis.[19] There is an association between the average metabolic control around the time of diagnosis and in future years.[20,21] In addition, those with poorer metabolic control around the time of diagnosis had increased diabetes-related complications of retinopathy and macroalbuminuria in early adult life.[20]

The patient charity Diabetes Ireland recently launched its TEST campaign. This is aimed at raising awareness of the symptoms of type 1 diabetes within both health professionals and the general population. This campaign is in collaboration with the Irish Childhood Diabetes National Register.

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**Presentations:** Cosentyx 150 mg solution for injection in pre-filled pen and Cosentyx 300 mg solution for injection in pre-filled pen. **Therapeutic Indications:** The treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy; the treatment of moderate to severe plaque psoriasis in children and adolescents from the age of 6 years who are candidates for systemic therapy; the treatment of active moderate to severe hidradenitis suppurativa (acne inversa) in adults with an inadequate response to conventional systemic HS therapy; the treatment, alone or in combination with methotrexate (MTX), of active psoriatic arthritis in adult patients when the response to previous disease-modifying anti-rheumatic drug (DMARD) therapy has been inadequate; the treatment of active ankylosing spondylitis in adults who have responded inadequately to conventional therapy; the treatment of active non-radiographic axial spondyloarthritis with objective signs of inflammation as indicated by elevated C-reactive protein (CRP) and/or magnetic resonance imaging (MRI) evidence in adults who have responded inadequately to non-steroidal anti-inflammatory drugs (NSAIDs); alone or in combination with methotrexate (MTX), the treatment of active enthesitis-related arthritis in patients 6 years and older whose disease has responded inadequately to, or who cannot tolerate, conventional therapy; alone or in combination with methotrexate (MTX), the treatment of active juvenile psoriatic arthritis in patients 6 years and older whose disease has responded inadequately to, or who cannot tolerate, conventional therapy. **Dosage & Method of Administration:** *Adult Plaque Psoriasis:* 300 mg given as one subcutaneous injection of 300 mg or as two subcutaneous injections of 150 mg. Dosing at Weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Based on clinical response, a maintenance dose of 300 mg every 2 weeks may provide additional benefit for patients with a body weight of 90 kg or higher. *Paediatric Plaque Psoriasis:* The recommended dose is based on body weight (see Table 1 in SmPC for full details) and administered by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Each 75 mg dose is given as 1 subcutaneous injection of 75 mg. Each 150 mg dose is given as 1 subcutaneous injection of 150 mg. Each 300 mg dose is given as one subcutaneous injection of 300 mg or as 2 subcutaneous injections of 150 mg. The 150 mg and 300mg solution for injection in pre-filled syringe and pre-filled pens are not indicated for administration to paediatric patients with a weight <50 kg. *Hidradenitis suppurativa (HS):* The recommended dose is 300 mg of secukinumab by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3, and 4, followed by monthly maintenance dosing. Based on clinical response, the maintenance dose can be increased to 300 mg every 2 weeks. Each 300 mg dose is given as one subcutaneous injection of 300 mg or as two subcutaneous injections of 150 mg. *Psoriatic Arthritis:* For patients with concomitant moderate to severe plaque psoriasis, please refer to adult plaque psoriasis recommendation. For patients who are anti-TNFα inadequate responders, the recommended dose is 300 mg by subcutaneous injection with initial dosing at Weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Each 300 mg dose is given as one subcutaneous injection of 300 mg or as two subcutaneous injections of 150 mg. For all other patients, the recommended dose is 150 mg by subcutaneous injection with initial dosing at Weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. Based on clinical response, the dose can be increased to 300 mg. *Ankylosing Spondylitis (AS, radiographic axial spondyloarthritis):* The recommended dose is 150 mg by subcutaneous injection with initial dosing at Weeks 0, 1, 2 3 and 4, followed by monthly maintenance dosing. Based on clinical response, the dose can be increased to 300 mg. *Non-radiographic axial spondyloarthritis (nr-axSpA):* The recommended dose is 150 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3 and 4, followed by monthly maintenance dosing. *Juvenile idiopathic arthritis (JIA): Enthesitis-related arthritis (ERA) and juvenile psoriatic arthritis (JPsA):* The recommended dose is based on body weight (see Table 2 in SmPC for full details) and administered by subcutaneous injection at weeks 0, 1, 2, 3, and 4, followed by monthly maintenance dosing. Each 75 mg dose is given as one subcutaneous injection of 75 mg. Each 150 mg dose is given as one subcutaneous injection of 150 mg. The 150 mg and 300 mg solution for injection in pre-filled syringe and in pre-filled pen are not indicated for administration to paediatric patients with a weight <50 kg. Cosentyx may be available in other strengths and/or presentations depending on the individual treatment needs. For all of the above indications, available data suggest that a clinical response is usually achieved within 16 weeks of treatment. Consideration should be given to discontinuing treatment in patients who have shown no response up to 16 weeks of treatment. Some patients with initially partial response may subsequently improve with continued treatment beyond 16 weeks. The safety and efficacy of Cosentyx in children with plaque psoriasis and in the juvenile idiopathic arthritis (JIA) categories of ERA and JPsA below the age of 6 years have not been established.The safety and efficacy in children below the age of 18 years in other indications have not yet been established. **Contraindications:** Severe hypersensitivity reactions to the active substance or to any of the excipients. Clinically important, active infection (e.g. active tuberculosis). **Warnings/Precautions:** *Infections:* Secukinumab has the potential to increase the risk of infections. Serious infections have been observed in patients receiving secukinumab in the post-marketing setting. Infections observed in clinical studies are mainly mild or moderate upper respiratory tract infections such as nasopharyngitis not requiring treatment discontinuation. Non-serious mucocutaneous candida infections more frequently reported for secukinumab than placebo in psoriasis clinical studies. Caution in patients with a chronic infection or a history of recurrent infection. Instruct patients to seek medical advice if signs or symptoms suggestive of an infection occur. If a patient develops a serious infection, close monitoring and discontinue treatment until the infection resolves. Should not be given to patients with active tuberculosis. Anti-tuberculosis therapy should be considered prior to initiation in patients with latent tuberculosis. *Inflammatory bowel disease:* Cases of new or exacerbations of inflammatory bowel disease have been reported with secukinumab. Secukinumab is not recommended in patients with inflammatory bowel disease. If a patient develops signs and symptoms of inflammatory bowel disease or experiences an exacerbation of pre-existing inflammatory bowel disease, secukinumab should be discontinued and appropriate medical management should be initiated. *Hypersensitivity reactions:* In clinical studies, rare cases of anaphylactic reactions have been observed in patients receiving secukinumab. If an anaphylactic or other serious allergic reactions occur, administration should be discontinued immediately and appropriate therapy initiated. *Latex-sensitive individuals:* The removable cap of the Cosentyx pre-filled pen contains a derivative of natural rubber latex. *Vaccinations:* Live vaccines should not be given concurrently with secukinumab. Patients may receive concurrent inactivated or non live vaccinations. Prior to initiating therapy with Cosentyx, it is recommended that paediatric patients receive all age appropriate immunisations as per current immunisation guidelines. *Concomitant immunosuppressive therapy:* Use in combination with immunosuppressants, including biologics, or phototherapy have not been evaluated. **Interactions:** Live vaccines should not be given concurrently with secukinumab. In a study in adult subjects with plaque psoriasis, no interaction was observed between secukinumab and midazolam (CYP 3A4 substrate. No interaction seen when administered concomitantly with methotrexate (MTX) and/or corticosteroids. Caution should be exercised when considering concomitant use of other immunosuppressants and secukinumab. **Fertility, Pregnancy and Lactation:** Women of childbearing potential should use an effective method of contraception during treatment and for at least 20 weeks after treatment. It is preferable to avoid the use of Cosentyx in pregnancy as there are no adequate data from the use of secukinumab in pregnant women. It is not known whether secukinumab is excreted in human milk. A decision on whether to discontinue breast feeding during treatment and up to 20 weeks after treatment or to discontinue therapy with Cosentyx must be made taking into account the benefit of breast-feeding to the child and the benefit of Cosentyx therapy to the woman. The effect of secukinumab on human fertility has not been evaluated. **Undesirable Effects:** *Very common (≥1/10);* Upper respiratory tract infections. *Common (≥1/100 to <1/10);* Oral herpes, rhinorrhoea, diarrhoea, fatigue, nausea and headache *Uncommon (≥1/1,000 to <1/100);* Oral candidiasis, otitis externa, urticaria, neutropenia, dyshidrotic eczema, conjunctivitis, lower respiratory tract infections, tinea pedis and inflammatory bowel disease. *Rare (≥1/10,000 to <1/1,000);* Anaphylactic reactions, exfoliative dermatitis and hypersensitivity vasculitis. Unknown: Mucosal and cutaneous candidiasis (including oesophageal candidiasis) and pyoderma gangrenosum. Please see Summary of Product Characteristics for further information on undesirable effects. **Legal Category:** POM. **Marketing Authorisation Holder:** Novartis Europharm Ltd, Vista Building, Elm Park, Merrion Road, Dublin 4, Ireland. **Marketing Authorisation Numbers:** EU/1/14/980/004 and EU/1/14/980/010. **Prescribing Information last revised:** May 2023. Full prescribing information is available upon request from: Novartis Ireland Limited, Vista Building, Elm Park Business Park, Elm Park, Dublin 4. 01-2601255 or at www.medicines.ie. Detailed information on this product is also available on the website of the European Medicines Agency http://www.ema.europa.eu.

**Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk profile of the medicinal product. All suspected adverse reactions should be reported to HPRA Pharmacovigilance at www.hpra.ie. Adverse events can also be reported to Novartis preferably at www.novartis.com/report, by emailing drugsafety.dublin@novartis.com or by calling (01) 2080 612.**

* Patients refers to patients that have been prescribed Cosentyx for any indication since launch. Data as of December 2022. Please note this is an estimated number.

PsA=psoriatic arthritis; axSpA=axial spondyloarthritis and includes ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (nr-axSpA).

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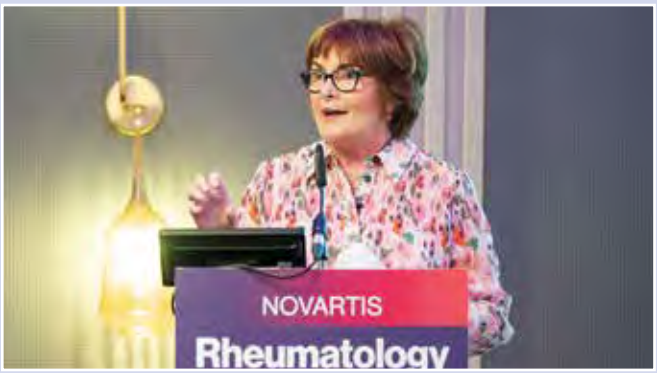
# Novartis Rheumatology and Dermatology Nurses Collaborative Forum

**Pictured at the Rheumatology and Dermatology Nurses Collaborative Forum hosted by Novartis were (l-r):** *Mary O'Sullivan, Ursula Bond, Michele Buckley, Carmel O'Sullivan, and Angela Murphy, all with the South Infirmary Cork dermatology team*




**Pictured presenting at the Forum was:** *Ursula Bond, South Infirmary Cork*

**Also pictured was:** *Patricia Minnock, Our Lady's Hospice and Care Services, Harold's Cross Dublin*

**Also pictured were (l-r):** *Irene Joseph, CNS, Connolly Hospital; Liz McGowan, CNS, Navan Hospital; and Joanne Denning, CNM2, Navan Hospital*

**Also pictured were (l-r):** *Mary O'Sullivan, CANP, South Infirmary Victoria University Hospital, Cork; and Mari O'Connor, ANP, University Hospital Kerry*


**Also pictured were (l-r):** *Brian Whately, Kristina Huebner, Kate Barton, Jackie Healy, Lorna Rice, Irene Webster and Patrick Kelly, all with Novartis Ireland*


**Also pictured was:** *Sharon Clernon, Cognitive Behavioural Therapist, Mindview Clinic*

# Leading by example: *Empowering your team's professional development*

## **Orla Kenny** reflects on her time as a clinical nurse manager charged with supporting the professional development of her teams

THE frontline clinical nurse/midwife manager has an integral role and a responsibility for the professional development of staff nurses/midwives working within their departments and units.[1] The wider multidisciplinary team can also be incorporated and influenced through this professional development, reflective of the recommendations in the Ockenden Report[2] that advocates for interdisciplinary professional development.

While the mandatory process of performance achievement[3] using tools such as a professional development plan (PDP) is individualistic and confidential between a nurse or midwife and their manager, there is scope for a team approach to professional development to complement this one-to-one interaction.[4]

I have had a career-long interest in the nursing-journal-club model to cultivate a culture of inquiry and to promote evidence-based practice among my peers and colleagues.[5] While working as a research nurse I established a neurology nursing journal club with my colleagues to create a platform for shared learning and an opportunity to discuss up-to-date neurology nursing concerns.

Participation in this journal club was enthusiastic with a willingness to engage and share responsibility for the running of the club. I carried this positive experience into my first clinical nurse manager role where I worked in day services with an experienced nursing team.

Navigating the professional development plans with this nursing team was a challenge as they had generally reached a high-level of competency and had completed all relevant professional development modules on offer in the hospital. One aspect of professional development that remained unexplored with this team was that of active engagement in the discussion of current research and its application to practice. Drawing on my previous positive experience with the journal-club model, I thought that this could be a way to introduce evidence-based practice discussion into the professional development process.

The intention was that each member of the nursing team would choose an article, policy or set of guidelines on a topic that was of interest to them and was relevant to their role; they would then give a presentation on this topic to the rest of the nursing team which would initiate a discussion on the application of this evidence to practice.

Initially the team was resistant, requiring a lot of encouragement and support to engage with the journal club. I managed this resistance by addressing the individual and interpersonal factors of resistance.[6] I obtained buy-in from one influential nursing team member who in turn encouraged more team members to engage with the process.[7]

Although the format of the journal club required adaptation to accommodate this nursing team, as the clinical nurse manager I was willing to make this change as it allowed for engagement with the initiative.

The journal club created debate and conversation among the multidisciplinary team (MDT). This was best reflected within the plastic surgery department where the nursing team was now empowered to compare the evidence concerning the management of skin grafting with their own clinical experience and then competently discuss treatment options with the plastic surgery MDT. One member of the nursing team and I presented a poster about our evidence review of skin graft management at a national conference[8] that was then displayed in the plastic surgery clinic – a great achievement for the nursing team.

In a subsequent role, I managed an acute unit that was staffed by a wonderfully enthusiastic, albeit junior, nursing team. Managing their professional development as a team required a grassroots approach. Having spoken with peers and senior colleagues, and taking into account the time and resource pressures within the department, I decided to run regular on-site clinical skills workshops for the junior staff nurses.

A notice board with high visibility to the nursing team was re-purposed as the staff communication board. Each week I would invite a clinical expert to attend the department and provide theory with practical demonstration to the nursing team.

Experts who attended included:

- A tissue viability clinical nurse socialist (CNS) who addressed specific aspects of wound care
- A surgical clinical facilitator who provided updates on best practice in PICC line and central line care
- The unit physiotherapist who demonstrated positive airway pressure set-up
- The ENT CNS who addressed new developments in tracheostomy care.

In accessing the expertise already available within the hospital this initiative allowed junior staff nurses to add to their undergraduate skill development and limited postgraduate experience in a practical setting with expert guidance, while being cost neutral to the organisation.

I created a timetable of upcoming sessions on the communication board. Sessions were offered on a rolling basis to accommodate those on night duty and

weekend work. Attendance sheets were maintained for each session for auditing purposes. Engagement with the sessions was mandatory within the department and merged into the staff nurses' continuous professional development portfolio.

By way of practical support, while these sessions were taking place, I would take up the staff nurses' duties to include medication administration, intravenous care, post-operative care, nutrition support etc. This allowed the work of the department to continue with no effect on direct patient care. The staff nurses were therefore not anxious to rush through training sessions to prevent a backlog in their duties, but were afforded the opportunity to focus on their professional development, confident in the knowledge that patient care would not be interrupted.

Supporting the staff nurse/midwife in their professional development, whether they are junior or senior in experience, is an important role for the frontline clinical nurse/midwife manager. It demonstrates good leadership[9] and shows a genuine commitment for the progression of competence within the nursing/midwifery team, in keeping with the effective building of high-trust relationships as promoted in Covey's habits of highly effective people.[10]

We can all think of an example of the nurse or midwife manager who spends the day behind a closed office door and we are familiar with the resulting frustration this can cause among the nursing team. The Mid Staffordshire report of 2013 highlighted this very point and requested the nurse leader to actively supervise and support nursing care as opposed to remaining office bound.[11]

Of course, the clinical nurse/midwife manager must be supported and empowered in their own role so that they can in turn support their team by ensuring adequate staffing levels. The clinical nurse/midwife manager who leads by example and promotes the importance of professional development by putting it high on their agenda will gain respect and followership from their nursing or midwifery team.

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# Advances in healthcare:

## *Digital assessment for pre-operative electives*

**Geraldine Otway** discusses how nurses at Cork University Hospital are using a digital platform to optimise the pre-operative assessment process

IN OUR preoperative assessment clinic (PAC) at Cork University Hospital, we have used different approaches to gather pre-admission-related patient data, including a paper-based health questionnaire, phone assessments, booking forms, letters, notes and also carrying out face-to-face assessments.

Our aim is to see the more complex patients, who are likely to need an anaesthetic review, in a face-to-face clinic and to assess the less complex patients by phone. We were looking for a way to use our specialist nurses' time efficiently, so that the right patients are assessed in the right clinic.

### Challenges

Our pre-operative and pre-assessment service is ever evolving which can present challenges. Some of the issues include:

- Older patients with more complex co-morbidities
- Increase in chronic diseases, higher risk surgeries being performed
- Urgent surgeries with short lead times
- A greater onus on shared decision making and patient choice
- Careful use of resources: theatre utilisation, necessity to reduce delays, ensuring correct appointment type, and requirement for all elective surgical patients to be pre-assessed.

### PAC team developments

Our PAC team has implemented ongoing developments to the service including:

- Introducing standardised pathways for patients using the service, standardised assessment documentation and completion of standardised nurse education programme (run via SETU which is a nationally recognised Certificate in pre-assessment – 10 credits at level 8)
- Ensuring ongoing support from a lead anaesthetic consultant to oversee service provision and advancement
- Establishing standardised policies and procedures to direct care and the use of standardised guidelines in pre-operative testing
- Development of a role for the staff nurse, clinical nurse specialist (CNS), clinical nurse manager (CNM) and advanced nurse practitioner (ANP), with expansion of the nursing role to include risk assessment, screening – for example for malnutrition and assessment of functional capacity – in addition to nursing assessment, observations and swabs.

Ongoing challenges, including navigating a pandemic, required the PAC team to explore other solutions that would optimise the pre-assessment process. This led to the implementation of a digital platform called 'My Pre Op' which was designed to streamline the pre-operative process for patients. It allows them to input essential medical and surgical information, history and other relevant details in an electronic format. We now use this platform to assist us to stream patients into either a phone or face-to-face appointment.

### Clinics

Our patients are booked into a phone or face-to-face clinic by the surgical team using a bed booking form and a supporting tool to identify what American Society of Anaesthesiology (ASA) grade to score the health of a patient. The ASA score is used with locally agreed guidelines and grades of surgery to direct patients to the most suitable appointment.

Patients are assessed in PAC using two pathways:

- Pre-admission assessment face-to-face clinic +/- My Pre Op online assessment software for patients who are ASA 3 to 4 and are having complex surgery
- Pre-assessment telephone clinic +/- My Pre Op online assessment software for patients who are an ASA 1 to 2 and having less complex surgery.

### Digital platform

Currently 44% of our patients have their pre-assessment by phone. The rest are seen in a face-to-face clinic, where up to half will need to be seen or reviewed by one of the anaesthetic team.

Almost one-quarter (24%) of all patients seen in our face-to-face clinic have been streamed using My Pre Op and half of our phone assessments have been streamed using the My Pre Op tool. This is a significant saving in resources. We monitor how many patients have been inappropriately booked into each clinic to help refine the booking process.

Patients are given verbal and written information about the digital platform at their surgical outpatient clinic appointment. The patient's details are registered by clerical staff and they are sent a link to their phone with a unique access code. The patient clicks on the link and completes the assessment. Up to three links are sent in total.

Our nurses monitor the reasons for non-completion of the online assessment and the user feedback, and suggestions are used to improve future services. Any issues are fed back to the PAC team, the anaesthetic lead and senior nurse management. The hospital's quality department has also assisted in developing policy and procedure around this initiative.

### Challenges

Feedback from patients includes fear of the link being a scam and that they were unaware of length of time needed to complete the assessment – which can be 30 to 70 minutes depending on a patient's history etc. Patients also reported that when they left the assessment and returned later, that sometimes they were unable to

get back in. As a result, we worked closely with the providers of the digital platform to resolve issues for patients.

The platform has a help link and users are advised to have a record of their medical and surgical history, allergies, and medications to hand when completing the assessment in order to speed up the process. Patients' data is stored securely in the provider's cloud-based system.

The online pre-operative assessment platform guides the user through each section of the preoperative assessment. The assessment uses algorithms to analyse the user's data to assess surgical and anaesthetic risks and it provides recommended testing based on NICE preoperative testing guidelines.

Once the assessments are returned, the patient is then streamed to a phone or face-to-face clinic by a senior nurse or a consultant anaesthetist. The anaesthetist has the option to make written recommendations for reviews, tests or medication etc, on the assessment document as needed.

When introducing an initiative like this it is important that there is an ongoing communication campaign to educate both current and new staff of its purpose. It is advisable to have a medical and nursing lead from pre-assessment staff to answer questions and follow up any feedback on issues arising.

This system is very useful for tracking where a patient is in the surgery process, and all staff involved in a patient's care can see their health status, ASA grading and anaesthetic risk factors, which is helpful in the planning of anaesthetic lists on the day of surgery.

*The PAC team: Eileen Murphy, PAC clerical; Lisa Murphy, PAC staff nurse; Dei Cliffe, PAC staff nurse; Geraldine Otway, CNM2; Colette Sweeney, CNM2; Sudha Ezhilalin, PAC clerical; and Wayne Allen, CNM3.Other team members include Noreen O'Leary, ADON and Dr Brian O'Donnell, consultant anaesthetic lead*

*Geraldine Otway is a clinical nurse specialist 2 in pre-assessment services at Cork University Hospital*

# Home is where the heart is

The case of a 59-year-old man who attends an advanced heart support clinic offers a window into how successful discharge of the chronic heart failure patient is achieved, writes **Christine Howley**

ADVANCED chronic heart failure (HF) is a condition in which HF has progressed to a stage where conventional evidence-based therapies are no longer effective,[1] and advanced therapies such as mechanical circulatory support, heart transplantation and/or palliative care are required.

Within this subgroup of patients are those who are ineligible for advanced therapies and remain symptomatic. The National Heart Programme *Heart Failure Model of Care*[2] published in 2021 outlines the structures that should be adopted in the care of patients with HF, including those living with advanced disease. These patients can be burdened with HF symptoms as their disease advances. The Model of Care emphasises the importance of the role of the clinical nurse specialist and advanced nurse practitioner in the care of people with HF in the hospital, community and integrated care teams.

As outlined in this model, it is important to consider end-of-life care and control HF symptoms. These patients can benefit from home inotropes to relieve symptoms, improve quality of life and improve mortality. Prognosis for patients on home inotropes is approximately six to nine months.[3]

This article looks at the case of a patient deemed unsuitable for advanced therapies who is currently managed with intravenous home inotropes.

**Table: Effects of IV milrinone on the patient's right heart catheterisation (RHC) pressures**

| RHC | Normal | On admission | IV milrinone 0.25mcgs/kg/min |
|---|---|---|---|
| RA | 0-5mmhg | 4mmhg | 2mmhg |
| RV | 15-25/4-8mmhg | 31/2 | 38/1 |
| PA | 15-25/4-12mmhg | 34/13 m 21 | 36/14 m 25 |
| PCWP | 6-12mmhg | 15mmhg | 11mmhg |
| PA Sat | < 70% | 63.3% | 74% |
| CO | 4-7l/min | 2.9l/min | 5.03l/min |
| PVR | < 2.5wu | 2.07wu | 1.39wu |

## Case report

The patient in this case is a 59-year-old man who is regularly followed up in the advanced heart support clinic. He was originally diagnosed with a dilated cardiomyopathy in 2013 and, despite optimum HF medications and subsequent implantable cardioverter defibrillator (ICD) upgrade to cardiac resynchronisation therapy (CRT) in 2022, his disease continued to progress. The patient required frequent admissions for management of his advanced HF symptoms.

Due to multiple comorbidities, cardiac cachexia and renal impairment, the patient was deemed unsuitable for heart transplantation or mechanical circulatory support at a multidisciplinary level. During hospitalisation, his symptoms improved and stabilised with intravenous milrinone administered via peripherally inserted central catheter line (PICC). Milrinone, an intravenous inodilator agent, is a phosphodiestase inhibitor that has been shown to increase cardiac output, reduce preload and afterload, and improve overall symptoms in advanced HF.[4] Significant improvement was noted in the patient's right heart catheterisation pressures and symptoms following intravenous milrinone *(see Table)*.

In joint evaluation, the multidisciplinary team, comprising the advanced HF and palliative care teams, the patient and his family, concluded that palliative care with a focus on symptom management and improved quality of life was the best approach. As his symptoms and right heart

catheterisation pressures improved, the option of discharging home with continuous milrinone infusion was discussed. The patient and his family were made aware of the potential risks and benefits and agreed to the use of milrinone to manage symptoms and improve quality of life.

An application was submitted to the HSE and funding was approved. The patient and his family received extensive education and training regarding the management of the infusion, troubleshooting the pump and changing the line and syringes. Nursing, pharmacy, physiotherapy, a dietitian, a social worker and the palliative care team all participated in the successful discharge home of this patient.

The patient was discharged on a stable regime of intravenous milrinone at 0.25mcg/kg/min and diuretics. Initially he was reviewed weekly in the heart support clinic where his symptoms were assessed, PICC line flushed and dressed and labs reviewed. Subsequently, this was changed to monthly reviews in the heart support clinic as he remained stable. The PICC line was dressed weekly by the community intervention team.

## Discussion

Worldwide, while the prevalence of advanced HF has increased, therapies and treatment options have improved.[5] This has brought about an increase in patients requiring home inotropes in order to relieve symptoms, improve quality of life and prevent mortality, both as a bridge to advanced therapies or as an integrated strategy for palliative care.

Intravenous milrinone has also reduced hospitalisations, as well as decreased the overall costs of advanced HF.[4] It appears that intravenous inotropes are an effective alternative for carefully selected patients who are severely symptomatic and advanced HF patients who are unsuitable for advanced therapies.

This case study describes the home use of intravenous inotropes to improve symptoms and quality of life of a patient living with advanced heart failure who is unsuitable for advanced therapies, i.e. mechanical circulatory support or cardiac transplantation.

The use of intravenous milrinone has allowed this patient to remain at home with his wife and two children. Although the patient still has limitations, he continues to work when he can, enjoys meeting friends and spending quality time with his family.

In his own words: "I feel very fortunate to have a huge amount of support in this regard. I won't claim to be partying like it's 1999 but I am enjoying good quality of life and time at home with my family that would not be possible without the freedom that this small milrinone infusion pump has given me."

*Christine Howley is a heart failure clinical nurse specialist at Mater University Hospital in Dublin*

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# Focus on male LUTS

## Updated European guidelines on the management of male LUTS recommend conservative management before surgery is considered

IN ITS recently updated guidelines on the management of non-neurogenic male lower urinary tract symptoms (LUTS), the European Association of Urology (EAU) carried out a forensic review of the surgical treatment of male LUTS and benign prostatic obstruction (BPO).

These EAU guidelines offer practical evidence-based guidance on the assessment and treatment of men aged 40 years or older with various non-neurogenic benign forms of LUTS, including symptoms secondary to BPO, detrusor overactivity/overactive bladder (OAB) and nocturnal polyuria.

The guidelines begin by stating the importance of a careful medical history and physical examination. Validated symptom scores, urine test, uroflowmetry and postvoid urine residual, should be used, as well as frequency-volume charts for patients with nocturia or predominately storage symptoms.

The guidelines include a flowchart illustrating conservative and pharmaceutical treatment choices *(see Table 1)*. Men with mild symptoms are candidates for watchful waiting. Behavioural modification should be offered to men with LUTS prior to, or concurrent with, treatment.

The choice of medical treatment depends on the assessment findings, predominant type of symptoms, ability of the treatment to change the findings, and the expectations to be met in terms of the speed of onset, efficacy, side effects and disease progression.

Surgery is the next step when patients have had insufficient relief of LUTS or post-void residual after conservative or pharmacological treatments.

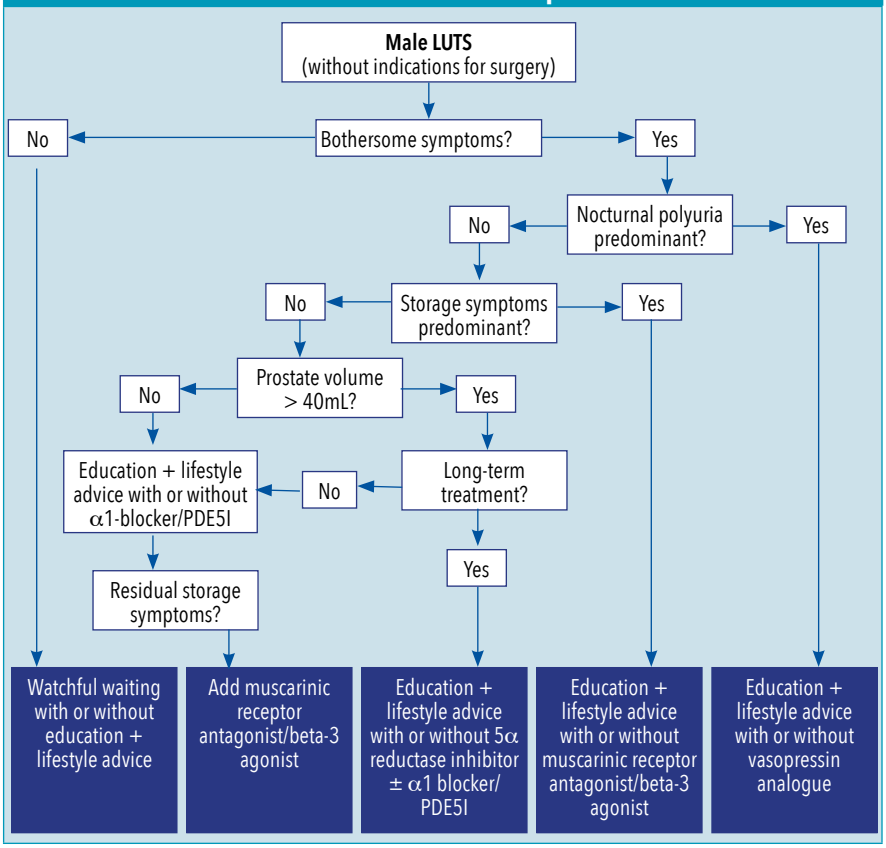
Surgical treatment is indicated in patients with recurrent or refractory urinary retention, overflow incontinence, recurrent urinary tract infections (UTIs), bladder stones or diverticular, treatment-resistant visible haematuria due to BPH, benign prostatic enlargement (BPE) or dilatation of the upper urinary tract due to BPO, with or without renal insufficiency.

Surgical management is divided by surgical approach into: resection, enucleation, vaporisation, alternative ablative techniques and non-ablative techniques. The choice of the surgical technique depends on prostate size, comorbidities, ability to undergo anaesthesia, patient's preference and willingness to accept surgery-associated side effects, as well as the availability of the surgical armamentarium and the experience of the surgeon.

The guidelines panel is promising a new section on underactive bladder, as well as a structured assessment of the literature, in next year's update of the guidelines on non-neurogenic male LUTS. The full 2023 guidelines and a pocket version are available at: **uroweb.org/guidelines/management-of-non-neurogenic-male-luts**

**–Tara Horan**

**Table 1. Algorithm for treatment of male LUTS using medical and/or conservative options**




49% of men with LUTS report bladder and prostate symptoms[1]

## VESOMNI treats the symptoms of both the bladder and prostate[2]

Vesomni™
solifenacin/tamsulosin

**Prescribing information: VESOMNI™ 6mg/0.4mg modified release tablets**
For full prescribing information, refer to the Summary of Product Characteristics (SPC). **Presentation:** VESOMNI modified release tablets contain a layer of 6 mg solifenacin succinate, corresponding to 4.5 mg solifenacin free base and a layer of 0.4 mg tamsulosin hydrochloride, corresponding to 0.37 mg of tamsulosin free base. **Indication:** Treatment of moderate to severe storage symptoms (urgency, increased micturition frequency) and voiding symptoms associated with benign prostatic hyperplasia (BPH) in men who are not adequately responding to treatment with monotherapy. **Posology and method of administration:** *Adult males, including older people:* One VESOMNI tablet (6 mg/0.4 mg) once daily taken orally with or without food. The maximum daily dose is one VESOMNI tablet. The tablet must be swallowed whole, intact without biting or chewing. Do not crush the tablet. *Special populations (see also contraindications below):* Renal impairment: *Severe renal impairment* (creatinine clearance ≤ 30 mL/min): Treat with caution, maximum daily dose in these patients is one VESOMNI tablet. Hepatic impairment: *Moderate hepatic impairment* (Child-Pugh score of 7-9): Treat with caution, maximum daily dose in these patients is one VESOMNI tablet. In patients with severe hepatic impairment (Child-Pugh score > 9), the use of VESOMNI is contraindicated. *Concomitant treatment with moderate and strong inhibitors of CYP450 3A4:* e.g. verapamil, ketoconazole, ritonavir, nelfinavir, itraconazole: Treat with caution, maximum daily dose should be limited to one VESOMNI tablet. *Paediatric population:* There is no relevant indication for use of VESOMNI in children and adolescents. **Contraindications:** Patients with hypersensitivy to the active substance(s) or to any of the excipients (see SPC). Patients undergoing haemodialysis. Patients with severe hepatic impairment. Patients with severe renal impairment who are also treated with a strong cytochrome P450 (CYP)3A4 inhibitor e.g. ketoconazole. Patients with moderate hepatic impairment who are also treated with a strong CYP3A4 inhibitor e.g. ketoconazole. Patients with severe gastrointestinal conditions (including toxic megacolon), myasthenia gravis or narrow-angle glaucoma and patients at risk for these conditions. Patients with a history of orthostatic hypotension. **Special Warnings and Precautions for Use:** VESOMNI should be used with caution in patients with: severe renal impairment; risk of urinary retention; gastrointestinal obstructive disorders; risk of decreased gastrointestinal motility; hiatus hernia/gastroesophageal reflux and/or who are concurrently taking medicinal products (such as bisphosphonates) that can cause or exacerbate oesophagitis; autonomic neuropathy. The patient should be examined in order to exclude the presence of other conditions, which can cause similar symptoms to benign prostatic hyperplasia. Other causes of frequent urination (heart failure or renal disease) should be assessed before treatment with VESOMNI is initiated. If a urinary tract infection is present, appropriate antibacterial therapy should be started. QT prolongation and Torsade de Pointes have been observed in patients with risk factors, such as pre-existing long QT syndrome and hypokalaemia, who are treated with solifenacin succinate. Angioedema with airway obstruction has been reported in some patients on solifenacin succinate and tamsulosin. If angioedema occurs, VESOMNI should be discontinued and not restarted. Appropriate therapy and/or measures should be taken. Anaphylactic reaction has been reported in some patients treated with solifenacin succinate. In patients who develop anaphylactic reactions, VESOMNI should be discontinued and appropriate therapy and/or measures should be taken. As with other alpha1-adrenoceptor antagonists, a reduction in blood pressure can occur in individual cases during treatment with tamsulosin, as a result of which, rarely, syncope can occur. Patients starting treatment with VESOMNI should be cautioned to sit or lie down at the first signs of orthostatic hypotension (dizziness, weakness) until the symptoms have disappeared. The 'Intraoperative Floppy Iris Syndrome' (IFIS, a variant of small pupil syndrome) has been observed during cataract and glaucoma surgery in some patients on or previously treated with tamsulosin hydrochloride. IFIS may increase the risk of eye complications during and after the operation. Therefore, the initiation of therapy with VESOMNI in patients for whom cataract or glaucoma surgery is scheduled is not recommended. Discontinuing treatment with VESOMNI 1-2 weeks prior to cataract or glaucoma surgery is anecdotally considered helpful, but the benefit of treatment discontinuation has not been established. During pre-operative assessment, surgeons and ophthalmic teams should consider whether patients scheduled for cataract or glaucoma surgery are being or have been treated with VESOMNI in order to ensure that appropriate measures will be in place to manage IFIS during surgery. VESOMNI should be used with caution in combination with moderate and strong inhibitors of CYP3A4 and it should not be used in combination with strong inhibitors of CYP3A4, e.g., ketoconazole, in patients who are of the CYP2D6 poor metaboliser phenotype or who are using strong inhibitors of CYP2D6, e.g., paroxetine. **Interactions:** *Pharmacological interactions:* Concomitant medication with other anticholinergic medicinal products may result in more pronounced therapeutic and undesirable effects. Allow approximately one week after stopping treatment with VESOMNI before commencing any anticholinergic therapy. The therapeutic effect of solifenacin may be reduced by concomitant administration of cholinergic receptor agonists. *Pharmacokinetic interactions:* *Pharmacokinetic interactions involving the potential for other medicinal products to affect VESOMNI exposures: Interactions with CYP3A4 and CYP2D6 inhibitors:* See Contraindications, Posology and administration and Special warnings and precautions above. Concomitant administration may lead to increased exposure to both solifenacin (ketoconazole 400 mg/day resulted in a 1.5-fold increase in $C_{max}$ and a 2.8-fold increase in AUC). and tamsulosin (ketoconazole 400 mg/day resulted in a 2.2-fold increase in $C_{max}$ and a 2.8-fold increase in AUC). VESOMNI should be used with caution in combination with strong CYP3A4 inhibitors. VESOMNI should not be given together with strong CYP3A4 inhibitors in patients who are also CYP2D6 poor metabolizer phenotype or who are using strong CYP2D6 inhibitors. See SPC for details of the effects of other CYP3A4 and CYP2D6 inhibitors. *Inducers:* Inducers of CYP3A4 (e.g. rifampicin) may decrease the plasma concentrations of solifenacin and tamsulosin. *Information available for the individual active substances:* Solifenacin can reduce the effect of medicinal products that stimulate the motility of the gastrointestinal tract, such as metoclopramide and cisapride. Solifenacin did not affect the pharmacokinetics of digoxin, or the pharmacokinetics or effect on prothrombin time of R- or S-warfarin. Co-administration of tamsulosin and other alpha1-adrenoreceptor antagonists could lead to hypotensive effects. Diclofenac and warfarin may increase the elimination rate of tamsulosin. No interactions have been seen when tamsulosin was given concurrently with atenolol, enalapril or theophylline. **Fertility, pregnancy and lactation:** The effect of VESOMNI on fertility has not been established. Ejaculation disorders have been observed in short and long term clinical studies with tamsulosin. Events of ejaculation disorder, retrograde ejaculation and ejaculation failure have been reported in the post authorization phase. VESOMNI is not indicated for use in women. **Driving and use of machines:** No studies have been performed, however patients should be informed about the possible occurrence of dizziness, blurred vision, fatigue and uncommonly somnolence, which may negatively affect the ability to drive or use machines. **Undesirable Effects:** *Summary of the safety profile:* VESOMNI may cause anticholinergic undesirable effects of, in general, mild to moderate severity. The most frequently reported adverse reactions during the clinical studies performed for the development of VESOMNI were dry mouth (9.5%), followed by constipation (3.2%) and dyspepsia (including abdominal pain; 2.4%). Other common undesirable effects are dizziness (including vertigo; 1.4%), vision blurred (1.2%), fatigue (1.2%), and ejaculation disorder (including retrograde ejaculation; 1.5%). Acute urinary retention (0.3%, uncommon) is the most serious adverse drug reaction that has been observed during treatment with VESOMNI in clinical studies. *List of adverse reactions:* the 'VESOMNI frequency' below reflects adverse drug reactions that have been observed during the double-blind clinical studies performed for the development of VESOMNI (based on reports of treatment-related adverse events, which have been reported by at least two patients and occurred with a frequency higher than for placebo in the double-blind studies). The 'solifenacin frequency' and 'tamsulosin frequency' below reflect adverse drug reactions (ADRs) previously reported with one of the individual components (as presented in the Summary of Product Characteristics (SmPCs) of solifenacin 5 and 10 mg and tamsulosin 0.4 mg respectively that may also occur when receiving VESOMNI (some of these have not been observed during the clinical development program of VESOMNI). 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), not known (cannot be estimated from the available data). The adverse events are grouped by MedDRA system organ class preferred term (PT). ***VESOMNI frequency:*** Nervous system disorders: *Common:* dizziness Eye disorders: *Common:* vision blurred Gastrointestinal disorders: *Common:* dry mouth, dyspepsia, constipation Skin and subcutaneous tissue disorders: *Uncommon:* pruritus Renal and urinary disorders: *Uncommon: Urinary retention**** Reproductive system and breast disorders: *Common:* ejaculation disorders including retrograde ejaculation and ejaculation failure General disorders and administration site conditions: *Common:* fatigue ***Solifenacin 5mg & 10mg frequency*:*** Infections and infestations: *Uncommon: urinary tract infection, cystitis* Immune system disorders: *Not known:* anaphylactic reaction* Metabolism and nutrition disorders: *Not known:* decreased appetite*, hyperkalemia* Psychiatric disorders: *Very rare:* hallucination*, confusional state* *Not known:* delirium* Nervous system disorders: *Uncommon:* somnolence, dysgeusia *Rare:* dizziness*, headache* Eye disorders: *Common:* vision blurred *Uncommon:* dry eyes *Not known:* glaucoma* Cardiac disorders: *Not known:* palpitations*, Torsade de Pointes*, electrocardiogram QT prolongation*, atrial fibrillation*, tachycardia* Respiratory, thoracic and mediastinal disorders: *Uncommon:* nasal dryness *Not known:* dysphonia* Gastrointestinal disorders: *Very common:* dry mouth *Common:* dyspepsia, constipation, nausea, abdominal pain *Uncommon:* gastro-oesophageal reflux disease, dry throat *Rare:* vomiting*, colonic obstruction, faecal impaction, *Not known:* ileus*, abdominal discomfort* Hepatobiliary disorders: *Not known:* liver disorder*, liver function test abnormal* Skin and subcutaneous tissue disorders: *Uncommon:* dry skin *Rare:* pruritus*, rash* *Very rare:* urticaria*, angioedema*, erythema multiforme* *Not known:* exfoliative dermatitis* Musculoskeletal and connective tissue disorders: *Not known:* muscular weakness* Renal and urinary disorders: *Uncommon:* difficulty in micturition *Rare:* urinary retention*** *Not known:* renal impairment* General disorders and administration site conditions: *Uncommon:* fatigue, peripheral oedema. ***Tamsulosin 0.4mg frequency*:*** Nervous system disorders: *Common:* dizziness *Uncommon:* headache *Rare:* syncope Eye disorders: *Not known:* vision blurred*, Intraoperative Floppy Iris Syndrome (IFIS)**, visual impairment* Cardiac disorders: *Uncommon:* palpitations *Not known:* atrial fibrillation*, arrhythmia*, tachycardia* Vascular disorders: *Uncommon:* orthostatic hypotension Respiratory, thoracic and mediastinal disorders: *Uncommon:* rhinitis *Not known:* dyspnoea*, epistaxis* Gastrointestinal disorders: *Uncommon:* constipation, nausea, diarrhea, vomiting Skin and subcutaneous tissue disorders: *Uncommon:* pruritus, rash, urticaria *Rare:* angioedema *Very Rare:* Stevens-Johnson syndrome *Not known:* erythema multiforme*, exfoliative dermatitis* Reproductive system and breast disorders: *Common:* ejaculation disorders including retrograde ejaculation and ejaculation failure *Very rare:* priapism General disorders and administration site conditions: *Uncommon:* asthenia. #: The ADRs from solifenacin and tamsulosin included are the ADRs listed in the summary of product characteristics of both products. *: from post-marketing reporting. Because these spontaneously reported events are from the worldwide post-marketing experience, the frequency of events and the role of solifenacin or tamsulosin and their causation cannot be reliably determined. **: from post-marketing reporting, observed during cataract and glaucoma surgery. ***: see Special warnings and precautions for use. *Long-term safety of VESOMNI:* The profile of undesirable effects seen with treatment up to 1 year was similar to that observed in the 12-week studies. The product is well-tolerated and no specific adverse reactions have been associated with long-term use. *Description of selected adverse reactions:* For urinary retention see Special warnings and precautions for use. *Older people:* The therapeutic indication of VESOMNI, moderate to severe storage symptoms (urgency, increased micturition frequency) and voiding symptoms associated with BPH, is a disease affecting elderly men. The clinical development of VESOMNI has been performed in patients 45 to 91 years of age, with an average age of 65 years. Adverse reactions in the elderly population were similar to the younger population. **Reporting of suspected adverse reactions:** see below. **Overdose:** Overdosage with the combination of solifenacin and tamsulosin can potentially result in severe anticholinergic effects plus acute hypotension. Refer to SPC for details of treatment of overdose. **Legal Category:** POM (S1B). **Nature and contents of container:** Aluminium blister packs containing 30 tablets. **Product Authorisation Number:** PA1241/016/001. **Marketing Authorisation holder:** Astellas Pharma Co., Ltd. **Further information is available from:** Astellas Pharma Co., Ltd, Damastown Road, Damastown Industrial Park, Mulhuddart, Dublin 15. Phone: +3531 467 1555. Summary of Product Characteristics with full prescribing information available upon request. **Job number:** MAT-IE-VESOM-2023-00001 **Date of preparation of API:** January 2023

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.

*** LUTS:** Lower Urinary Tract Symptoms
**BPH:** Benign prostatic Hypertrophy

**References: 1.** Sexton CC, et al. BJU Int 2009; 103(Suppl 3): 12-23. **2.** VESOMNI Summary of Product Characteristics.

**Date of preparation:** January 2023 **Job code:** MAT-IE-VESOM-2023-00002

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# Focus on: Chronic kidney disease

## *WIN* looks at two contrasting cases of risk assessment in the management of patients with kidney disease

THE management of chronic kidney disease (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 ongoing monitoring for complications of CKD, such as hyperkalaemia, metabolic acidosis, hyperphosphataemia, vitamin D deficiency, secondary hyperparathyroidism and anaemia.[1] The following two cases show contrasting risk assessments.

### Case study 1

*A 45-year-old man with CKD 4 secondary to IgA nephropathy presents to the emergency department with a swollen leg and acute shortness of breath.*

A pulmonary embolus is expected. A CT pulmonary angiogram is ordered but the radiologist is concerned that giving IV contrast may cause contrast-associated acute kidney injury (CA-AKI).

CA-AKI, formerly known as contrast-induced nephropathy (CIN), has become an increasingly debated entity. Intravenous contrast is now thought likely to be a rare cause of acute kidney injury. The underlying disorders present at the time, necessitating the scan, are the more likely culprits.

In this case, the risk-benefit balance is clearly in favour of proceeding with the scan, rather than delaying the diagnosis of a life threatening condition out of a misplaced sense of concern for the patient's renal function. Avoiding contrast and using sub-optimal tests likely delays diagnosis and may result in more harm.

Therapies historically used to reduce the risk of CA-AKI include N-acetylcysteine and sodium bicarbonate – when compared head to head with normal saline, no difference was found, and they subsequently fell out of favour.

The key is ensuring that patients are not volume deplete at time of contrast administration, so making sure they are not dehydrated and holding their diuretic on the day of the scan are key interventions. There is no role for post-contrast dialysis.

### Case study 2

*An 84-year-old woman presents to her primary care centre for a routine check-up after several years of not seeing a doctor.*

She is generally in good health. Her only regular medication is amlodipine and her blood pressure is 138/82. Her laboratory results return with a creatinine of 105mmol/l, giving her an estimated glomerular filtration rate (eGFR) of 42ml/min/1.73m2.

She has no blood or proteinuria on urine dip and her urine ACR is 2mg/g. An ultrasound is arranged as an outpatient which shows bilateral kidneys measuring 9cm each, and loss of corticomedullary differentiation with several sub-centimetre cysts. She asks should she see a kidney specialist.

This patient's risk of developing end-stage kidney disease can be calculated easily by using the Kidney Failure Risk Equation, which can be found at **www.kidneyfailurerisk.com.** Age, sex, eGFR and proteinuria are all that is required to calculate a two and five year risk of end-stage kidney disease.

For this patient, her five year risk of ESKD is 0.3%, ie. low (< 5%). Patients with < 5% risk of progression to end-stage kidney disease at five years do not require specialist nephrology referral. Indications for referral to a nephrology clinic would be microscopic haematuria or heavy proteinuria (uPCR > 100mg/mmol).

Patients with mild CKD at low risk of progression should ensure they have modifiable cardiovascular risk factors addressed, such as good blood pressure and lipid control, and ensure medications are appropriately dosed for their eGFR. Her ultrasound is consistent with normal ageing and in the absence of other concerning features of intrinsic renal disease is not of concern.

**Table 1. Clinical, sociodemographic and genetic risk factors for chronic kidney disease**

| Clinical | Sociodemographic | Genetic |
|---|---|---|
| Diabetes | Age > 60 years | APOL1 risk alleles |
| Hypertension | Low income | Sickle cell trait and disease |
| Autoimmune diseases | Low education | Polycystic kidney disease |
| Systemic infections (eg. HIV, hepatitis B virus, hepatitis C virus), drug use | Non white race | Alport syndrome |
| Nephrotoxic medications (eg. NSAIDs, herbal remedies, lithium) | | Congenital anomalies of the kidney and urinary tract |
| Recurrent UTIs/ kidney stones/urinary tract obstruction/malignancy | Tofacitinib | Other familial cause |
| Obesity/smoking/family history | | |

*Adapted from Kidney Disease: Improving Global Outcomes (KDIGO) CKD Work Group. KDIGO 2012 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease. Kidney Int Suppl 2013; 3(1):1-150*

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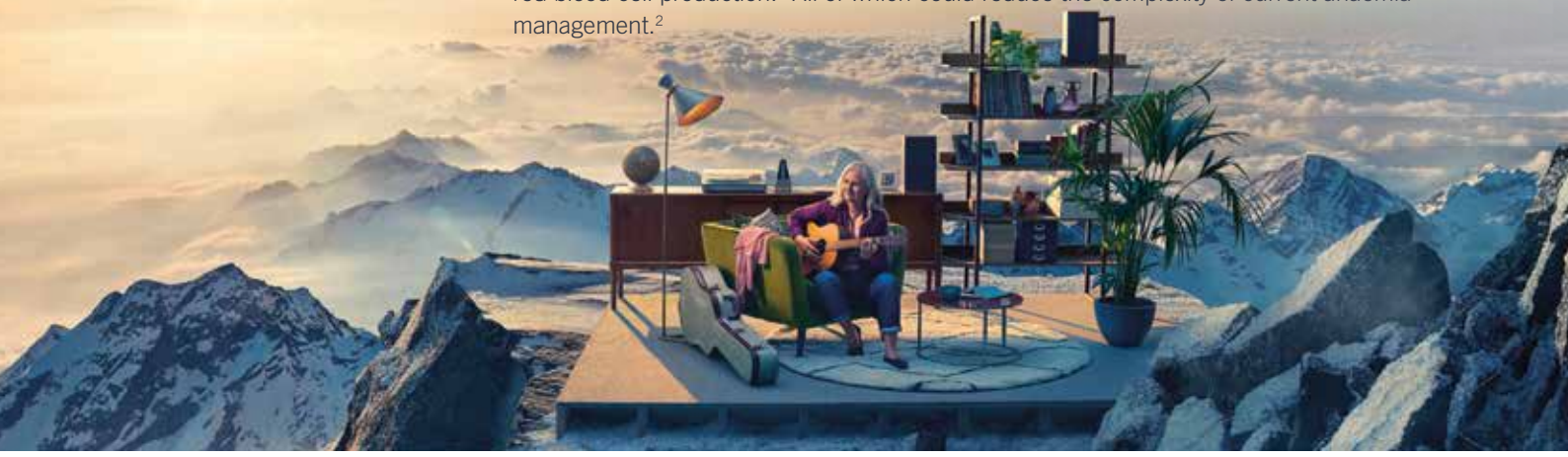
# EVRENZO™ is like a breath of fresh air, in symptomatic anaemia of CKD

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

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# Injection site *for sore eyes*

## Advances in ophthalmology offer hope to patients with sight-threatening conditions, writes **Adebusola Owokole**

EYE injections, or intraocular injections, have revolutionised the field of ophthalmology by providing targeted and effective treatment for various eye conditions. These injections involve the direct administration of medications into the eye, bypassing the traditional oral or topical routes. This is an area in which nurses have expanded their scope of practice and eye injections are a procedure that can be carried out by clinical nurse specialists.

This article explores the significance, types, administration techniques, associated risks, benefits, patient safety considerations and relevant guidelines for eye injections in Ireland.[1]

Significantly, eye injections have emerged as a breakthrough treatment modality in ophthalmology due to their ability to deliver medications directly to the site of the problem within the eye. Traditional treatments such as eye drops or oral medications may not reach therapeutic concentrations within the eye due to the blood-retinal barrier, limited bioavailability or poor ocular penetration. In contrast, eye injections ensure higher drug concentration at the target site, leading to improved treatment outcomes.[2]

Another type of injection is corticosteroid injections, such as triamcinolone acetonide or dexamethasone, which are used to treat conditions such as uveitis, macular oedema and specific inflammations. These injections possess anti-inflammatory properties that reduce swelling and suppress immune responses within the eye.[3] Immunomodulatory injections, including methotrexate or adalimumab, are employed for the management of inflammatory eye conditions such as non-infectious uveitis or ocular surface diseases. These injections modulate the immune system, diminishing inflammation and preventing further ocular tissue damage.[4]

In administering eye injections, ophthalmologists or retina specialists typically perform the procedure in an outpatient setting. The process involves several steps to ensure safety and efficacy. To minimise discomfort, the eye is numbed using topical anaesthetic eye drops, and in some cases a sterile lid speculum may be used to keep the eyelids open.[5] The injection itself is administered by the ophthalmologist using a small-gauge needle, targeting the sclera (white part of the eye) or the area around the iris (*pars plana*), depending on the specific area requiring treatment.[6] Following the injection, patients may receive antibiotic or anti-inflammatory eye drops to prevent infection or manage post-injection inflammation. Compliance with post-injection care instructions provided by the ophthalmologist is crucial for optimal outcomes.[7]

Patient safety is of utmost importance during eye injections, and HSE guidelines help to ensure safe practices. Infection control measures are closely followed, emphasising proper hand hygiene, aseptic technique and appropriate sterilisation of equipment to prevent injection site infections.[8] Patient identification procedures and obtaining informed consent are essential steps to ensure accurate administration of the injection and involve the patient in the decision-making process.[9]

Healthcare professionals involved in eye injections receive adequate training and demonstrate competency in the procedure, with regular updates and continuing education to maintain their knowledge and skills.[10] Comprehensive documentation of the injection procedure, including medication used, dosage, injection site and any adverse events, is vital for patient safety, continuity of care and medico-legal purposes.[11] Collectively, these guidelines contribute to the safe and effective administration of eye injections, prioritising patient wellbeing.

In summary, eye injections have revolutionised the management of ocular conditions. Different types of injections, such as anti-VEGF, corticosteroid and immunomodulatory injections, offer specific therapeutic benefits.

Adhering to proper administration techniques and following patient safety guidelines, including infection control measures, patient identification and consent, staff competency and training, as well as meticulous documentation, ensures the safe and effective use of eye injections.

These advancements in ophthalmology offer hope for patients with sight-threatening diseases and contribute to improved visual outcomes and quality of life.

*Adebusola Owokole is a perioperative CNM2 at University Hospital Limerick and is founder/president of the Operating Room Global (**www.operatingroomissues.org**)*

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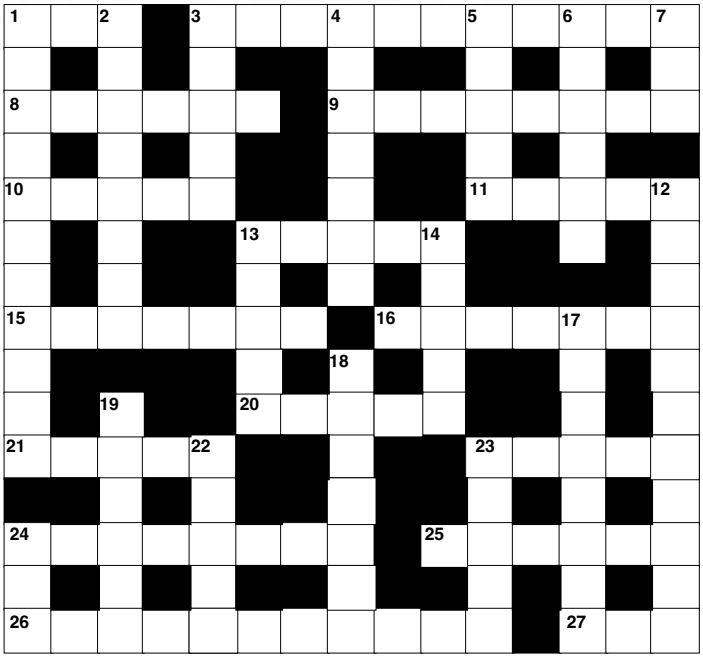
## Across

1 Concealed (3)
3 Where Sherlock Holmes lived, or a song by Gerry Rafferty (5,6)
8 Have an informal meal in the outdoors (6)
9 & 10 In favour of a political unit? Note, alight on part of the body! (8,5)
11 Perspiration (5)
13 Obstruct (5)
15 Sorrow (7)
16 Blue rot can create such difficulty! (7)
20 The American term for what we call sweets (5)
21 Sensational in a melodramatic way (5)
23 Males get confused about where witches were tried (5)
24 Sport in an alley is deemed foul by soccer players (8)
25 Short snooze (6)
26 It's a shocking way to injure someone! (11)
27 Vote of 'No', the opposite of 'Aye' (3)

## Down

1 A nerve relating to the tongue has a kind of splashy logo (11)
2 Announced assertively (8)
3 Construct (5)
4 Might the poem err in identifying a ruler? (7)
5 Elephants' teeth (5)
6 Rubbed out (6)
7 Digit on the foot (3)
12 The amount of your wage left after the taxman has been at it (4-4,3)
13 Elementary, fundamental (5)
14 Irish county - 'The Kingdom' (5)
17 Nine bled remaking the sheets (3,5)
18 Cherubic (7)
19 Paris is its capital (6)
22 Charge for reassembling the bidet (5)
23 Natural protection from direct sunlight (5)
24 Garden implement (3)



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## October crossword solution

Across: 1 App 3 Tight-lipped 8 Muesli 9 Lilliput 10 Susan 11 Threw 13 Twang 15 Evening 16 Godsend 20 Dusty 21 Champ 23 Cases 24 Lemonade 25a & 22d Pinot grigio 26 Peritonitis 27 Ten

Down: 1 & 2 Atmospheric pressure 3 Talon 4 Holiday 5 Inlet 6 Pop Art 7 Dot 12 Wooden spoon 13 Toned 14 Glory 17 Eyesight 18 Israeli 19 Hammer 23 Curls 24 Lap

**The winner of the October crossword sponsored by MedMedia is Bernadette Campion, Dublin**

# Irish contribution to NHS celebrated with tree-planting ceremony

## Event at Mayo University Hospital honoured Irish nurses in the UK

MAYO University Hospital (MUH) hosted a tree-planting ceremony in August to honour the contribution of more than 30,000 Irish nurses to the UK's National Health Service (NHS) since its foundation 75 years ago.

The first tree was planted by Dame Elizabeth Anionwu, emeritus professor of nursing at the University of West London. Dame Anionwu is an Irish/Nigerian nurse who was honoured with a Damehood in 2017 and an Order of Merit in 2022 for her work in improving the health and wellbeing of multi-ethnic communities. Only 24 living people can hold the Order of Merit title at any one time and Dame Anionwu is the first nurse since Florence Nightingale to be awarded this title.

She commended the positive impact that Irish nurses have made to the NHS and spoke about the importance of working collaboratively and celebrating the unique and rich cultural heritage upon which the nursing community is built.

The ceremony celebrated the legacy of the nursing community locally in Mayo and internationally, with a special focus on Irish nurses' contribution to the NHS. It was attended by members of MUH nursing staff. Also in attendance were Olayinka Aremu, president of the Association of Nigerian Nurses in Ireland, Conrad Bryan, director of the Mixed-Race Irish Association, and Kevin Bourke and Marianne Staunton from the Mayo Emigrant Liaison Committee.

*Dame Elizabeth Anionwu, emeritus professor of nursing, University of West London, planting a tree on the grounds of Mayo University Hospital to honour the contribution of Irish nurses to the UK's NHS over the past 75 years*

"It was a huge honour for us to welcome Dame Elizabeth to MUH. She is a passionate advocate for the nursing profession and her work in campaigning for health equality is inspiring. We are extremely proud of our nursing team in MUH and were delighted to host this ceremony which acknowledges the commitment, professionalism and compassion of nurses both locally and globally," said Padraig O Luanaigh, director of nursing at MUH.

# Staffing shortages continue to fuel abuse of healthcare professionals, new survey finds

BACKING up research carried out by the INMO, some 60% of respondents to a recent Medical Protection Society (MPS) survey said they have experienced or witnessed verbal or physical abuse from patients or their relatives within the past 12 months, with 37% reporting that these incidents were the result of staffing shortages.

A total of 86% of the nearly 900 healthcare professionals surveyed said that they had experienced or witnessed abuse in the past 12 months, reporting that it negatively affected their mental health. More than a quarter (26%) said an increase in abuse and intimidation from patients has made them reconsider their career in healthcare.

A quarter of respondents also said they felt that abuse against healthcare professionals was not taken seriously by gardaí.

Experiencing and witnessing abuse can have profound effects on the mental health of healthcare professionals, which can be detrimental to both the individual and to patient care. It can also result in healthcare staff needing time off work or even contemplating leaving the healthcare profession altogether.

"While long referral waiting lists and staff shortages understandably cause stress to patients and their families, healthcare professionals are doing their best under challenging circumstances. While most patients are respectful, it is troubling that so many healthcare workers face aggression and intimidation.

"Healthcare professionals – whether working in primary care, the HSE or private clinics – must feel their safety is a priority and be encouraged to report all abusive behaviour," said Dr James Thorpe, deputy medical director at MPS.

"All healthcare settings should provide an appropriate forum where those who witness or experience any kind of abuse from patients can talk about it and seek appropriate wellbeing support.

"Peer support networks can also help to foster a supportive environment where experiences can be shared and reflected on, and staff should be offered practical advice on de-escalation techniques," he added.

The healthcare professionals who participated in the survey did so anonymously.

# Mental health of nursing home staff worse now than during pandemic

A NEW study has revealed a further decline in the mental health of staff working in nursing homes across Ireland, which coincided with the easing of public health restrictions following the Covid-19 pandemic.

The findings from phase two of the COWORKER research study from St Patrick's Mental Health Services, Trinity College Dublin, the Royal College of Surgeons Ireland and Nursing Homes Ireland showed that nursing home staff working after Ireland's pandemic restrictions had been lifted, reported substantially higher levels of post-traumatic stress, moral injury, low mood and suicidal thinking than during the pandemic.

Almost two-thirds (65%) of respondents reported moderate or severe symptoms of post-traumatic stress disorder (PTSD), while 57% of nursing home staff reported low mood in the second phase of the research.

Researchers also found that levels of suicidal thinking and low mood both increased. Some staff also reported concerns about infection control processes.

"Despite the easing of public health restrictions and the widespread rollout of vaccinations among staff and residents of nursing homes, findings from phase two of the COWORKER study show that the mental health effects of Covid-19 are ongoing and require continued monitoring to inform appropriate responses.

"Through the publication of these findings, it is hoped that key areas of concern for nursing home staff's mental health can be highlighted and addressed as required, and we would encourage any nursing home staff who are experiencing mental health difficulties following the pandemic to seek support as needed," said Declan McLoughlin, research professor of psychiatry at TCD and consultant psychiatrist at St Patrick's Mental Health Services.

With the research highlighting high levels of low mood (57%), suicidal ideation (18%) and suicidal planning (15%), lead author of the study Dr Conan Brady has demonstrated the importance of providing support to those working in the nursing home sector.

"Findings from the COWORKER study emphasise the scale of the mental health impacts of Covid-19 on nursing home staff and identify some key areas where staff may require support, such as for PTSD and moral injury. The nursing home sector is one that will become more and more critical as our population ages. Like many areas of the healthcare sector, it is vital that we ensure that the mental health of staff working in nursing homes is supported," said Dr Brady.

The results of phase two of the study were published in *PLOS ONE* in September.

## Awareness campaign aims to highlight warning signs of type 1 diabetes


*Diabetes Ireland, in collaboration with the Irish Childhood Diabetes National Register, recently launched a campaign that aims to raise awareness of the symptoms of Type 1 diabetes so that people who exhibit these early signs can seek help and avoid the development of diabetic ketoacidosis (DKA), a potentially life-threatening complication of the condition. As part of the campaign, Diabetes Ireland has developed the acronym TEST, which stands for: Thirst (increased), Energy (reduced), Sudden (weight change) and Toilet (trips increased).*
*Pictured at the campaign's launch were (l-r): Norah Casey, Eva and Danny Lee, Jay Hickey, Prof Edna Roche (ICDNR) and Christina Hamilton (Diabetes Ireland). See pages 40-41 for more on the TEST campaign*

## Four in 10 parents hesitant to give children flu vaccine

FOUR in 10 parents hesitate to get their children the free winter flu vaccine, according to research from the Irish Parents Association (IPA). Despite 1,274 children being hospitalised with the virus during the flu season last year, more than a quarter of parents perceive the winter flu as not having serious consequences for their children.

In response to this, the IPA's 'Flunited' campaign emphasises the importance of the children's flu vaccine and aims to increase uptake, highlighting that for young children sometimes the consequences of flu can be serious and lead to problems such as pneumonia, bronchitis and encephalitis.

The children's flu vaccine, administered as a free nasal spray to of all children aged between two and 12 and children aged 13-17 at high risk of flu, is accessible from local GPs, participating pharmacies and, for the first time this year, in participating schools across the country.

## November

**Wednesday 22**
Assistant Directors Section
Masterclass, INMO Head Office

**Saturday 25**
Midwives Section meeting from 9:30am

**Wednesday 29**
CPC Section meeting. Online 11am

**Thursday 30**
OHN Section conference. Limerick Strand Hotel. See *page 24*

## December

**Saturday 2**
PHN Section meeting. Online 10.30am

**Saturday 2**
Midwives Section meeting. Online from 09.30am

**Wednesday 6**
International Nurses Section conference. Richmond Education and Event Centre

**Wednesday 13**
RNID Section meeting. 11am online

## January

**Monday 15**
Advanced Practice Section AGM online from 11am

**Tuesday 16**
Retired Section meeting. Richmond Education and Event Centre from 11am

**Wednesday 17**
Children's Nurses Section AGM from 11am

**Tuesday 23**
ODN Section AGM. 7pm online

**Wednesday 24**
RNID Section 2pm online

**Thursday 25**
Assistant Directors Section AGM 2.30pm online

**Saturday 27**
PHN Section AGM. 10.30 online

**Monday 29**
Nurse/Midwife Education Section 9am online

**Tuesday 30**
Radiology Section AGM. 7pm online

**Wednesday 31**
CIT Section AGM. 11am online

## February

**Wednesday 7**
Telephone Triage Section AGM. 11am online

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

## Condolences

- We extend our deepest sympathies to the family and friends of Kay Gordon. Kay set high standards as a PHN in Dublin West for over 30 years. She also ran the Covid-19 test centre in her region at the beginning of the pandemic and joined the school immunisation team in vaccinating people in nursing homes in Jan 2021 when Covid-19 was at its height. Her colleagues remember her kindness, gentleness, strength and bravery. May she rest in peace.
- We offer our sincere condolences to Ibukun Oyedele and her extended family on the recent passing of her beloved father Pa Elkanah Akinyele Awogbindin. He will be fondly remembered by his family and friends. May his gentle soul rest in peace


## INMO Membership Fees 2024

| | | |
|---|---|---|
| A | Registered nurse/midwife<br>*(including part-time/temporary nurses/midwives in prolonged employment)* | €299 |
| B | Short-time/Relief<br>*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)<br>*Lecturing (employed in universities & IT institutes)* | €116 |
| E | Associate members<br>*Not working* | €75 |
| F | Retired associate members | €25 |
| G | Student members | No Fee |

## Social events

- The Retired Nurses and Midwives Section get-together will take place in Wynne's Hotel, Abbey St, Dublin 1 on Thursday, January 11, 2024 at 6pm. Dinner €45. Bed and breakfast: twin room €115 or single room €99. Contact Ann Gee on 087 145 9289 for further information or call Wynne's Hotel directly on 01 874 5131.
- The INMO Annual Golf Classic will take place on May 24, 2024 at Callan Golf Club, Kilkenny. Contact Patsy Murphy 087 6440203 to book your place. This event is open to all nurses and midwives.

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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



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**Word count: 400**

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For a detailed Job Description or expressions of interets, please contact Ann Dolan, Director of HR **adolan@galwayhospice.ie**

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