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WIN

World of Irish Nursing & Midwifery

INMO
Journal of the
Irish Nurses and
Midwives Organisation

Latest INMO CPD education programme
See page 33

8,586 nurses and midwives assaulted since 2020

0 prosecutions under the **Criminal Justice Act 2006**

THIS LAW
MUST BE ENFORCED

Workplace assault

HSE must act urgently to protect frontline staff

A direct way to treat MAC-PD[1,2]

ARIKAYCE® liposomal delivers amikacin to the site of infection within the lung macrophages

ARIKAYCE liposomal is indicated for the treatment of non-tuberculous mycobacterial (NTM) lung infections caused by Mycobacterium avium Complex (MAC) in adults with limited treatment options who do not have cystic fibrosis. ARIKAYCE liposomal treatment should be initiated and managed by physicians experienced in the treatment of non-tuberculous lung disease due to MAC. ARIKAYCE liposomal should be used in conjunction with other antibacterial agents active against MAC lung infections.

Recommended by Guidelines

In patients who have failed to achieve culture conversion after ≥6 months of oral GBT, it is a strong recommendation to add ARIKAYCE liposomal to the regimen[3†,*]. 3x more patients culture converted with ARIKAYCE liposomal + oral GBT than with oral GBT alone[4–6]

Durable Culture Conversion

Durable culture conversion in CONVERT at 3 months off treatment was achieved by 16.1% [36/224] vs. 0% [0/112]; p-value <0.0001 in Arikayce plus GBT arm vs GBT alone arm[5,6]

CONVERT Study: Safety Profile

Evaluated in >400 patients,[4,7] AEs were mostly respiratory in nature, 87.4% and 50.0% of patients in the ALIS plus GBT and GBT alone arms respectively[4]

ARIKAYCE LIPOSOMAL 590 MG NEBULISER DISPERSION (AMIKACIN SULFATE) - ABBREVIATED PRESCRIBING INFORMATION (API)

Prescribers are recommended to consult the summary of product characteristics before prescribing.

Presentations
Each vial contains amikacin sulfate equivalent to 590 mg amikacin in a liposomal formulation. The mean delivered dose per vial is approximately 312 mg of amikacin.

Indication
Arikayce liposomal is indicated for the treatment of non-tuberculous mycobacterial (NTM) lung infections caused by *Mycobacterium avium* complex (MAC) in adults with limited treatment options who do not have cystic fibrosis.
Consideration should be given to official guidance on the appropriate use of antibacterial agents.

Posology and method of administration
Arikayce liposomal treatment should be initiated and managed by physicians experienced in the treatment of non-tuberculous lung disease due to Mycobacterium avium complex.
Arikayce liposomal should be used in conjunction with other antibacterial agents active against *Mycobacterium avium complex* lung infections.
Arikayce liposomal recommended dosage: one vial (590 mg) administered once daily, by oral inhalation.
Duration of treatment: Treatment with Arikayce liposomal, as part of a combination antibacterial regimen, should be continued for 12 months after sputum culture conversion. Treatment should not continue beyond a maximum of 6 months if sputum culture conversion (SCC) has not been confirmed by then. The maximum duration of treatment should not exceed 18 months.
Hepatic/renal impairment: Arikayce liposomal has not been studied in patients with hepatic or renal impairment. No dose adjustments based on hepatic impairment are required since amikacin is not hepatically metabolised. Use is contraindicated in severe renal impairment.
Paediatrics: The safety and efficacy of Arikayce liposomal in paediatric patients below 18 years of age have not been established. No data are available.
Missed doses: If a daily dose of Arikayce liposomal is missed, the next dose should be administered the next day. A double dose should not be given to make up for the missed dose.
Method of administration: Arikayce lipsomal is for inhalation use only. Arikayce liposomal must only be used with the Lamira Nebuliser System (nebuliser handset, aerosol head and controller). It must not be administered by any other route or using any other type of inhalation delivery system.
Refer to full SmPC for full information on posology and administration.

Contraindications
- Hypersensitivity to active substance, to any aminoglycoside antibacterial agent, or any excipient.
- Hypersensitivity to soya.
- Co-administration with any aminoglycoside administered via any route of administration.
- Severe renal impairment.

Special warnings and precautions for use
Anaphylaxis and hypersensitivity reactions: Serious and potentially life-threatening hypersensitivity reactions, including anaphylaxis, have been reported in patients taking inhaled liposomal amikacin.
Allergic alveolitis: Allergic alveolitis and pneumonitis have been reported with the use of inhaled liposomal amikacin.
Bronchospasm: Bronchospasm has been reported with the use of inhaled liposomal amikacin.
Exacerbation of underlying pulmonary disease: In clinical trials, exacerbation of underlying pulmonary disease (chronic obstructive pulmonary disease, infective exacerbation of chronic obstructive pulmonary disease, infective exacerbation of bronchiectasis) was reported with a higher frequency in patients treated with inhaled liposomal amikacin.
Ototoxicity: In clinical trials, ototoxicity, (including deafness, dizziness, presyncope, tinnitus, and vertigo) was reported with a higher frequency in patients treated with inhaled liposomal amikacin.
Nephrotoxicity: Nephrotoxicity was reported in clinical trials in patients treated with inhaled liposomal amikacin. Renal function should be monitored periodically during treatment in all patients and frequent monitoring is advised in patients with pre-existing renal dysfunction.
Neuromuscular blockade: In clinical trials, neuromuscular disorders (reported as muscle weakness, neuropathy peripheral and balance disorder) have been reported with inhaled liposomal amikacin. Use of inhaled liposomal amikacin in patients with myasthenia gravis is not recommended.
Refer to full SmPC for further information on warnings and precautions.

Interaction with other medicinal products and other forms of interaction
No clinical drug interaction studies have been conducted with inhaled liposomal amikacin.
Co-administration of inhaled liposomal amikacin with any aminoglycoside administered by any route is contraindicated.
Co-administration with any other medicinal product affecting auditory function, vestibular function or renal function (including diuretics) is not recommended.
Concurrent and/or sequential use of inhaled liposomal amikacin is not recommended with other medicinal products with neurotoxic, nephrotoxic or ototoxic potential that can enhance aminoglycoside toxicity (e.g. diuretic compounds such as ethacrynic acid, furosemide or intravenous mannitol).
Refer to full SmPC for further information on interactions.

Fertility, pregnancy and lactation
Human data on use during pregnancy or lactation are not available. No fertility studies were conducted with inhaled liposomal amikacin.

Effects on ability to drive and use machines
Amikacin has minor influence on the ability to drive and use machines. The administration of inhaled liposomal amikacin can cause dizziness and other vestibular disturbances.

Undesirable effects
Very common adverse events: dysphonia, dyspnoea, cough, haemoptysis. Common adverse events: infective exacerbation of bronchiectasis, laryngitis, oral candidiasis, headache, dizziness, dysgeusia, aphonia, balance disorder, tinnitus, deafness, oropharyngeal pain, allergic alveolitis, chronic obstructive pulmonary disease, wheezing, productive cough, sputum increased, bronchospasm, pneumonitis, vocal cord inflammation, throat irritation, diarrhoea, nausea, vomiting, dry mouth, decrease of appetite, rash, pruritus, myalgia, arthralgia, renal impairment, fatigue, pyrexia, chest discomfort, weight decreased.
Refer to full SmPC for further information.

Overdose
Adverse reactions specifically associated with overdose of inhaled liposomal amikacin have not been identified in clinical trials. Overdose in subjects with pre-existing impaired renal function, deafness or vestibular disturbance, or impaired neuromuscular transmission may develop worsening of the pre-existing disorder.
Refer to full SmPC for further information on overdose.

Legal Category
Prescription only medicine.

Pack quantities and costs
Pack-size of 28 vials. The carton also contains the Lamira Nebuliser Handset and 4 aerosol heads. £9,513 per pack.

Marketing Authorisation Holder
Insmed Netherlands B.V.
Stadsplateau 7
3521 AZ Utrecht
Netherlands

Marketing Authorisation Number
PLGB 47434/0001 EU/1/20/1469/001

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 Google play or Apple App store. Adverse events should also be reported via safety@insmed.com Additonal information is available on request from medicalinformation@insmed.com

Date of last revision of the API text
March 2022 REF-4139

† ARIKAYCE liposomal is an add-on therapy to oral guideline-based therapy (GBT); failure on oral GBT is defined as failure to culture convert despite ≥6 months GBT with three oral antibiotics.

* In the CONVERT study in patients who failed to convert after ≥6 months oral GBT, 29.0% (65/224) patients on ARIKAYCE liposomal + oral GBT vs 8.9% (10/112) patients treated with oral GBT alone achieved culture conversion (P<0.0001).[5,6] Sustained culture conversion for those on ARIKAYCE liposomal + oral GBT was seen 18.3% (41/224) patients vs 2.7% (3/112) on oral GBT alone.[8] Durable conversion when all therapy was discontinued was observed after 3 months in 16.1% (36/224) ARIKAYCE liposomal + oral GBT patients vs 0% oral GBT alone.[5,6]

References: 1. Malinin V *et al. Antimicrob Agents Chemother* 2016;60:6540-49; **2.** Zhang J et al. Front Microbiol 2018;9:915; **3.** Daley CL et al. Eur Respir J 2020;56:2000535; **4.** Griffith DE et al. Am J Respir Crit Care Med 2018;198:1559-69; **5.** ARIKAYCE liposomal. EU Summary of Product Characteristics; October 2020; **6.** ARIKAYCE liposomal. GB Summary of Product Characteristics; January 2021. **7.** Olivier KN et al. Am J Respir Crit Care Med 2017; 195:814-23; **8.** Griffith DE et al. Chest 2021;160:831–842.

June 2022 | PP-ARIK-UK-00119

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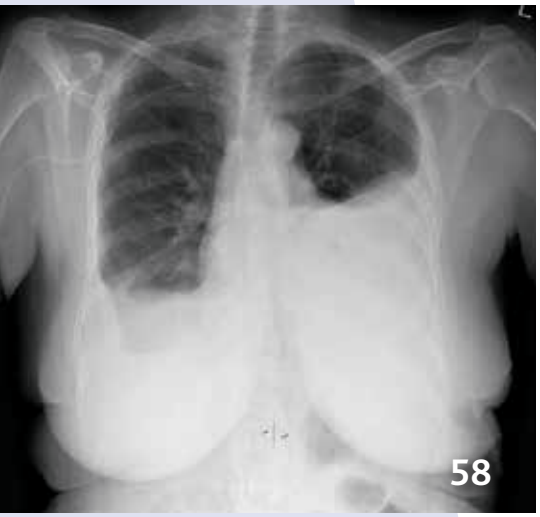

NEWS & VIEWS

FEATURES

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LIVING

JOBS & TRAINING

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

Nurse and Midwife Representative Training 2023

Thank you 2022 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. By the end of 2022 the INMO will have trained in excess of 100 new representatives.

The aim of this 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 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 2023, please make contact with your INMO official and they will issue you with an "Expression of Interest Form" to complete and return.

2023 DATES*		
February	**March**	**May**
7th & 8th Cork	1st & 2nd Dublin	24th & 25th Waterford
21st & 22nd Dublin	28th & 29th Galway	
27th & 28th Dublin (Advanced rep training course)		

June	**September**	**October**
13th & 14th Dublin	20th & 21st Dublin	3rd & 4th Cork
20th & 21st Midlands/Cavan	27th & 28th Sligo	12th & 13th Dublin
27th & 28th Limerick		

**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

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Assault in the workplace

THIS month we are examining the impact of workplace assault on nurses and midwives. The INMO has always sought to keep this issue in the public domain as it deserves national attention.

We know that assaults occur when employers have not put adequate protection in place. More than 8,586 nurses and midwives in the public system have been assaulted since January 2020. We do not have figures for private settings. There are negotiated schemes to protect pay and employment of those assaulted in the public service but not in the private sector, however not enough nurses and midwives know their rights under the Criminal Justice Act of 2006 when it comes to assault.

As nurses and midwives we can take stock of behavioural patterns and ask for protective measures to be put in place. For example, nurses working in the community – often alone – may ask for a second worker to accompany them when a high-risk situation is anticipated. What never ceases to amaze me is the number of times PHNs or community RGNs have to argue heavily for this kind of protection.

I had a head-in-hands moment recently when I read the most recent draft of the HSE's Lone Worker Policy where it described what a lone worker should do if their vehicle broke down while on community rounds, the instruction to "remember to put on the hazard lights" was a particular gem. The draft policy does not provide any specific practical guidance for those working out of hours and weekends when the base is closed and supervisors are not on duty. We sent these comments to the draft policy writers as it was worth reminding them that the health service operates on a 24/7 basis.

During the recent balloting process, while in several hospitals I was struck by the layout of some of the new builds. The design can have nurses far removed from their main corridor or workstation with solid doors separating cubicles, with no visibility for those outside.

Unfortunately, we have many examples of assaults in these types of situations and the consequences can be stark. Some of these events are career ending or leave an emotional scar on a worker when facing these environments on their eventual return to work.

One case of a member who was assaulted highlights the risks. Gardaí were called to a violent domestic incident, they brought one of the people involved to the ED but no one thought it was a risk to leave a nurse alone with this patient. The nurse was badly assaulted and had to crawl from the room to reach the panic button, which was not working. She managed to open the door and call for assistance, later working until the end of her shift, at which time the panic set in. It was two weeks before she received a call from her supervisor at home and she was unaware of the assault-at-work scheme. Her assault had not been notified to the Health and Safety Authority as her employer felt that as she had worked until the end of her shift and had days off following the event, her sick leave was unrelated to the assault. The INMO was involved in correcting this and ensured the nurse received her entitlements under the assault at work scheme. That event took place 18 months ago and the nurse in question has been unable to work since. *See pages 18-19 for our cover story on this topic.*

The reported figures for assaults only give us part of the picture as there is an accepted under-reporting of assaults. The long-term effects on the careers of nurses and midwives is also underplayed.

A zero-tolerance approach must be taken by employers and protective measures, including safety for workers as a paramount focus of design of any space where care is provided. Worker safety is the employer's responsibility. Policies are important but must be practical and transferable to all work environments and situations. The INMO will continue to represent this view and ask that you contact us if you have concerns relating to your safety at work.

Phil Ní Sheaghdha
General Secretary, INMO

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

Webinars & Conferences for Nurses and Midwives

INMO Public Health Nurses Section Webinar

Public Health Nursing – Signposting and directing into the future

FREE LIVE ONLINE EVENT
FOR INMO MEMBERS

Saturday, 12 November 2022

Time: 10.30am to 1.00pm

Proudly sponsored by
Home Instead
To us, it's personal

PROGRAMME

Chairperson: Eilish Fitzgerald, PHN Committee

- **Opening address** - Karen McGowan, INMO President
- **The experience of community nurses in Scotland following the introduction of health and care (staffing) (Scotland) Act 2019 and its potential impact**
  Speaker: Eileen McKenna, Associate Director, RCN Scotland
- **Safe staffing framework for community nursing**
  Speaker: Jonathan Drennan, Professor of Nursing and Health Services Research, UCC
- **An introduction from Home Instead**
  Speaker: Michael Wright, Director of Public Affairs, Home Instead Ireland

COFFEE BREAK

Chairperson: Liz Balfe, PHN Committee

- **NMBI review of PHN staff requirements**
  Speaker: Carolyn Donoghue, Director of Education Policy and Standards, NMBI
- **Integrated care and the role of the PHN**
  Speaker: Georgina Bassett, Deputy Chief Nursing Officer, Department of Health
- **Minding your health and wellbeing**
  Speaker: Workplace Health and Wellbeing Unit, HSE
- **Evaluation and Closing Address**
  Mary Tully, First Vice President, INMO and Chairperson, INMO PHN Section
- **RAFFLE:** Patricia Marteinnson, INMO PHN Committee

CLOSE OF CONFERENCE

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For further details go to
www.inmoprofessional.ie/conference or call 01 6640641/18

A positive focus with the president

Karen McGowan, INMO president

EFN general assembly

I WAS honoured to attend the general assembly for the European Federation of Nursing Associations (EFN) hosted in Slovenia last month. It was a very productive assembly with papers on topics such as advanced practice and planetary health. It was interesting to see a European perspective in relation to advances in nursing but it was also clear that some have a long way to go. It made me realise how strengthened we are as a union to be affiliated to EFN from a collective perspective. It also allows us to support other countries in their journey to improving their positions. Elizabeth Adams, president of EFN, hosted a fantastic meeting and is representing the INMO so well at a European level. I also attended the Operating Department Nurses Section conference in Limerick. The array of key speakers was fantastic. They have raised the bar on the standard and I look forward to attending again next year. Congratulations to the organisers on a job well done.

Labour hopscotch: a midwife-led innovation

I LOVE to speak to nurses and midwives about their roles and hear about the initiatives they have launched. This month I spoke with Sinead Thompson, designer and creator of 'labour hopscotch'. Ms Thompson trained in Letterkenny University Hospital and also worked at the National Maternity Hospital (NMH) where she was a community midwife manager (CMM2) on the Domino and Homebirth scheme and the Early Transfer Home Scheme for a total of 18 years.

Labour hopscotch creator and midwife, Sinead Thompson

Ms Thompson is currently working with the National Women and Infant's Programme as project co-ordinator for the implementation of the national standards for antenatal education In Ireland 2020. She has been co-ordinating a multidisciplinary team on designing a programme of content for parent educators to deliver high standard antenatal services in line with the recommendations set out in the national standards.

Ms Thompson told *WIN* that labour hopscotch was created in response to the increase in medical intervention and the national increase in Caesarean sections to protect and promote physiological birth. She works as part of a research network between NMH and UCD where the labour hopscotch framework has been researched with the findings published in 2019.

"The findings proved that with a multidisciplinary approach to birth preparation, labour hopscotch can significantly lower the C-section and epidural rates but most of all increases birth satisfaction rates for women and their partners. In March 2020 as part of this team of researchers from the Joint Research Network we submitted three papers on the labour hopscotch findings. I'm incredibly passionate about education being the way to empower mothers and to give them the births they want and in the manner they wish. Knowledge is power for their bodies and babies," she said.

Ms Thompson has presented at both national and international midwifery conferences. She provides training workshops in the 19 maternity units for all allied healthcare professionals and in UCD to students up to master's-degree level to promote active birth.

She is very proud to have had huge support and encouragement from Mary Brosnan, director of nursing and midwifery at the NMH who was instrumental in helping her progress labour hopscotch. "Having ideas is great but it's getting the support and belief in the idea that drives it on to progression," she explained.

Follow Sinead on Twitter at: @hopscotchlabour for further updates

See also: WIN Thompson S, O'Brien D. WIN 2015; 23(8): 64-65 for more on labour hopscotch

Executive Council update

THE Executive Council met in person in October. The recent result of the national ballot was satisfying but a lot of work remains ahead of us. There were robust discussions as always in particular on the HSE's winter plan. The Emergency Department Section held a meeting to discuss the plan with its members echoing the sentiments the Executive has in regard to its shortcomings.

We are seeing crisis after crisis across our hospitals nationwide. Staffing levels are being further hit with high numbers of senior nurses and midwives resigning, a phenomenon that is particularly prevalent in acute hospitals. The INMO has repeatedly highlighted that the HSE must do everything in its power to keep nurses and midwives in the health service. The Framework for Safe Nurse Staffing and Skill Mix has been well documented and the implementation strategy is in progress inclusive of key stake holders.

Recruitment, retention and the cost of living were the topics being raised by members of the Executive Council. These issues affect our members hugely and will be discussed on an ongoing basis. I can say that our in-person meetings are by far the most productive and informative of discussions.

Executive Council members also reported on a busy month of conferences nationally and internationally in various areas, including care of the older person, midwifery, occupational health and theatre nursing. Executive Council members also represented the INMO at the ICTU women's conference.

Plans for ADC 2023 have commenced and local committees have been engaging well with progressing plans.

The next Executive Council meeting will be held November 17 and 18.

Please get in contact with me at the email address below if you would like to showcase an initiative or service.

Get in touch

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

Overcrowding chaos leading to inhumane conditions

FOLLOWING consultation with emergency department (ED) representatives, the INMO Executive Council last month called for the HSE and government to come up with an immediate operations plan to tackle the chronic and dangerous overcrowding in our emergency departments.

This comes as 92,324 patients have been on trolleys so far this year, a 45% increase on the year previous.

INMO general secretary Phil Ní Sheaghdha said: "INMO members in emergency departments throughout the country are once again sounding the alarm on grim conditions in each ED across the country.

"We know anecdotally that many nurses in EDs are moving to elsewhere in their hospital or are leaving the profession altogether because of the conditions in which they work and a lack of safe staffing. For example, in St Vincent's University Hospital, 18 nurses are needed for any given shift in the ED, our members there are reporting that in reality only nine to 11 nurses are rostered for most shifts. In University Hospital Galway there are over 42 unfilled nursing posts in the ED.

"Nurses and midwives have just come out of the worst of Covid-19 and are now working in a system that is sleepwalking into another overcrowding crisis. Our members are demanding that the HSE's recently published winter plan separates staffing for ED attendances and admitted patients.

"If the decision to cancel all elective care needs to be taken, then that decision must be made swiftly.

"It is now necessary that all those who have a role to play in improving the conditions in our EDs, including the Health and Information Quality Agency, the Health and Safety Authority and the Nursing and Midwifery Board of Ireland, attend the next Emergency Department Taskforce meeting.

"Our ED nurses are not willing to put up with the conditions that they find themselves working in. This is reflected in the high numbers of resignations. It is vital now that the HSE and the government meet with these nurses, hear their concerns and take immediate action.

"If numbers continue to rise on trolleys, coupled with extremely unsafe staffing, our Organisation will have no choice but to consult with members on the next steps."

INMO president Karen McGowan said: "Nurses and midwives do not believe that the Department of Health or the HSE are putting in place adequate measures to deal with the stark increase in resignations among our professions. Our ED nurses can no longer cope with their workplace being the first port of call in many instances.

"If the government and HSE are serious about keeping Irish nurses in Irish hospitals then they must take immediate action on safe staffing, fast tracking recruitment and getting private hospitals on the pitch now."

EDs and hospitals braced for catastrophic winter

THE INMO recorded 10,515 patients on trolleys in the month of September. This is the second worst September for overcrowding in Irish hospitals (2019 being worse). As we went to press, figures for October were even worse – with 669 people, including 28 children, without a bed on October 25 and there had been a 27% increase of patients on trolleys since the previous week.

The top five most overcrowded hospitals in September 2022 were:

- University Hospital Limerick – 1,382 patients on trolleys
- Cork University Hospital (CUH) – 1,260 patients on trolleys
- University Hospital Galway – 1,032 patients on trolleys
- Sligo University Hospital – 790 patients on trolleys
- Letterkenny University Hospital – 666 patients on trolleys.

Last month in Cork, members at both CUH and Mercy University Hospital described conditions inside their hospitals as unsafe and intolerable, coupled with significant ambulance wait times outside.

In Dublin, members working in the ED and throughout the Mater University Hospital indicated that their place of work was no longer safe for the patients they're trying to care for, or the staff working there. "Day after day and night after night, members are reporting that while the ED is bursting at its seams, the nursing staff are being swamped and unable to take even short breaks. This is dangerous on so many different levels," INMO assistant director of IR Maeve Brehony

INMO general secretary Phil Ní Sheaghdha said: "It is clear from September's overcrowding figures that we are on a path to a catastrophic winter in our hospitals. It is unsafe for nurses and the patients they care for.

"The ongoing problems with overcrowding are leaving nurses completely and utterly demoralised. We have a severe recruitment and retention problem within the health service. In one week alone last month in a large teaching hospital in Dublin, over a dozen nurses working in a busy ED handed in their notice. Our members are now voting with their feet and saying that they will not stand for another winter where they are demoralised, burned out and abused in their workplace because of the excessive workloads.

"Despite promises from senior hospital management that things have improved, University Hospital Limerick is once again the most overcrowded hospital in the country. On a recent visit to the hospital, the INMO saw first hand the conditions our members are working in. There is no dignity for patients who end up in UHL. Their care is no doubt being compromised because of the conditions.

"It is not enough for the Minister for Health and senior HSE leadership to acknowledge that we are in for an undesirable winter. We need to know when the private hospitals will be coming on the pitch, we need to know what exact measures are being implemented to keep our nurses in the system, when extra capacity will be coming through in communities to allow discharging of patients to happen in a timely manner. Patients need assurances that they will be cared for in a safe environment that ensures their care is not compromised."

HSE must remove recruitment red tape before winter plan can work

COMMENTING on the publication of the HSE Winter Plan last month, the INMO has said removing the bureaucracy around recruitment must be a core tenet of any winter plan.

INMO deputy general secretary Edward Mathews said: "The INMO has welcomed the publication of the Winter Plan for the upcoming months. The inclusion of a hospital-by-hospital allocation is something that the INMO has long called for.

"However, plans and reality are two very different things. The reality is unless we have the staff, announcing additional capacity is futile.

"We know that many of our emergency departments are not staffed adequately or safely at present. In order to allow for more nurses and midwives to be recruited at the pace in which we need them, directors of nursing and midwifery in each hospital should have a greater role in recruitment.

"As part of the winter plan, nurses, midwives and the patients they care for need to be assured that every bed possible, including beds in the private hospitals, will be used this winter. This, coupled with ensuring that diagnostics are made available in the community and at weekends, should relieve pressure on our emergency departments.

"In the longer-term, we need assurances from the Minister for Health that the commissioning of elective-only hospitals, as per the Sláintecare plan, will be sped up. This will be a game changer in winters to come.

"Our members are currently overburdened and overworked in the situations they are working in, they are telling us that they are not willing to put up with another winter in intolerable conditions, with many voting with their feet and leaving the profession altogether. We must ensure that there is a legal basis for the implementation of safe staffing levels," he said.

Call for more detail on Budget health spending

FOLLOWING the announcement of Budget 2023, the INMO called for the allocation to health spending to be ambitious when it comes to workforce planning. This came as the government announced that €23.4 billion will be spent in health in 2023.

The INMO sought greater detail on the overall budget package on areas including:

- The exact number of nurses and midwives that will be recruited by the end of 2023
- The implementation plan for the Safe Staffing Framework in Nursing, which uses a scientific model to set staffing levels and requires a legal basis for implementation to ensure safety is prioritised
- The supports made available for undergraduate student nurses and midwives.

INMO general secretary Phil Ní Sheaghdha said: "The continued increase in health spending is welcome if it is guaranteed that money is spent in an efficient way. We need to ensure that money allocated to the Department of Health is spent to get staffing right, building up capacity and moving to the universal care model as envisioned by Sláintecare.

She said that while the Minister for Public Expenditure and Reform had said that an additional 6,000 workers would be employed across the health sector, no specifics were offered on exactly how many nurses and midwives would be recruited. "Recruitment and retention of nurses and midwives deserves a laser focus in the year ahead," Ms Ní Sheaghdha said.

"In the same way we have a pupil-teacher ratio embedded in budgets year on year, we need to see a patient-nurse ratio that dictates what the safest level of staffing should be in each of our acute hospitals. When our children enter school we expect them to be in an environment where they can get the attention they need to thrive – why don't we expect the same when a loved one is in hospital?

"We are currently seeing levels of 15 patients to one nurse. We are seeing instances of maternity wards closing because of staffing issues. This is unsustainable."

While welcoming the reductions to the student contribution charge for student members she said student nurses and midwives are still paying above the odds for accommodation costs to carry out their placements, which is a core part of their training. "The Minister for Finance must clarify if students qualify for the renters' tax credit. Moreover, the government will have to go further than a tax credit for renters to keep the future of our health service in Ireland", she said.

INMO members accept pay proposals by 97%

FOLLOWING overwhelming acceptance of the pay proposals on public sector pay arising from the review of Building Momentum, the INMO has pledged to continuing to monitor cost-of-living increases to ensure the pay of nurses and midwives keeps pace.

In addition, the INMO said serious concerns about safety were raised by members at workplaces throughout the country during the information meetings held in the run-up to the ballot.

INMO general secretary Phil Ní Sheaghdha said: "Our members accepted the pay proposals by a margin of 97%. It is clear from our information meetings that workplace after workplace are raising serious concerns about their ability to provide a safe level of care this winter. We are now engaging with members separately in workplaces to look at measures to provide them with realistic workloads. We will continue to monitor the cost-of-living increases, in light of warnings by the Central Bank of Ireland that inflation is forecast to continue.

See also page 12 (IR Update)

Thousands still await pandemic bonus

THE National Joint Council of ICTU Health Sector Trade Unions (INMO, SIPTU, Fórsa, IMO, Unite, MLSA and Connect union working as one) called on the Minister for Health to urgently intervene in the non-payment of the Pandemic Recognition Payment at the end of September.

This came as non-HSE health staff (including nurses, health care assistants, cleaners, clerical workers, social care assistants, porters, security staff and many more) were yet to be paid the Pandemic Recognition Payment which was announced by government on January 19, 2022.

These staff working as agency or contractors were central to the health service response to Covid-19. Also, staff employed by Section 39 agencies, private nursing homes, Tusla, the Irish Blood Transfusion Service and others feel abandoned by the Department of Health and the government.

Chairperson of the NJC unions and INMO director of professional services Tony Fitzpatrick said: "Thousands of Irish people now know that they will be receiving payments to deal with the cost-of-living crisis in the months ahead, but healthcare workers are still none the wiser as to when they will be getting their long awaited Pandemic Recognition Payment.

"The government announced what was supposed to be a goodwill gesture last January but have provided absolutely no mechanism to pay these workers who played a key role in the protection of the State in our hour of need."

Fórsa head of health and welfare Ashley Connolly added: "Despite many requests, Minister Donnelly and his officials have yet to meet unions to hear the concerns our members are putting to us daily.

"What was meant to be a payment to show respect to healthcare workers has proved to be the very opposite. At a time when budgets are stretched, many of our members, particularly those in Section 39 organisations, who have yet to see a pay increase this year, have factored this money into their household spending.

SIPTU health divisional organiser Kevin Figgis said: "It is unacceptable to us as unions that thousands of healthcare workers, who showed up when the rest of us were told to stay home, are continued to be kept in the dark about the status of their Pandemic Recognition Payment. The Minister for Health and his officials must end their hands off approach to this issue and outline precisely how and when these workers who they were quick to call heroes will be paid what is due to them."

Owen Reidy appointed ICTU general secretary

OWEN REIDY, the outgoing assistant general secretary was ratified as the new general secretary of the Irish Congress of Trade Unions last month, following Patricia King, after she stepped down from the post earlier in the month.

Mr Reidy, a father of two and a native of Donegal, has 24 years full-time experience in the Irish trade union movement. He started his career as a union official in SIPTU in the west of Ireland and occupied a range of roles in the union representing and organising workers in the aviation, insurance and finance, non-commercial semi-states, and cleaning and security sectors. He was appointed one of SIPTU's five divisional organisers in 2013 when he managed and ran the union's Transport, Energy, Aviation and Construction Division. During this time he was involved in a number of high profile and successful industrial disputes including the Greyhound lockout, the Luas dispute, and pay disputes in the CIE transport companies.

In 2016 Reidy took up the position of assistant general secretary of the ICTU with primary responsibility for the Congress in Northern Ireland. He has coordinated the work and voice of the trade union movement in Northern Ireland in response to Brexit, political stalemate and the current cost of living crisis. Mr Reidy came through a competitive interview process to be selected as the new general secretary of Congress.

Mr Reidy said: "I am delighted and humbled to be selected for this important leadership role in our trade union movement. I want to pay tribute to my friend, colleague and mentor Patricia King, for her work and the valuable legacy she has left us all in her work both in SIPTU and as general secretary of our Congress. I think we have the potential to rebuild and grow our movement and reach out to workers currently not organised in trade unions. We need to make work pay for all and build a more inclusive economy and society.

New ICTU general secretary meets INMO: *New ICTU general secretary Owen Reidy(right) pictured with INMO general secretary Phil Ni Sheaghdha and deputy general secretary Edward Mathews recently*

He said the number one priority must be to transpose the recent EU directive on adequate minimum wages, which he said "has a transformative potential when it comes to collective bargaining in Ireland". He also pointed to the pressing need to legislate for the Labour Employer Economic Forum (LEEF) High Level Group report on collective bargaining in Ireland. "I look forward to working with my colleagues in a collective leadership to strengthen collective bargaining, to grow our movement, and to improve workers voice in society and the economy," he said.

ICTU president Kevin Callinan said: "With Irish and European collective bargaining structures set to be overhauled, we are entering an exciting new phase for the trade union movement. As general secretary Owen Reidy said, this will bring fresh energy to the task of ensuring that these changes happen in a way that produces real improvements in the pay and conditions of workers. In his previous roles with SIPTU and as the lead Congress official for Northern Ireland, he has shown that he has the qualities to unite the movement in pursuit of such core objectives."

NMBI State of the Register report highlights workforce pressure points

THE NMBI released this month its new data report, the *State of the Register 2022*, providing a breakdown of the number of nurses and midwives registered in Ireland.

The report provides information on the 75,871 practising registered nurses and midwives and is aimed at supporting policymaking and workforce planning.

The INMO welcomes the publication of these figures, which will help us better understand what our members need from us as a union, as well as the pressure points in the national workforce where INMO intervention is needed.

The report provides a breakdown of registrants across practice areas with 54,797 active general nurses, 3,999 practising intellectual disability nurses, and 3,371 practising children's nurses. The report also shows there are 4,561 practising midwives on the register.

Of the 4,937 new registrants from June 2021 to May 2022, the report noted that 3,021 (61%) trained in non-EU countries. The top overseas countries for new registrants were India (2,364), Philippines (391), the UK (250) and Zimbabwe (132). Of the total registrants, 15.8% are of Indian nationality and 7.8% are Filipino.

In terms of gender breakdown, the report shows more than 90% of those on the NMBI register are women, with the highest proportion of male registrants among psychiatric nurses (22%), nurse tutors (10.7%) and general nurses (10%). The lowest proportion of male registrants was among children's nurses (1.5%), public health nurses (0.5%) and in midwifery, where there are a total of 17 male registrants.

The NMBI report also breaks down the geographical spread of nurses and midwives across the country, with 38,334 (over 50%) predictably concentrated in counties with larger cities, namely Dublin (33.6%), Cork (10.9%) and Galway (6%).

The register also provides insight into the age range of the nursing and midwifery population in Ireland, with under 10,000 practising nurses and midwives under the age of 30 and 30% over the age of 50.

Commenting on the report, Tony Fitzpatrick, INMO director of professional services, said: "It is very clear from this register data that the Irish health service is highly reliant on the skills of nurses and midwives who have trained overseas. Therefore, ensuring that Ireland is an attractive place to work must be high on the government's list of priorities.

"It is also clear that the international data concerning the aging nursing and midwifery workforce is reflected in Ireland, and it is vital that we do everything possible to retain graduates in their professions if we are to have a functioning health service in the coming years and decades."

Results of the NMBI Board Election 2022

THREE candidates endorsed by the INMO in the recent elections to the NMBI board were successfully elected, namely: Mary Rose Loughnane (RNID category), Mary Leahy (public health category) and Kate O'Halloran (midwife category).

The poll to elect five registrants to be members of the board of NMBI closed on Wednesday, September 21, 2022. The successful candidates were:

- Registered nurse from the practice of psychiatric nursing engaged in clinical practice – Mark Johnston
- Registered nurse from the practice of intellectual disability nursing – Mary Rose Loughnane *(INMO endorsed candidate)*
- Registered nurse from the area of nursing engaged in the care of older persons – Mittu Fabin Alungal
- Registered nurse or registered midwife from the practice of public health nursing – Mary Leahy *(INMO endorsed candidate)*
- Registered midwife engaged in clinical practice – Kate O'Halloran *(INMO endorsed – only candidate in category)*.

Annual retention fee can be paid from Nov 1

THE facility to renew your registration and pay the annual retention fee for 2023 will open on November 2 this year.

The 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.

Members have expressed significant challenges around the timeframes for paying their annual retention fee to the NMBI and asked the union to advocate for them so that they would have a better process and more time to pay.

The outcome of this was that the NMBI extended the time period for payment, opening the system for annual renewals and payment earlier, and closing it later. 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 200 116 or email: regservices@nmbi.ie to request your notice.

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

HSE to review patient numbers in line with safe staffing framework

FOLLOWING a recent meeting of the Workplace Relations Commission INMO ED Forum, it was agreed that the HSE will conduct a review of admitted patients in line with the Safe Staffing Framework Phase 1 as a matter of urgency.

In addition, the INMO has secured agreement that a similar exercise will be carried out as per the ED Safe Staffing Framework Phase 2 in respect of the baseline staffing in all emergency departments.

It was also raised and agreed that hospital group forums would be re-established to deal with issues arising over the winter period. It is expected that there will be a meeting of the INMO Emergency Department Section to update on the outcome of the forum meeting.

At the time of writing, the INMO planned to write to the hospital groups seeking a number of necessary measures around the ongoing unacceptable overcrowding in emergency departments.

The HSE's winter plan, which was published in October, included a very welcome hospital-by-hospital spending allocation. The plan also cited additional capacity in acute and community services, as well as the expansion of patient flow and discharge teams in hospitals and community and additional investment to support expansion of community intervention teams.

The INMO has stated firmly that a timeline for these measures is urgently needed. The union has also called for additional focus on adequate clinical facilitator capacity in emergency departments, access to private hospital capacity to meet increased demand over the winter and a legal underpinning for the Safe Staffing Framework to ensure patient and staff safety.

Given the high level of Covid-related hospitalisation that is anticipated this winter, the INMO will continue to insist that staffing and capacity are a top priority for the HSE over the coming weeks.

Conciliation on staffing of temporary ED in UHG

A CONCILIATION meeting was held on October 7, 2022 between the INMO and management at University Hospital Galway in relation to the opening of a temporary emergency department (ED) without prior agreement on staffing levels.

The INMO Executive Council had previously authorised a ballot of members at the hospital following a directive by hospital management stating that the department would open without agreement.

However, a subsequent WRC conciliation was convened and agreement was reached on a number of staffing and logistical issues. It was further agreed to reconvene within a number weekend to evaluate those matters.

Members vote to accept proposals under Building Momentum review

INMO members voted overwhelmingly through the ballot box, by a margin of 97%, to accept proposals arising from the review of the Building Momentum agreement.

The proposals, which emerged following talks chaired by the Workplace Relations Commission, contain a number of measures to increase pay for nurses and midwives employed by the public sector and included:

- A 3% increase on annualised salary to be back paid to February 2, 2022
- A 2% increase on annualised salary from March 1, 2023:
- A 1.5% increase or €750, whichever is the greater, from October 1, 2023.

This is in addition to the 1% or €500 increase due to members from October 1, 2022, as previously agreed.

The total ICTU public service vote was counted on Friday October 7, with the proposals carried by the aggregate ballot of the public service unions.

The INMO has written to private acute hospitals such as the Mater Private and the Bon Secours group, as well as to the HR directors of voluntary hospitals, seeking an adjustment in pay in line with the agreement in the public service.

Further to the above increases, the HSE issued a circular to payroll departments on October 5 regarding the pay adjustment of 3.28% for promotional grades, and grades paid on the promotional salary scale. The INMO will be seeking urgent payment of this increase.

HSE and INMO engage over public health nursing

DUE to considerable pressures on time and the resulting need to cross-cover vacant posts, PHNs are being overwhelmed by extra work. This is exacerbated by various assessment tools, some of which are paper based and very lengthy.

There have been a number of meetings with the HSE on these issues and it has been agreed that there will be internal HSE engagement with PHNs, which will include INMO-nominated representatives.

It was also agreed that a forum would review the forms and processes involved in a number of PHN matters.

HSE assistant national HR director Jackie Nix has accepted an invitation to address the INMO PHN Section on the HSE's plans on the future of public health nurses at its section meeting in November 2022.

current national issues

DoH finally engaging on long-Covid as occupational injury issue

FOLLOWING the campaign by the INMO and other unions for an occupational injuries benefit to be available to healthcare workers who are living with long Covid, a meeting has finally taken place between the unions and the Department of Health.

Previously the Department had refused to engage on this issue with the various groups that the INMO believe should be included in this process.

The meeting, held in early October, also discussed the second cohort of employees who are due to receive the special pandemic recognition payment and the INMO felt that the outcome was most satisfactory.

The matter of occupational injuries benefit was also discussed at a recent meeting of the Health Service Oversight Body. Agreement was reached by both the employers and trade unions that it would be referred to the Public Service Advisory Group. The unions have subsequently written to the secretariat of this body requesting that the issue be dealt with at its next meeting.

See also page 10 for details on delayed pandemic payments

Union intervention to prevent the closure of Clifden District Hospital

The HSE's sudden decision to close Clifden District Hospital is shocking and the INMO, together with SIPTU, said emergency engagement is needed with staff and representatives through the auspices of the Workplace Relations Commission.

The INMO and SIPTU, representing members in the hospital, have stated that every possible effort must be made to maintain and increase bed capacity in the community, adding that regressive steps such as the closure of this hospital will cause severe problems in the area.

INMO IRO Anne Burke said: "The announcement on October 21 from the HSE that they are closing Clifden District Hospital is shocking for the nursing staff, the hospital and wider community.

"At a time when the health service is struggling so profoundly in terms of capacity, every possible effort must be made to maintain and increase bed capacity in the community – not regressive steps to reduce capacity and, in turn, create difficulties for both the public and staff.

"Neither staff nor their trade union representatives were given prior notice that this decision would be announced.

"This flies in the face of all that nursing staff have done to maintain services in Clifden District Hospital, particularly over the last number of weeks. It is not acceptable to our members that staff and the community have been treated this way.

"There is now an urgent need for the employer to engage with staff and their representatives. To this end the INMO is now seeking an emergency conciliation conference under the auspices of the Workplace Relations Commission."

Prior to the HSE's closure announcement, the INMO had intervened in a dispute over changes to rosters at the Clifden hospital, which would have seen nurses in one unit forced to work an extra half an hour per day.

The unions are now seeking an emergency conciliation conference at the Workplace Relations Commission to resolve the matter and prevent this hospital closure.

WRC: agreement reached on children's disability networks talks process

A PROCESS has been agreed under the auspices of the Workplace Relations Commission for discussions on issues surrounding the children's disability network teams including public sector pay parity.

Unions have been seeking discussion in relation to employment and policy matters in respect of the networks. The main concern is in relation to Section 39 employers and the disparity in relation to pay and terms and conditions compared to the public sector.

A meeting on reporting relationships took place on October 5, 2022 between the nursing unions – led by the INMO and SIPTU – and HSE senior management. The INMO stated that it does not recognise the Labour Court recommendation accepted by Fórsa regarding health and social care professionals reporting to a network manager. The INMO has proposed that the newly commenced implementation group for the Expert Review of Nursing Management Structures is the appropriate forum to deal with these issues, which the HSE has agreed to.

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

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

ICN backs calls for action to protect mental health of nurses

Two new reports underline need for governments to act now

THE International Council of Nurses (ICN), of which the INMO is the Irish national nursing association, has given its full support to a report calling for more action to protect the mental health of nurses and other healthcare workers.

The negative effects of the Covid-19 pandemic on the mental health of nurses and other healthcare workers have been underscored in a new report from the World Innovation Summit for Health (WISH) and the World Health Organization (WHO).

The report, on which ICN chief executive Howard Catton was an advisor, found that there had been a failure to protect the mental health and wellbeing of health and care workers and that at least one-quarter of them have reported anxiety, depression and the symptoms of burnout. These results mirror research carried out by the INMO with its members on the effects of working through the Covid-19 pandemic.

Speaking at the launch of the *Our duty of care: A global call to action to protect the mental health of health and care workers* report, at the recent WISH conference in Doha, Qatar, Mr Catton said that the public had realised the value of nurses during the pandemic, but politicians were less willing to turn praise into investment.

He remarked that there was a historic lack of value placed on nursing. Politicians make the case about investing in the economy, infrastructure and technologies, but Mr Catton observed that you never hear similar discussion about nursing, stating that the profession was both an undervalued and devalued currency.

"Nurses need to have decent safe conditions at work and that includes mental health support, they must feel valued and recognised that they do make a difference. They want their voice to be heard by employers and governments and, yes, to receive fair remuneration for their expertise and dedication," he said.

Mr Catton reflected on the economic value placed on nursing and questioned whether nurses really are 'the average worker' and asked what paying them at that level, or below, says about how we really value them?

He said that the world's nurses deserve a pay rise for the sake of all our health.

The ICN chief also emphasised that health included both physical and mental health, and that the mental health of nurses had been profoundly adversely affected by Covid-19. He said that since the start of the pandemic, nurses have been reporting that their mental health has been a significant concern.

The ICN and the global nursing community have been struck by the complexity of the issues arising. These include stress and burnout of course, but we have also seen nurses abused and attacked. They have been confronted by anti-vaxxers who say that

Covid is fake, while they continue to deal with the harsh realities of the pandemic on a daily basis.

The intensity of the pandemic was quite different from what nurses were used to as many of them had to step into the shoes of the loved ones of the dying during their last moments. This was a mass traumatisation of the nursing workforce, and it has taken its toll.

The *Our duty of care* report highlights 10 policy actions that WISH and the WHO says should be introduced immediately, including investing in workplace environments and cultures that prevent burnout, promote staff wellbeing and support quality care.

The ICN also recently welcomed the publication of the WHO's latest workforce report, which revealed shortages which Hans Kluge, the WHO regional director for Europe, described as a "ticking timebomb".

The *Health and Care Workforce in Europe: Time to Act* report highlights many of the issues that the ICN has raised since the start of the pandemic, including the findings in the *Sustain and Retain* report, including:

- The ageing nursing workforce
- The uneven distribution of nurses throughout the world
- Failure of governments to train enough of their own nurses rather than rely on international recruitment
- The 'Covid-effect', which has led to greater sickness absences, increased burnout and mental health problems among nurses, and higher levels of intention to leave the profession.

Reflecting on the report, Mr Catton remarked that it provided baseline information about the health and care workforce across Europe, and should be replicated across all WHO's regions. It highlights the many severe pressures and demands that nurses and others are under at this time.

Mr Catton said that the ICN fully endorses the report's findings, including its 10-point plan, which serves as an urgent call for governments to act immediately to grow their

global nursing and midwifery news

own nursing and healthcare workforces so that they can be self-sufficient in meeting their populations' needs.

"The report recognises the obligation nations have in increasing access to healthcare, but we will only be able to maintain and retain the nursing and healthcare workforce if we support their training and education, and enable them to advance their careers," said Mr Catton.

He further remarked that, such action cannot wait.

"We need action now, not some five- or 10-year plan that never comes to fruition. It is a call to action that must be put in place now: to do otherwise would be to risk that ticking time-bomb blowing up in our faces."

Mr Catton said the WHO must regularly monitor progress on the 10-point plan (following) and report on its delivery.

WHO's 10-point plan:

- Align education with population needs and health service requirements
- Strengthen professional development to equip workforce with new knowledge and competencies
- Expand the use of digital tools that support the workforce
- Develop strategies to recruit and retain workers in rural areas
- Create working conditions that promote a healthy work-life balance
- Protect the health and mental wellbeing of the workforce
- Build leadership capacity for workforce governance and planning
- Improve health information systems for better data collection and analysis
- Increase public investment in workforce education, development and protection
- Optimise the use of funds for

'Warm Irish welcome' for advanced practice conference appreciated – ICN's chief nurse

MICHELLE Acorn, the International Council of Nurse's (ICN) chief nursing officer, on her visit to Ireland for the ICN Advanced Practice Network conference – organised by the INMO and partners in the Irish Advanced Practice Association – remarked that the warm Irish welcome extended was authentic and appreciated.

The international event marked 26 years of advanced nursing and midwifery in Ireland as more than 600 delegates from 61 countries attended the conference.

It showcased advances and how evidence-informed practices can support global health, address inequalities, lead innovation in healthcare delivery and build a global health advanced practice workforce around the world.

Ms Acorn's keynote address highlighted the need for diversity of practice to strengthen systems and advance primary healthcare. She highlighted the success of nurse practitioner (NP)-led geriatric care teams and how positioning the NP as lead providers for hospital inpatients, from admission to discharge, has demonstrated evidence-informed care, along with added value and quality.

She said that the ICN recognises that now is the time to advocate, invest and leverage nurse-led models of care locally to globally.

HIQA reports underline need for recruitment and retention plans

RESPONDING to the HIQA inspection reports into Cork University Hospital, Cavan and Monaghan Hospital, and St Columcille's Hospital, Loughlinstown, the INMO has said that a bespoke recruitment and retention plan is urgently needed.

Commenting on the findings INMO general secretary Phil Ní Sheaghdha said: "We welcome the role HIQA has played in inspecting Cork University Hospital, Cavan and Monaghan Hospital, and St Columcille's Hospital.

"We know following HIQA's report into University Hospital Limerick that subsequent action is key. Bespoke recruitment and retention measures are needed hospital by hospital this winter. The funding allocated in the Winter Plan to implement the Safe Staffing Framework is welcome to ensure that a safe nurse to patient staffing and skill mix ratio exists in each emergency department is key.

"As outlined in the HSE Winter Plan just published, each ED should conduct an urgent analysis to identify and address gaps and risks, each hospital must move to undertake this process immediately.

Assistant director of industrial relations for the Southern Region, Colm Porter said: "HIQA's findings into Cork University Hospital are particularly stark. On the day that HIQA carried out its inspection (June 15), 62 people were without a bed. Since then, more than 4,469 patients have been on trolleys in Cork University Hospital.

Speaking on a day when the hospital was the most overcrowded hospital in Ireland, he continued: "The bed deficit that currently exists in both Cork University Hospital and the wider Cork community is adding to the pressure in this emergency department.

"HIQA's report raises questions on the safety of staffing levels in Cork University Hospital. A bespoke taskforce is now needed to tackle the ongoing issues in the hospital, focusing on staffing and timely discharging of patients in order to improve patient flow."

Members in Milford Care Centre vote to accept management proposal on holiday premiums

INMO members employed in Milford Care Centre have accepted a proposal from management to address the non-payment of holiday premiums in this service.

The INMO queried this further to enquiries from new staff to the service. Management acknowledged the error and the non-payment of holiday premiums to staff, and immediately agreed to pay holiday premiums for 2022 when it falls due (July 2023).

The INMO and SIPTU engaged with management to address the historic non-payment and a proposal to pay retrospection for 2021 and 2020 was put to members by ballot. Members voted overwhelmingly to accept this proposal.

The INMO is now engaged with management on a payment date for the two years retrospection to secure immediate payment of same.

Separately this service is now paying more than half of both staff and senior staff nurses applicants on the enhanced nurse pay scale. There remains a small cohort of nurses who have not completed the verification form and the INMO encourages all staff and senior staff nurses to avail of this enhancement in pay.

Management also advise that a number of contracts remain with members so please return immediately to be processed by payroll and receive the enhanced pay due to you.

– Karen Liston, INMO IRE

Covid-19 booster now available for nurses and midwives

NURSES and midwives, alongside all other healthcare workers, now qualify for an additional Covid-19 vaccine booster. If it is at least four months since you had your last booster or four months since you had a Covid-19 infection, you can now access a booster vaccine either through online booking or through your local participating general practitioner or pharmacy.

The latest adapted vaccines are being used in this booster programme.

As winter and the associated increased overcrowding approaches, it is important to protect yourself and your colleagues by keeping your influenza and Covid-19 vaccinations up to date.

Car parking at UHL update

FURTHER to a meeting with local management, the arrangements for staff car parking at University Hospital Limerick were set out to the INMO following some members raising issues. The hospital currently has 765 parking spaces, including 10 disability spaces, for staff. Due to building works, staff parking has been reduced, however alternative arrangements have been put in place by management with a shuttle bus service running daily from 7am-1pm and 3pm-9pm. Carpooling is also available and to be used by approved carpooling staff only, with ongoing monitoring and review. To further support staff all cars must be registered with Euro Car Parks via the office in car park two. Should there be further changes in respect of staff car parking management has committed to notifying the unions in advance.

– Mary Fogarty, INMO assistant director of IR

INMO: Fire safety, injury and infection among overcrowding risks in Sligo

THE INMO has called for an urgent inspection of Sligo University Hospital by the Health and Safety Authority (HSA) in response to increased overcrowding and safety issues.

In a letter to the HSA, the union stated that a high level of patient attendance at the hospital, coupled with delays in discharging patients, were leading to health and safety risks to hospital staff.

While noting that the overcrowding problem extends throughout the hospital, the INMO has stated that safety issues are particularly severe in the emergency department, with Sligo University Hospital seeing extraordinarily high levels of overcrowding this year, and 5,901 patients having been treated on trolleys since January.

The INMO said that due to the large numbers of patients being treated in corridors on trolleys and chairs, staff were concerned about specific safety issues including the ability to safely evacuate in the event of a fire, higher risk of assaults on staff, a very high risk of infection transmission and increased risk of injury due to severely reduced space in which to work and move between patients.

The INMO also noted that the increased workload and pressures on staff was leading to stress and increasing risk of trauma and burnout, with staff regularly unable to take appropriate breaks during their shifts due to staffing and workload issues.

INMO IRO for Sligo, Neal Donohue said: "These safety issues extend throughout the hospital, but the conditions in the emergency department are so concerning we have no choice but to call for an urgent inspection.

***Unacceptable:** "We cannot expect people to work under these conditions without seeing long-term effects." - Neal Donohue, IRO*

"It's simply not acceptable for staff to be at this much risk inside a hospital, and it is beyond demoralising for our members when even their basic safety needs are not being met.

"We need to be making nursing and midwifery more attractive as careers, but at the moment we're not even meeting the minimum standards in terms of working conditions. We need to consider how this will affect future staffing as well as the daily risks to patients and our members.

"We can't expect people to work under these conditions indefinitely, and when staff leave the area or leave the nursing profession because the pressure is too much, we're going to see long-term effects in health services across the region."

Alleged overpayment arrears faced by member, reduced by INMO

FOLLOWING representations from INMO staff in the region, arrears of an alleged overpayment by the HSE to a member over a 10-year period have been reduced by nearly 50%.

This was achieved by carrying out a forensic review of the alleged overpayment. This review was carried out with the member and the INMO in conjunction with the relevant line managers.

It was originally alleged that the overpayment had occurred owing to an error on roster returns. However, during the review the roster returns showed that the employer had been incorrect in their calculations of the overall arrears.

Liam Conway, INMO industrial relations officer, urged members to attain full information in relation to an alleged overpayment if they are advised one has occurred.

Liam Conway, INMO IRO, Southern Region

"It is vital that you seek clarity in relation to how the overpayment has occurred and the breakdown of the overpayment for the duration of the time. It is very important that you seek the advice of the INMO following receipt of these details from payroll and/or management.

Mr Conway added that it was important to acknowledge that it may be the case that an overpayment must be repaid in full when a legitimate overpayment has occurred.

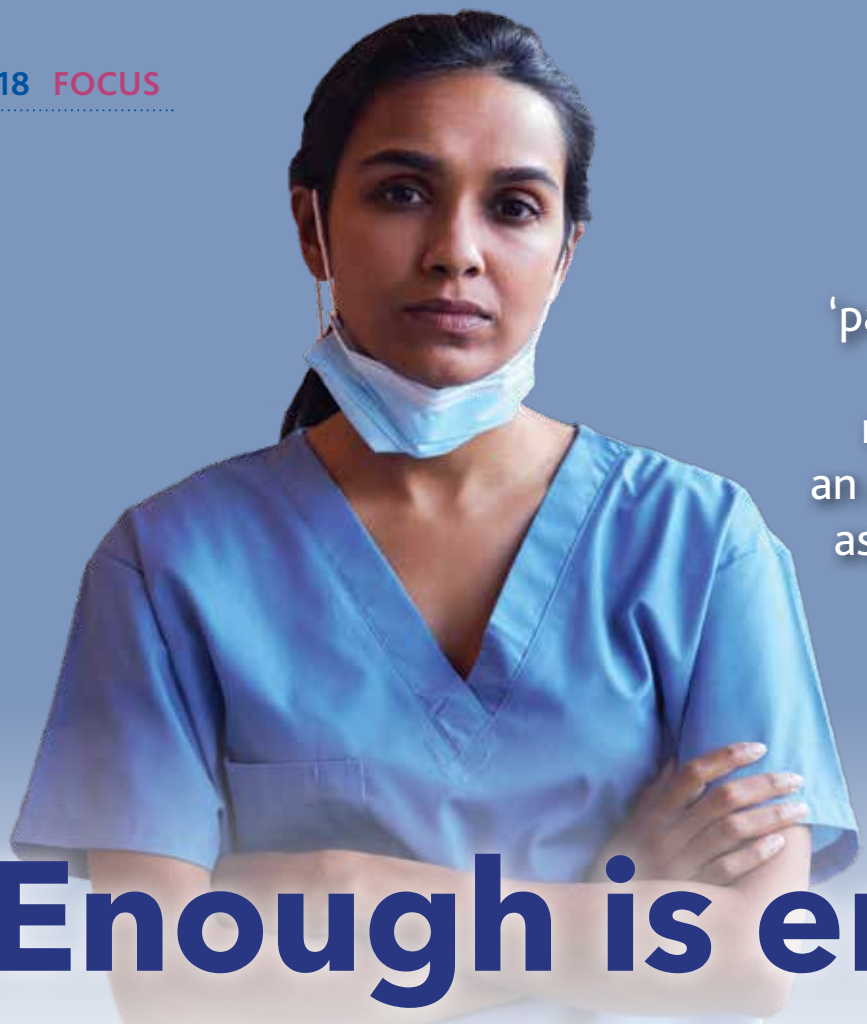
"Repayments must be made under the HSE national financial regulations or within the specific terms of your contact, if you do not work within the HSE. It is important to note that the employee has the right to agree a repayment plan in advance of an employer making any deductions from an employee's wages," he said.

Critical issues in paediatric unit in Limerick

THE INMO wrote to University Hospital Limerick management in June 2022 regarding matters arising in the paediatric unit relating to staffing, increased levels of activity, nursing governance 24/7, paediatric HDU and the admission of Child and Adult Mental Health Services patients without adequate training and support protocols.

Two meetings have taken place to date with little progress. We are seeking an urgent review of staffing and 24/7 CNM2 presence to support the service and compliance with the operation of an agreement on the paediatric HDU. The next meeting is scheduled for November 23.

- Mary Fogarty, INMO assistant director of IR



Being assaulted should never be considered 'part of the job' no matter where you work, yet recent Irish figures show an average of 12 nurses are assaulted on a daily basis. **Freda Hughes** reports

Enough is enough

IN AUGUST 2022 in response to parliamentary questions, the HSE released figures relating to reported workplace assault. These figures paint a shocking picture of our health service with more than 7,300 physical, verbal or sexual assaults on healthcare staff reported in the previous 18 months. Worryingly, the figures also revealed that nurses suffered the highest number of assaults within this cohort, reporting 4,420 incidents on the National Incident Management System over the past 18 months.

The figures suggest an average of 12 or 13 incidents are happening daily in Irish hospitals. In the month of June alone, five or more nurses were physically, verbally or sexually assaulted per day.

INMO president Karen McGowan, who is a qualified advanced nurse practitioner in emergency care, says she has seen abusive behaviour in her workplace many times.

"Part of our role in the emergency department often involves trying to defuse situations before people get to a volatile state. Penalties need to be stronger for those who cause harm to healthcare workers," she told *WIN*.

The INMO has long called for a zero-tolerance approach in dealing with workplace assault. Due to staffing shortages patients and their families are often left for very long periods, sometimes days, in inappropriate areas of hospitals while they wait for a bed. People become upset as a result and, unfortunately, if they do vent their frustrations, frontline nurses and midwives are the ones who often end up taking the brunt – be it physical or verbal – of the abuse. Being assaulted should never be considered 'part of the job'.

With chronic overcrowding and understaffing across all acute hospitals in Ireland, nurses and midwives will continue to face an avoidable highly volatile workplace where things can easily get out of control.

One ED nurse working in the west of Ireland spoke of her harrowing experience of assault and subsequent post traumatic stress disorder (PTSD). While putting a patient back into bed, she felt a hand around her neck and her other hand being grabbed behind her back. As she was pulled backwards another patient tried to raise the alarm. She kicked the waste paper basket over as she was being dragged and the noise attracted attention.

"I was aware the patient had hepatitis C so I worried he would bite me. There was a bit of a struggle. Next thing I was on the ground and so was he and everybody was on top of us and my glasses went flying. He put his hand across my mouth. It took five people to pull him off me," she said.

After her ordeal she was told to go into the tea room and then sent home without any further discussion on what had occurred. She took two weeks off and thought she was fine when she went back to work but that was when the PTSD started to kick in.

"Everything started gradually. I started double checking everything I did in work. I was always a very confident senior nurse but I was beginning to question myself all the time. It went on day after day. My thought process started to change. My heart would be racing. I was getting colleagues to cross check my work. I got preoccupied overthinking things and would question if I had done things correctly. I never felt sure of myself. It was taking its toll. I was so weary.

"I started to realise that what was happening to me wasn't right or normal. I was referred to a clinical psychologist and she confirmed I had post-traumatic stress. I didn't realise there was a name for what I was going through. It had gotten to a stage where I wasn't a good decision maker in work. It was affecting everything. I took five months off work to deal with it. My occupational therapist confirmed that it is possible to get over this."

After five months she went back to work and was told that she had used her sick leave allowance as she was not off due to an injury at work. At this point she went to the INMO and explained her position in detail. The union took the matter to the Labour Court and got her sick leave reinstated and her expenses covered.

She subsequently decided she wanted to leave the emergency department and took

up a position in the acute medical assessment unit (AMAU), which was a nine to five post, with no weekends or night shifts. However, even though she had a higher diploma in emergency medicine her allowance was stopped when she moved to the AMAU.

In 2020 during the Covid-19 pandemic she was moved back to the ED regularly. On one of these occasions, she encountered a patient who was really aggressive and found the experience very difficult to cope with.

"I started crying and went to nursing admin. They asked me if I was sure I was able to work at all. I said I was, but not in ED. Throughout the pandemic I was asked to work nights in the ED with reduced staff. To avoid this, I took early retirement in October 2020 and went on to work in the community as a swabber. I was 53 and had been in line to go into a CNM2 post before the assault but that was taken away from me by what happened," she explained.

This nurse feels that a debriefing and being provided with an opportunity to talk through what happened would have helped her to cope with the effects of the assault at work and would have made a huge difference to her stress. As it was she had to report the incident to the Gardaí on her own, without assistance from her employer.

Another nurse, who also wished to remain anonymous, told *WIN* about her hugely stressful experiences as a children's nurse in a busy Dublin hospital where she works as a triage nurse. She reported an increase in verbal and physical abuse since the start of the Covid-19 pandemic.

"I was triaging a child in an area where only one parent was allowed at a time. A second adult female followed and I asked her to step outside. She said she knew where I parked my car and that she would wait for me after work and kill me. She called me names and invaded my personal space. I felt so intimidated.

"There is always that unspoken rule that we put on a brave face and get the job done. The child is our number one priority so I kept going but my voice was shaking and I thought, what did I do to deserve that. I wondered, am I safe here? I had to provide repeated care episodes to that child and that caused even more anxiety. After an incident like that you second guess yourself and if you're doing that repeatedly it impacts on your confidence."

She also agreed that the lengthy waiting times are a significant trigger for aggression. Patients often have to wait five or six hours to be seen. She said that there is a certain perception that if you work in a stressful environment like ED, assaults and aggression are bound to occur but this isn't the expectation in other jobs.

"My shift leaders, CNM3 and assistant director of nursing are amazing. I never had a problem going to them and explaining what happened. I don't think we call the Gardaí enough, though I feel guilty when we do because it is a children's hospital and we don't want to frighten the children or further stress out the parents. Abuse at work is so prevalent. With wait times of over four hours, it has got to the stage were I don't feel safe in my workplace."

The INMO has stated that ensuring security is available across all areas of any hospital campus is a basic need that is not fulfilled in many workplaces. While we see high levels of assaults in EDs, there is a need for 24-hour security in all areas of hospitals.

In 2021, a staggering 90% of INMO members reported being mentally exhausted during or after work and inadequate safety protections only add to the burnout.

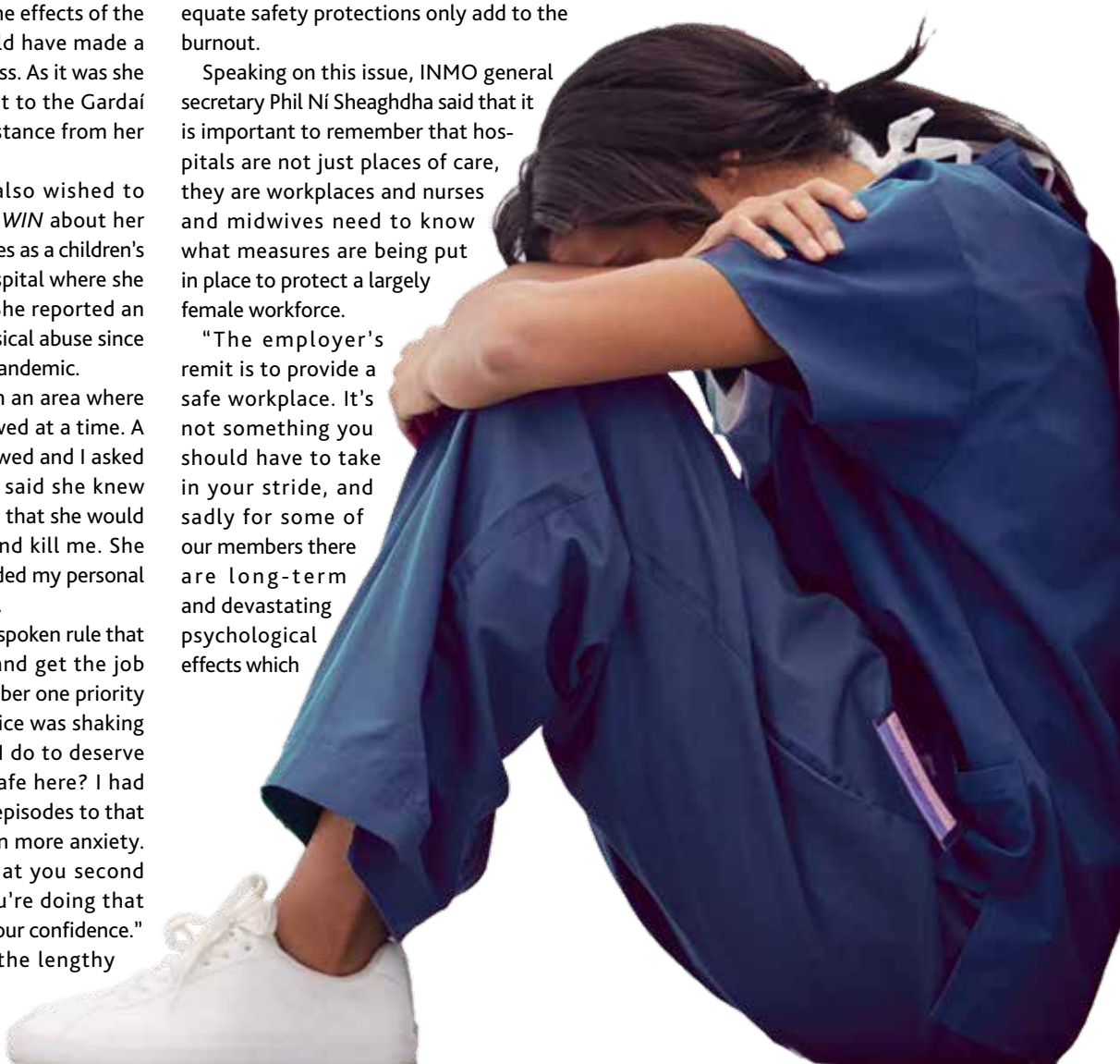
Speaking on this issue, INMO general secretary Phil Ní Sheaghdha said that it is important to remember that hospitals are not just places of care, they are workplaces and nurses and midwives need to know what measures are being put in place to protect a largely female workforce.

"The employer's remit is to provide a safe workplace. It's not something you should have to take in your stride, and sadly for some of our members there are long-term and devastating psychological effects which can be life changing and career ending.

"Nurses are facing the brunt of physical and verbal aggression in hospitals. In some cases, our members are victims of career-ending assaults. Anecdotally we know that many nurses and midwives do not report many of the incidents that take place in our hospitals because they do not have support to do so. Nurses and midwives need hospital management to use the powers they have and support staff, and make complaints to Gardaí – zero tolerance is required and that is not the case at present.

"The Health and Safety Authority needs to play an enhanced role in tackling assaults on nurses. There must be more inspections and prosecutions of employers who fail to keep staff safe. There must be a dedicated division established within the HSA to deal directly with the health service. This is an ask the INMO has put directly to government and the Authority itself," said Ms Ní Sheaghdha.

For guidance on dealing with workplace violence see the International Council of Nurses' Position Statement on 'Prevention and management of workplace violence', to which the INMO made a contribution (www.icn.ch/nursing-policy/position-statements)



If not now, then when?

Now is the time for nurses to be shown the respect and remuneration the role deserves, writes **Yanqing Yang** (with **Angela Flynn**)

AS A nurse who worked in a general hospital in China for more than eight years, my experience has shown me that nurses deserve to be shown more respect by both their employers and much of the public. Nurses are the largest group among healthcare workers internationally, we are important healthcare providers in both primary and secondary care, and play a key role in connecting other healthcare professionals and patients.[1,2]

Nursing in China

Although the quality of nursing care in China has improved a great deal and the Chinese government has made efforts to improve nurses' social status, nurses there are often exposed to physical violence. In one incident in 2017, in Xianning in Hubei, a nurse who was pregnant was assaulted by a patient's family member and subsequently lost her baby.

During the pandemic, while nurses were under huge pressure fighting the virus, many experienced physical or verbal violence.[3,4] In Shanghai in March 2022, a nurse experienced physical violence from a doctor colleague because the nurse refused to work on the frontline as the PPE was inadequate and infection control training was not provided.

I also experienced similar situations when I worked in clinical practice. This paper will explore the issue of respect for the nursing profession and will draw on the context of China as well as on some Irish examples.

It is important to ask ourselves what other factors are at play when we consider how society views the profession of nurses. The unique cultural context of China plays an important role in shaping how people view nurses and other health professionals. Many Chinese people hold the old idea that nurses are the person who only takes care of sick people and their duty is only to follow what the doctors order.

Nursing as a subject developed later than medicine in China. More than half of nurses have a nursing diploma and do not have a bachelor's degree.[5] Similar to the Irish experience, before nursing became a degree course, nurses were trained via an apprenticeship model. This gave the impression that nursing was not as professional or complex as medicine and nurses were seen as being 'less important' than doctors.

Patients can be more concerned about the outcomes of their hospitalisation and treatment than the process. Hence, patients appreciate that they have recovered from ill health while ignoring the contribution of nursing care to their recovery. Further, there are no healthcare assistants in general wards in China, so nurses are very busy with fundamental care tasks.

Some of these points are unique to the context of Chinese nursing, but others are familiar to other developed countries. In Ireland, there have been almost 3,500 assaults on nursing staff reported between 2021-2022.[6,7]

International view

Nursing is a highly skilled and highly valued profession. Nursing is an art, and it is defined as "autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings" by WHO.[2]

The American Nurses Association (ANA) described nursing as a glue for holding the healthcare experience together,[8] which means that nurses play the crucial role of connecting the health professionals and patients in healthcare service. Although care can be provided by others, professional care can only be delivered by nurses. The aims of nursing are promoting health, preventing illness and caring for ill, disabled and dying people. The duty of nurses is to ensure these aims are achieved through professional care.[2]

Nurses play a key role in healthcare and have an increasingly collaborative relationship with patients, physicians and other healthcare professionals. Firstly, nurses spend more time with patients than other healthcare professionals do. Butler et al stated that patients spend more than 86% of their time with nurses, while only around 13% is with doctors.[9]

Furthermore, nurses working on the frontline are often the first people to notice any changes in their patients and this awareness can prevent further deterioration. Moreover, nurses support patients in keeping healthy, physically and emotionally. Nurses are also educators,

who can positively affect the lifestyle of patients, therefore playing a crucial role in health promotion.

Challenges

According to the WHO, nearly 50% of health professionals are nurses and midwives. The current shortage of nurses globally is about four million,[10] which means that nurses and midwives are taking on increasingly larger workloads than they should. Despite this, as frontline workers, nurses and midwives continue to contend with the effects of the pandemic, with their workloads often affected by the shortage of nurses.

As a result of their experiences through the pandemic,[11] nurses are at risk of mental health problems such as depression, PTSD, anxiety and burnout.[12,13] Despite the pressures that they are under through their work, evidence suggests that nurses are not adequately respected.

A study in the UK showed that nurses suffer negative experiences despite being knowledgeable and experienced.[14] In Australia, 61% of nurses experienced bullying in the workplace.[15] Similarly, more than 36% of nurses were exposed to physical violence and 70% of all nurses experienced non-physical violence.[16]

Despite the fact that nurses played a key role in fighting the Covid-19 virus, in many cases they still do not feel as respected and valued as expected. Özkan Şat et al reported in 2021 that more than half of nurses were exposed to verbal violence and 8.4% of nurses experienced physical violence in Turkey during the pandemic.[17]

In the US, the prevalence of verbal violence and physical violence were 67.8% and 44.4% respectively.[18] There is a risk that these dangerous working environments could dissuade students from choosing a career in nursing, further exacerbating the shortage of nurses and impacting on the quality of nursing care.

Value of nursing

As professionally educated nursing staff, providing high-quality nursing care to patients is central to our role. It is likely that the public is not fully aware of the depth of knowledge and education that nurses actually possess. They may not understand that nurses provide unique professional support and help.

Similarly, there is a risk that policy makers and politicians have a poor understanding of nursing and its centrality to any functioning health system. Globally, nursing needs to become more politically involved so that the profession can inform high-level policy decisions that impact healthcare. This is why positions like that of a chief nursing officer, like we have in Ireland, is so important.

Nurses themselves should engage in self-value awareness. We should be proud of what we do and maintain a high self-value. What nurses do matters.

Leadership

Nurses deserve respect. Those who are in positions of leadership in nursing and healthcare must listen to nurses' voices. Managers also need to ensure they provide adequate autonomy to nurses, which will greatly contribute to the motivation of nurses. Hiring more nursing staff helps to improve the quality of nursing care. Griffiths et al reported that insufficient nursing staff is one of the main causes when low quality nursing care occurs.[19] It is imperative that government funds the health service to employ more nursing staff to reduce current workloads and improve the wellbeing of nurses.

Salary is of course an important demonstration of value and respect. Social status is often measured by looking at salaries paid to different professions. Health employers should increase nurses' salaries and benefits to illustrate the respect and value they place on the profession.

Conclusion

In summary, as a critically important contributor to healthcare, nurses and the nursing profession deserve respect from the public. The pandemic has increased people's awareness of the role nurses play in our health services. We must harness this to ensure nursing is seen as an attractive career option and is properly remunerated and respected by policy makers. If not now, then when?

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Nursing/midwifery salary scales

Application of 3% due on February 2, 2022 and 1% or €500 (whichever is greater) due on October 1, 2022. Includes application of 3.28% to management grades effective from February 1, 2022

Incremental point	1	2	3	4	5	6	7	8	9	10	11	12
Student nurse/midwife/ intellectual disability	16,155 (*degree students 36 weeks rostered placement)*											
Staff nurse/midwife (post qualification, pre registration)	27,979											
Staff nurse/midwife	32,542	34,437	35,405	36,684	38,297	39,908	41,511	42,898	44,288	45,672	47,057	48,417
LSI after three years on maximum												49,868
Senior staff nurse/midwife	52,235											
Enhanced nurse/midwife dual qualified nurse/midwife	39,291	41,702	42,989	43,979	45,070	46,522	47,936	50,018				
LSI after three years on maximum												51,482
Senior enhanced nurse/midwife dual qualified nurse/midwife	53,947											
Clinical nurse/midwife manager 1	50,915	51,838	53,141	54,466	55,783	57,108	58,585	59,961				
Clinical nurse/midwife manager 2/ specialist	55,248	56,164	56,937	58,201	59,597	60,968	62,338	63,882	65,316			
(plus allowance of €886 per annum payable on a red-circle basis to theatre/night sisters who were in posts on 5/11/'99)												
Clinical instructor	57,646	58,579	59,270	60,551	61,843	63,237	64,638	66,038	67,435			
Clinical nurse/midwife manager 3	63,574	64,832	68,012	69,263	70,521	71,795						
Nurse tutor	65,025	65,908	66,788	67,673	68,555	69,440	70,318	71,204	72,087	72,969		
Principal nurse tutor	68,196	69,482	70,657	74,328	75,612	75,659	77,160	79,208				
Student public health nurse	36,460											
Public health nurse	53,838	54,725	55,487	56,688	58,069	59,406	60,754	62,268	63,678			
(plus allowance of €1,771 per annum payable on a red-circle basis to staff who were in posts on 5/11/'99)												
Assistant director of public health nursing	63,578	67,071	68,506	69,829	71,165	72,994						
Director of public health nursing	83,467	85,997	88,535	91,179	93,607	96,145						
Advanced nurse practitioner	64,188	65,431	66,630	70,312	71,472	72,818	74,077	75,327	79,212			
Advanced nurse practitioner candidate	63,574	64,832	68,012	69,263	70,521	71,795						
Assistant director of nursing band 1	64,188	65,431	66,630	70,312	71,472	72,818	74,077	75,327	79,212			
Assistant director of nursing non band 1 hospitals	60,958	62,257	63,578	67,071	68,506	69,829	71,165	72,993				
Director of nursing band 1	85,140	87,507	89,878	92,240	94,605	96,979	99,343					
Director of nursing band 2	79,317	81,550	83,788	86,019	88,262	90,497	92,735					
Director of nursing band 2a	78,682	80,086	81,494	82,896	84,304	85,706	87,112					
Director of nursing band 3	74,278	74,747	76,340	77,981	79,615	81,262	82,896					
Director of nursing band 4	69,404	71,504	73,597	75,699	76,628	78,746	80,859					
Director of nursing band 5	64,927	66,332	67,736	69,137	70,540	71,949	73,355					
Area director – nursing & midwifery planning development unit	90,076	92,858	95,611	97,972	100,604	103,290	105,938					
Director – nursing & midwifery planning development unit	81,800	84,090	86,613	89,384	92,423	95,543						
Director centre of nurse education	74,654	75,816	78,147	80,500	82,850	85,203	87,553	90,005				
Hospital group director of nursing and midwifery	110,535	115,447	120,360	125,270	130,185	135,096						

Location and qualification allowances

3% due on February 2, 2022 and 1% due on October 1, 2022

Eligibility
Nurses/midwives eligible for payment of location/qualification allowances are staff nurses/midwives, senior staff nurses, CNMs 1 & 2 (incl. theatre sisters). Nurse/midwife may benefit from either a qualification allowance or a location allowance when eligible – the higher of the two – when working on qualifying duties. Pro-rata arrangements apply to job-sharing and part-time staff.

Grade	Nature of Allowance	€
Registered general nurses	**Employed on duties in the following locations:** Accident and emergency departments, theatre/operating room, renal units, intensive/coronary care units, cancer/oncology units, geriatric units/long-stay hospital or units in county homes, high dependency units, neonatal units (ICU), endoscopy units, specialist ambulatory, dialysis units, units for severe and profoundly handicapped in mental handicap services, acute admission units in mental health services, secure units in mental health services, dedicated care of the elderly (excluding day care centres) and Alzheimer's units in mental health services and the intellectual disability sector (including psycho-geriatric wards, elderly mentally infirm units, psychiatry of later life services), medical/surgical wards, maternity departments. *(Allowance effective from March 1, 2019)*	2,466
Registered nurses	**a) Employed on duties in specialist areas appropriate to the following qualifications where they hold the relevant qualifications:** • Accident and emergency nursing course • Anaesthetic nursing course • Behaviour modification course • Behavioural therapy course • Burns nursing course • Child and adolescent psychiatry nursing course • Coronary care course • Diabetes nursing course • Ear, nose and throat nursing course • Forensic psychiatry nursing course • Gerontological nursing course • Higher diploma in midwifery • Higher diploma in paediatrics • Infection control nursing course • Intensive care nursing course • Neurological/neurosurgical nursing course • Operating theatre nursing course (including paediatric operation theatre) • Ophthalmic nursing course • Orthopaedic nursing course • Higher diploma in cardiovascular nursing/diabetes nursing/oncological nursing/palliative care nursing/accident and emergency nursing • Rehabilitation nursing course • Renal nursing course • Stoma care nursing course	3,704
With effect from March 1, 2002, payment of the Specialist Qualification Allowance is extended to all specialist courses confirmed as Category II or equivalent by the NMBI.		
Registered general nurses	b) Holding recognised post-registration qualifications in midwifery or sick children's nursing and employed on duties appropriate to their qualification	3,704
Public health nurses and assistant directors of public health nursing	Qualification Allowance	3,704
With effect from March 1, 2019, the location allowance is extended to public health nurses not holding a midwifery qualification but engaged in provision of midwifery services as part of their duties.		
Public health nurses		2,466

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

(a) Nurses who were paid on the dual qualified scale on October 1, 1996 and in receipt of a location allowance at August 1, 1998 or eligible for a new location/qualification allowance from March 31, 1999. In such cases the value of the location/qualification allowance is **€1,542** which they receive in addition to their dual qualified scale.

(b) With effect from November 26, 2003, nurses who are paid on the dual qualified scale and who then move to an area that attracts a location/qualification allowance will continue to be paid on the dual qualified scale and will also receive the abated value of the location/qualification allowance of **€1,542**. Payment of the allowance will cease if the nurse moves out of the qualifying area.

Other allowances

3% due on 2nd February 2022 and 1% due on October 1, 2022

Grade	Nature of allowance	€
Public health nurses	Island inducement allowance*	1,953
Public health nurses	Fixed payment	31.13
Weekend work	First call on Saturday and first call on Sunday Each subsequent call on Saturday and Sunday Payment in lieu of time off for emergency work	41.32 20.69 31.09
Theatre nurses/midwives who participate in the on-call/standby emergency services	**On-call with standby – each day** Monday to Friday Saturday Sunday and public holidays *All of these figures based on a 12-hour period. Pro rata to apply after hours.*	 46.83 60.15 81.30
	Call-out rate – Monday to Sunday (a) Fee per operation per 2 hours (17.00-22.00 hours) (b) (i) Operation lasting > 2 hours and up to 3 hours (17.00-22.00 hours) (ii) Operation lasting > 4 hours and up to 5 hours (c) Fee per operation per hour (after 22.00 hours)	 46.83 70.23 117.05 46.83
	On-call without standby (i) Fee per operation, call-in without standby (ii) overruns from roster at normal overtime rates (no time back in lieu)	93.65
	On-call over weekend In situations where no roster duty is available over the weekend, the following will apply on a pro-rata basis (ie. appropriate rate divided by 12, then multiplied by number of hours available). No time back in lieu will apply.	
	Nurse co-ordinator allowance A shift allowance of €20.00 will be paid to a staff nurse who undertakes the role of formalising the reporting and accountability relationship with the theatre superintendent. The allowance only applies to a nurse who fulfils specified duties when called in (DOH circular refers).	
	Specialist co-ordinator allowance	4,777
How to work our hourly rate of pay for nurses/midwives: Example: senior enhanced salary scale €53,947. Take €53,947, divide by 52.18 and divide by 37.5, equals hourly rate of pay €27.56. This formula applies for all grades.		

Know your rights and entitlements

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

Catherine Hopkins and Catherine O'Connor at
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Mon to Thur 8.30am-5pm; Fri 8.30am-4.30pm

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

Introducing Executive Council members

Mary Dunne

CNM2, University Hospital Waterford

MARY Dunne is CNM2 in the emergency department (ED) in University Hospital Waterford. The peer support she experienced throughout her training and career has always been a big plus. Having qualified, Ms Dunne moved to the UK where she worked as a general nurse for a short time before taking up a post the emergency department (ED) in Waterford where she had trained.

As an ED nurse for most of her working life, Ms Dunne wants to use her voice on the Executive Council to tackle overcrowding and staff shortages. Safe staffing has become her passionate pursuit and she described understaffing as a serious health and safety risk for staff and patients alike in EDs and across the wider health service.

"I've been a member of the union all my life, but I got actively involved when we moved to a new ED with increased attendance but we didn't have enough staff to run it. I became active with the INMO ED Section and attended national meetings on behalf of ED nurses nationwide. I could see that we could achieve more together and that our collective voice was stronger."

Ms Dunne is currently secretary of the ED Section and is also an active member of the Waterford Branch. Her advice to new graduates is to always support each other. "Get involved in the union. Nursing is a great career but it is challenging due to staffing levels. I would like to see better processes in place to retain our new graduates and support them by easing them into the workforce. The peer support offered through these functions of the union are invaluable and we always try to help each other out and share information."

Elizabeth Egan

CNM1, St John of God's Community Services

ELIZABETH Egan is a CNM1 in Saint John of God Community Services working with people with intellectual disabilities. She started her training in 1998 in Cregg House, Sligo between the end of the apprenticeship model and the introduction of the degree in nursing. Her training was via a diploma course with lots of opportunity for placement. She also subsequently completed a BSc in nursing management. Having worked in various locations in Ireland, and in the UK in a rehabilitation unit for people with brain injuries, she returned and took up a post with Saint John of God.

"With new legislation, people with intellectual disabilities are being moved to community settings and the RNID will be an essential part of ensuring they receive the best care. We need to do more to retain nurses and make ID nursing an attractive profession. There is a lot of uncertainty around the role of the RNID in the future community setting. The ID nurse needs to be seen as an equal partner within the health and social care sector," said Ms Egan.

Ms Egan is a preceptor for students and advises them to join the union, not just for fitness to practise insurance but also for the shared learning opportunities and peer support. She is a member of the RNID Section and believes it is a great way to keep up to date with best practice. She is also active in her branch and relishes the opportunity to discover what is happening in other disciplines.

"Through the INMO I have been able to meet colleagues from different organisations and we've been able to share information and learning. We can share our struggles and learn from each other. When we take on students it is important to make sure that they are enriched and actively learning while they're here because today's students are tomorrow's colleagues."

Ester Fitzgerald

CNM2, Cork University Hospital

ESTER Fitzgerald is CNM2 in the ICU in Cork University Hospital (CUH). After her general training in CUH she went on to complete a higher diploma in critical care in UCD and a BA in Law in DIT. She then returned to CUH, where she still works in ICU as a CNM2, and became an INMO workplace rep. She also completed a master's in healthcare risk management and quality in UCD.

Ms Fitzgerald had been a student rep and became active with the union again on returning to Cork. She has been chairperson of the Cork HSE Branch since 2020 and was secretary of the strike committee in 2019. In early 2022 she worked as a released INMO rep which involved working directly for the INMO as an industrial relations support worker for the Cork region.

"My experience is mainly in acute hospitals but it was great to see the bigger picture and work with members in the community. The problems are the same across the board. It's all about recruitment and retention. On the Executive Council we are trying to improve working conditions for all nurses and midwives."

Restoration of hours is a priority for Ms Fitzgerald, especially working in a high stress environment in ICU. The extension of special leave with pay for staff who have long Covid is a health and safety issue and one that is close to her heart. She feels union membership is essential for all nurses and midwives, telling students and new graduates: "Welcome to a fabulous career. It will be challenging at times but you have a job for life that you will get more job satisfaction out of on a good day than you may have gotten in another job in your entire life. United we stand, divided we fall. Join your union. Your opinion will be heard and valued and used to inform negotiations on our behalf."

A watchful eye

PHNs play a key role in school vision screening but this would be greatly enhanced by nationally co-ordinated data collection, writes **Kay Varden**

SCHOOLCHILDREN in Ireland have their vision screened by a public health nurse, while in many other countries, including parts of the UK, New Zealand and Australia, orthoptists or suitably trained technicians carry out this role.

Historically, children on school entry (junior infants) and primary school leaving (sixth class) were screened, but only junior infants are screened now due to current recommendations.

The logMAR (log of the Minimum Angle of Resolution) is recognised as the Gold Standard in screening equipment and is the tool that is now adapted widely across the country.[1]

The two conditions that are picked up during this screening process are myopia (sometimes referred to as near sightedness) and amblyopia (lazy eye). Early diagnosis of amblyopia is crucial as after the age of seven years treatments, including patching and prescription glasses, have found to be significantly less effective.

Background

I qualified as a PHN in 2002 and since 2013 my role includes vision screening in primary schools throughout CHO9, specifically Dublin North Central. This encompasses schools located in a diverse mix of social and economic classes.

Some of the areas have a number of DEIS schools. DEIS schools are generally located in disadvantaged areas. Shortly after taking up this role I noticed some common trends surrounding visual health. Primarily that there appeared to be a larger percentage of referrals from DEIS schools to the eye clinic in comparison to those located in 'more affluent' areas.

The issue of socio-economic circumstance is widely researched and there is a vast amount of literature both nationally and internationally to suggest that poorer health is synonymous with poorer socioeconomic status. With this in mind I wanted to establish if this may also apply to visual health.

Initially, I considered conducting some research myself on this subject but when the opportunity to commence a master's degree programme in Dublin City University (DCU) arose I decided to embark on this journey of further education and proceed with my hypothesis through an academic setting.

The concept terrified me as it had been many years since I had been on any formal course of academic study. However, with the encouragement from my family and work colleagues I enrolled in the programme in DCU. My fears were somewhat alleviated when I discovered that my anxieties were no different to practically all of my classmates. In addition to writing assignments, I now had to grapple with a whole new world of information technology.

I was soon to learn that the days of handing in hard copies of course work were a thing of the past and that the academic world was now inextricably aligned to the digital world. My laptop replaced text books and conversations that once were about nights out and days off were replaced by subjects that involved search engines, USB sticks and referencing software.

Following completion of a number of modules in first year – and thankfully passing them all – in the second year focus shifted to my research thesis which looked at onward referral following vision screening in schools. The data I compiled included referral rates from DEIS and non-DEIS schools in Dublin North Central to the Eye Clinic. I also collected and analysed vision test results, which were divided into three categories, ie 0.225-0.375, 0.4-0.575 and 0.6-0.8. Gender and age were examined and finally DNA (did not attend) rates and data collation were also considered.

Interestingly, the university also required that each student work outside their area of practice for a minimum of two weeks. I chose the eye clinic where many of the children who are reviewed are those referred by the PHN after failing their school vision screening.

Experiencing the management of these children by a team of orthoptists, optometrists and ophthalmologists proved to be more valuable than I had expected. Among other things it highlighted the valuable role that the school nurse plays in identifying children with visual concerns, as indeed a large percentage go on to require prescription glasses and further interventions.

Due to an excellent relationship I had with the eye clinic and my school nurse colleagues in CHO 9, I was well on the way to collecting my data. While some of the information I required was in digital format, much of it was not, which in turn influenced the end results of my study. It was a paper trail that involved going through hundreds of past referrals from the schools in my area.

As is commonly the case, while collecting this information other questions arose, but for the purpose of this article I will discuss just three. I chose the academic year 2015-2016 which included a population of 1,858 students from Dublin North Central.

This research was quantitative and I used SPSS (Statistical Package for the Social Sciences), a software package used for analysis of statistical data.

Findings

DEIS versus non-DEIS

A total population of 1,858 children were offered school vision screening between 2015-2016, and from that figure 94% were tested. A further breakdown of these figures indicated that 56% of this cohort were from non-DEIS schools while 38% were from DEIS. From this total, 17.3% failed and were referred to the eye clinic.

Although a higher number of children in the population screened were from non-DEIS schools (56%), in comparison to DEIS schools (38%), it was the population from the DEIS category that indicated the highest referral rate by the PHN to the eye clinic: ie. 44.7% from the DEIS category, in comparison to 13.8% from the non-DEIS schools. In other words, DEIS schools displayed the highest overall percentage of children who were referred.

Therefore the results of this study may support other literature that poorer socio-demographic factors play a significant role in visual health.

Gender

While some studies agree that higher rates of myopia may exist in girls compared with boys,[2,3,4] other work contests these findings, asserting that incidence rates are higher in the male population.[5,6] The data that was available to me indicated that 28% of boys in comparison to 20.4% of girls required treatment. This suggests that a higher incidence of myopia exists in the male population of this cohort.

Benefits of vision screening

Much debate continues surrounding the benefits of vision screening, with some questioning its cost effectiveness.[7] The results from this study indicate that from the referrals made by the PHN, 91.2% who were reviewed within six months were prescribed glasses. These children were seen sooner as their school test indicated poorer vision. Of those seen beyond this timeframe half were discharged without any further treatment and the other half were prescribed glasses.

These findings indicate the pivotal role the PHN plays in school screening and the enormous benefits to children in the school setting where visual deficits exist.

Attendance rates

While I hadn't considered looking at this statistic, the evidence was so apparent that I felt compelled to address it. Failure to attend the eye clinic or DNA (did not attend) rate was high ranging from 27.9-32.9%. Many conclusions, including accessibility to services, waiting times and low income can be speculated on as barriers to accessing services. However regardless of the reasons, the fact remains that service provision is being under-utilised and financial resources overspent on clinic appointments that are not being kept.

Some international studies have highlighted the benefits of providing optometry services more locally, which in turn increases accessibility to populations as a whole.[8] There are many health centres throughout Dublin north city and county that have been refurbished to a very high standard in recent years. These health centres are located in the heart of communities with ease of accessibility to large populations. If eye clinic personnel were to routinely operate mobile clinics in health centres scattered throughout the region, perhaps uptake of services and reduced DNA rates may result.

Data collection

One of the biggest limitations in conducting this study was the amount of data unavailable for analysis. There were a number of reasons cited for this. Without doubt there is a wealth of information within medical and nursing science that is currently being wasted due to this.

Had data been available electronically, the findings of this study would have been enhanced considerably. While some regions are electronically collating data in a systematic manner, a national co-ordinated approach does not exist. If a uniform national database collection system were to be established, this would result in improved statistical analysis which in turn would identify:

- The magnitude of vision impairment
- A natural history of eye disease from a public health perspective
- Increased understanding on how specific interventions can halt the progression from early to advanced stages
- Continuous evaluation of prevention and control strategies.

The outcomes from this study are varied. There appears to be a significant correlation between school type and referral rate to the Eye Clinic which may support other literature that espouses the belief that socioeconomic status can effect visual health. While the relevant literature on gender and myopia remains contradictory, the population in this study suggests that the prevalence is higher in younger males than females.

The value of screening continues to be explored and the outcomes of this study would strongly support its benefits. Accessibility to services has been identified as a possible reason that DNA rates are high and providing services at a more local level may reduce the incidence of this.

Finally, throughout this analysis, missing data in most cases needs to be considered. Therefore a co-ordinated approach needs to be considered surrounding data compilation.

Kay Varden is a public health nurses in CHO 9, Dublin North Central

Acknowledgment: Thanks to Dr Yvonne Corcoran, supervisor DCU; Dr Brian Kelleher, DCU; Ita Kavanagh, PHN; Anne McDonald, PHN; and Jane Behan, PHN

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INMO Professional

Irish Nurses and Midwives Organisation
Working Together

Webinars & Conferences for Nurses and Midwives

Webinars and Conferences 2022

ONLINE AND IN-PERSON EVENTS

All conferences and webinars are Category 1 approved by NMBI

Saturday 12 NOVEMBER — Public Health Nurses Section Webinar

Thursday 24 NOVEMBER — ADON Section Webinar

Thursday 17 NOVEMBER — All Ireland Midwifery Conference

Monday 28 NOVEMBER — Retired Nurses Section Bi-Annual Conference

Saturday 26 NOVEMBER — National Childrens Nurses Section Webinar

SCAN for more information

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

Q and A Bulletin Board

With INMO director of industrial relations Albert Murphy

Higher allowance applies

Q. I receive a location allowance as I work in ICU. I have just completed a postgraduate higher diploma in ICU nursing – am I eligible for the specialist qualification allowance?

Yes, if your postgraduate qualification is recognised by the NMBI as being category II or equivalent and your employer deems you are working in an area where you are using the qualification as part of your duties, you are eligible for the specialist qualification allowance. A nurse/midwife may benefit from either a qualification allowance or a location allowance when eligible – the higher of the two. Pro-rata arrangements apply to job-sharing and part-time staff.

Annual leave or sick leave

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

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

Overtime when part time

Q. I work part time and have been advised that I cannot get overtime payment – is this correct?

Generally speaking, part-time employees who work additional hours, ie. hours over and above their contracted hours on a pre-arranged basis, will be paid at their normal rates until the standard weekly working hours for the grade have been worked. Part-time employees are entitled to earn overtime payments once they have worked over and above the standard weekly working hours of the whole time equivalent in the given week. Additionally, part-time employees can earn overtime in accordance with the Agreement on Flexible Working in the health service. Nurses and midwives who work reduced hours are entitled to earn overtime payments for additional hours worked in certain circumstances. The following are some examples:

- A nurse or midwife working in a department or unit with a three or four-shift cycle would be eligible for overtime payment were they to work a full normal shift and were then requested to work additional hours outside the span of the shift
- A nurse or midwife working mornings only (8am-1pm) in a department or unit where the normal shift is 8am-4pm would be paid at flat time if requested by their employer to work from 1pm-4pm. If asked to work from 1pm-6pm (having started at 8am) the hours from 4pm-6pm would attract payment at overtime rates. (This would apply whether the nurse or midwife had actually worked the hours 1pm-4pm or not). In circumstances where a 12-hour shift applies, payment would be at flat time in respect of any additional hours worked within the span of the shift
- A nurse or midwife working a 'week-on/week-off' arrangement would be eligible for overtime payment if requested by their employer to work on their rostered days off, ie. to work in excess of the full-time hours for the grade. They would be eligible for payment at flat time if requested by their employer to work their usual hours or a normal shift during their 'week off'. If you work additional hours on flat rate for part-time workers, you can earn additional annual leave up to whole time equivalent hours. This does not include time worked as overtime.

Illness benefit and sick leave

Q. I am on sick leave and paying class A1 PRSI. I started working in the HSE in 2001. My employer has advised that I will have to apply for illness benefit. As an employee of the HSE I know I am paid full sick pay under normal rules for three months, but I was not aware I had to apply for illness benefit. Is this correct?

This is correct. You need to apply to the Department of Social Protection for illness benefit. To apply for illness benefit, you must be examined by a doctor (usually a GP) who will provide you with an illness benefit (IB1) claim form to complete. You should claim the benefit within six weeks of becoming ill. Illness benefit is not paid for the first three days you are on sick leave. Depending on your employer's arrangements, the illness benefit may be paid directly to your employer in which case they will pay you your full sick leave inclusive of the benefit. If the illness benefit is paid directly to you, your employer will pay the balance to make up your full sick pay.

INMO Professional

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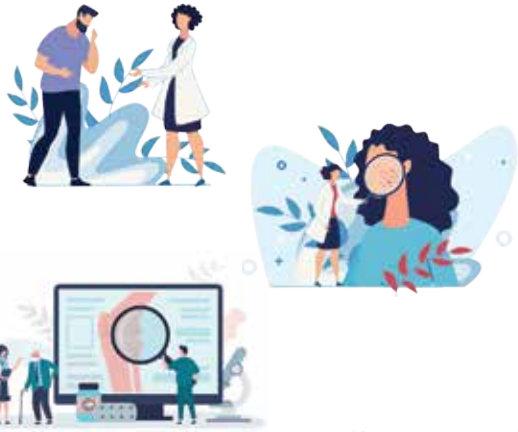
IRNF
Irish Rheumatology Nursing Forum

Attention Students, Interns, Graduates and Staff Nurses

Nursing Career Options in Chronic Disease:



Meet the experts from

- **Rheumatology,**
- **Inflammatory Bowel Disease**
- **Dermatology**

Thursday, 19 January 2023

Venue: The Richmond Education and Event Centre
Time: 10.30am - 3.00pm

Supported by an unrestricted educational grant by
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Retired Nurses Section Bi-Annual Conference

Monday, 28 November 2022

Time: 11.00am to 2.00pm
Venue: The Richmond Education and Event Centre, Dublin

IN PERSON ONLY EVENT
No option to join online

Fee: €20 INMO Members;
€65 non members

International Origins of TB Sanatoriums
Speaker: Alan Carthy, PhD

Beat the bills: Energy and Sustainability Tips for your Home
Speaker: Cathryn Buckley, Manager, HSE Estates Climate Action & Sustainability Office

A Diagnosis of Parkinsons
Speakers: Mary Butler and Gary Boyle, Parkinsons Association of Ireland; Dublin Branch

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

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Section focus

INMO Professional

Jean Carroll, Section Development Officer

TT Section conference discusses winter illness ahead of flu season

PROF Sam McConkey was among the varied line up of speakers at the INMO Telephone Triage Section conference which took place in Portlaoise in September. The conference also heard from Lisa Egan, an ANP in paediatric asthma and allergy.

Telephone triage nursing is a diverse role that requires competencies in many clinical areas. This was reflected in the variety of topics covered on the day.

Prof McConkey, who is associate professor and head of the Department of International Health and Tropical Medicine, RCSI, addressed the conference on how to identify patients presenting with haemorrhagic illnesses.

Ms Egan described her role in caring for children with allergic diseases such as eczema, asthma and allergic rhinitis, while Dr Fazal Rabi, consultant paediatrician, Midland Regional Hospital, Portlaoise, presented on diagnosis and management of asthma, croup and respiratory syncytial virus (RSV). Attendees found these presentations of particular value given the rise in respiratory presentations in wintertime.

Eithne Ní Dhomhnaill spoke about falls in nursing homes from a legal perspective. Ms Ní Dhomhnaill has a particular interest in care of older persons and played a key role in the establishment of one of the first nursing development units in older person services in Ireland during the 1990s. She was a member of the working group that published the 2009 *National Quality Standards for Residential Care Services for Older People*.

Pictured at the Telephone Triage Section conference were (l-r): Prof Sam McConkey, RCSI; Niamh Adams, INMO librarian and Tony Fitzpatrick, director of professional services, INMO

Also pictured at the conference were (l-r): Hazel James, chairperson, TT Section; Edwina Commerford, education officer, TT Section; Tony Fitzpatrick, director of professional services and Fiona Kennedy, vice chairperson, TT Section

Ella Meaney gave a presentation on catheterisation in the community and home-care management. Ms Meaney holds a master's degree in urology from the RCSI and is currently working on the community intervention team.

Sarah Devilly, who also presented at the conference, is a qualified and accredited psychotherapist and has worked in this role with One Family since 2016, providing unplanned pregnancy and post-abortion counselling prior to the 2018 Health (Regulation of Termination of Pregnancy) Act.

Ms Devilly's work includes providing counselling to those who continue pregnancy and become parents following an unplanned pregnancy.

Lisa Byrne, superintendent pharmacist for the McCabes Pharmacy Group, also addressed the conference, outlining her interest in the management of diabetes, her passion for patient education and customer service, and the pharmacy's role in supporting primary care in the community.

Get involved

Keep an eye out for the next meeting and do your best to get involved.

– Hazel James, chairperson, Telephone Triage Section

In brief...

Midwifery conference

'VISIBLE and Valued' is the theme for this year's All-Ireland Midwifery Conference, which will take place on Thursday, November 17 in the Slieve Russell Hotel in Cavan.

Angela Dunne, HSE national lead midwife, Women and Infant Health Programme, will open the conference and will be followed by a number of other midwifery experts. The conference will hear about the All-Ireland Midwifery Network and homebirth services in the north and south.

Workshops will be held before and after lunch.

Burnout, a topic pertinent to many in the professions, will be the focus of the afternoon session, along with a panel discussion involving all speakers.

To reserve your place email: education@inmo.ie
See *page 15* for more details.

PHN Section webinar

THE PHN Section webinar will take place on Saturday, November 12 from 11am.

Send an email to: education@inmo.ie including your membership number or call us on 01-6640618/41 to confirm your place.

Attendance is free for INMO members but booking is essential.

Get in touch

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

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LIVE ONLINE EVENTS

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ONLINE

Person Centred Care Planning

Wednesday, 16 November 2022

Time: 10am - 1pm

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

3 NMBI CEUS

Fee: €30 INMO members; €65 Non members

ONLINE

The Importance of Documentation - Getting in right

Wednesday, 23 November 2022

Time: 10.00am - 1.00pm

This short programme will assist nurses and midwives in understanding their duty of care and responsibility in the area of best practice in documentation, keeping good records and their ethical and legal responsibility of getting it right! Introduction to legal and Professional Requirements: NMBI Code and Guidance for Recording Clinical Practice relevant HIQA regulations and standards,

3 NMBI CEUS

Fee: €30 INMO members; €65 Non members

ONLINE

Restrictive Practices in Residential Care Settings for Older People

Thursday, 8 December 2022

Time: 10.00am - 1.00pm

This course will encourage participants to reflect on interventions that could be seen as restraining residents if viewed from a resident's perspective. Many interventions within healthcare environments can restrict movement of older people.

3 NMBI CEUS

Fee: €30 INMO members; €65 Non members

HOW TO BOOK

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Continuing professional development for nurses and midwives

INMO EDUCATION PROGRAMMES

In the pull-out this month…

Become More Assertive

Nov 9

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

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

Leg Ulcer Assessment and Management

Nov 9

This short online course will advise participants on leg ulcer management. Upon completion of the course, attendees should: have an understanding of the theory and concepts of the different causes of leg ulcerations; have a deeper understanding of the pathophysiology of leg ulceration; be aware of different non-invasive assessment for leg ulcerations; understand the importance of compression for venous leg ulcerations.

€30 INMO members; €65 non-members

Diabetes CBT and General Wellbeing

Nov 17

This online course is for nurses and midwives who have an interest in the management of patients with diabetes. The literature would suggest that diabetes, chronic disease management and the associated self-care bring high incidence rates of depression, anxiety and negative thoughts. The course will cover the use of different strategies, cognitive behavioural therapy (CBT) and clinical trials in the area of wellbeing, as well as theories and models that can help clients and healthcare providers to formulate plans to manage these issues.

€30 INMO members; €65 non-members

Steve Pitman
Head of Education and Professional Development

Busy winter planned at INMO Professional

INMO PROFESSIONAL continues to develop and deliver training, conferences and resources for members. We expect to introduce more resources for members in 2023 in anticipation of the NMBI Monitoring and Maintenance of Professional Competence (MMPC) process. The MMPC will affect all nurses and midwives, and we expect to learn more about it next year.

Recent reports on increasing Covid-19 infection rates indicate that the virus has not disappeared. This, coupled with high reported rates of overcrowding in Irish hospitals, with 10,641 patients without a bed in September, is a clear sign of the pressure on health services. It is vital that we continue to be vigilant and ensure that infection prevention and control measures are followed to combat Covid. However, this is not enough, and there is an urgent need for the HSE to access capacity within private hospitals to relieve pressure and to take active measures to retain nurses by ensuring a safe working environment for all.

Library

The library has just recently updated the library access management system for members. The new OpenAthens system will enable easier access for members to the wide range of journals and other resources available through the library. This new system will be introduced gradually over the next year in parallel with developments and updates to the membership systems within the INMO. If you are interested in accessing the library resources through OpenAthens please see the information on the library page or at **www.inmo.ie**

Remember, the INMO Library and Information Service is Ireland's most comprehensive nursing/midwifery library, providing members with a specialist information service. Library resources available to members include CINAHL Complete, Joanna Briggs Institute Evidence-Based Practice, Medline, *Nursing Times*, RCNi Journals (*Nursing Standard*, *Nursing Older People*, *Emergency Nurse*), Maternity and Infant Care and RCM iLearn.

Conferences

Autumn is conference season, and the INMO has already held a range of conferences. In September and October, INMO Professional hosted the Care of the Older Person Section webinar, the Clinical Placement Coordinator annual seminar and the Telephone Triage Nurse Section, Occupational Health Nurses Section and Operating Theatre Nurses Section conferences. November will also be busy, with the PHN Section webinar, National Children's Nurses Section webinar and the Retired Nurses Section biennial conference. If you are interested in attending or joining an INMO section, please contact jean.carroll@inmo.ie Information on all of these conferences is available in this issue of *WIN* and on the **www.inmoprofessional.ie** website.

Midwives

The All-Ireland Midwifery Conference takes place on November 17 in the Slieve Russell Hotel, Cavan. This annual event, which is jointly hosted by the INMO and RCM Northern Ireland, is a fantastic opportunity for midwives across the island to meet, network and share ideas. This will be the first in-person conference since Covid-19.

Sections

Following the hugely successful ICN NP/APN Network Conference hosted by the INMO and IAANMP in August, the INMO has been approached by members to set up an INMO ANP/AMP section. If you are interested in becoming involved, please contact jean.carroll@inmo.ie

Pure Foundation Award

The standard of nurses and midwives nominated for the Pure Foundation Fund Bursary Award was extremely high again this year. This exemplifies the commitment of nurses and midwives to providing compassionate and high-quality care to babies and their families in Ireland.

The INMO would like to congratulate Mairead Martin, a midwife from Our Lady of Lourdes Hospital, Drogheda, on winning the Award and all those that were nominated. Mairead was nominated by her colleagues and is an example of a midwife committed to caring for women and babies and a champion for midwifery. Mairead's colleagues described her as "the true meaning of a midwife – 'with women'."

CJ Coleman Award

The Annual CJ Coleman Award will be advertised in *WIN*'s December-January edition. If you have completed research or a quality improvement project, look out for the details on how to apply. The winner is awarded €1,000.

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: 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

Book three education programmes and get the fourth free
www.inmoprofessional.ie

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

Nov 8 **Best practice for Clinical Audit for Nurses and Midwives**

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

Nov 9 **Become More Assertive**

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

Nov 9 **Leg Ulcer Assessment and Management**

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

Nov 16 **Medication Management Best Practice Guidance for Nurses and Midwives**

This education programme supports nurses and midwives in providing safe, evidence-based practice in the area of medication management thus preventing medication errors and near misses. The programme will cover key topics such as: the key principles of medication management, the medication management cycle, management of controlled drugs and medication safety.

Nov 16 **Person-centred Care Planning**

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

Nov 17 **Diabetes CBT and General Wellbeing**

This online course is for nurses and midwives who have an interest in the management of patients with diabetes. The literature would suggest that diabetes, chronic disease management and the associated self-care bring high incidence rates of depression, anxiety and negative thoughts. The course will cover the use of different strategies, cognitive behavioural therapy (CBT) and clinical trials in the area of wellbeing, as well as theories and models that can help clients and healthcare providers to formulate plans to manage these issues.

Nov 17 **An Introduction to the Management of Chronic Disease in Primary Healthcare**

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

Nov 23 **End of Life Care in Residential Care Settings for Older Persons**

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

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

Nov 23 **Wound 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.

Nov 24 **The Importance of Documentation for Nurses and Midwives**

This short programme will assist nurses and midwives in understanding their duty of care and responsibility in the area of best practice in documentation, keeping good records and their ethical and legal responsibility. The course will feature an introduction to legal and professional requirements including the NMBI Code and Guidance for Recording Clinical Practice, relevant HIQA regulations and standards, adhering to consent and data protection legislation in record keeping, the purpose of healthcare records and the dos and don'ts of documentation.

Nov 25 **Healthcare Provider CPR** *(in person at the Richmond Education and Event Centre, Dublin)*

This course will equip the participants with the necessary theory and skills for the provision of CPR (cardiopulmonary resuscitation) and AED (automated external defibrillation) use in emergency situations, in line with the latest guidelines recommended by the American Heart Association. The care of the adult, child and infant will be included. The certificate awarded on completion of the course has a life span of 2 years. After this time it will then be necessary for nurses and midwives to re-certify. Times: 9-10.30am, Fee: €135 INMO members; €175 non members.

Nov 29 **Competency-based Interview Preparation for Nurses and Midwives**

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

Nov 30 **Introduction to Treating and Preventing Pressure Ulcers**

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

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

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

Dec 2 **Tools for Safe Practice** *(free for INMO members)*

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

Dec 6 **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.

Dec 7 **Introduction to Management and Leadership Skills for Nurses and Midwives**

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

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

Dec 7 **Introduction to Management and Leadership Skills for Nurses and Midwives**

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

Dec 8 **Restrictive Practices in Residential Care Settings for Older People**

Restrictive practices in the residential care is a half-day webinar programme that encourages participants to reflect on interventions that could be seen as restraining residents if viewed from a resident's perspective. Many interventions within healthcare environments can restrict movement of older people. They are unintentional and can be argued as in the best interest or for the protection of residents, for example, a nursing home locked at night to protect residents and staff from intruders.

Dec 13 **Phlebotomy** *(sold out)*

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

Jan 6 **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-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.

Jan 11 **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 5 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.

Jan 18 **Infection Control Risk Register: Regulation 27; Development and Review**

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

Jan 19 **Medication Management Best Practice 2020 Guidance for Nurses and Midwives**

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

Jan 20 **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 COPD 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 COPD utilising current best practice.

Jan 20 **Delegation Principles and Practices**

This programme is aimed at all nurses, midwives and clinical nurse and midwife managers who work with health care assistants. It explores the issues surrounding delegation and decision making, including appropriate clinical supervision for delegated functions. Participants will learn the difference between clinical and managerial delegation and how delegation differs from assignment of a task. Guidance will be provided on the assessment of a delegate's experience and role, and how best to match appropriate clinical supervision to a specific delegated function. The professional, legal and quality of care issues involved when deciding to delegate a function will also be explored.

Jan 25 **Phlebotomy**

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

Jan 25 **End of Life Care in Residential Care Settings for Older Persons**

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

Jan 26 **Retirement Planning Seminar** *(in person)*

This seminar is an in-person event with speakers on the day to ensure you are fully prepared for a secure retirement. Topics covered will include: superannuation and your entitlements; options for drawing down your AVC at retirement; lump sum AVCs before retirement; protecting your lump sum against inflation; key steps to long-term investing and top tax tips for retirement. Fee: €10 INMO members; €45 non-members.

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

This course is for staff who are interested in infection prevention and control standards. It will identify key areas relevant to the new focused HIQA infection control guidelines/inspections (October 2021). This programme will provide information and outline the actions required by registered providers to ensure that procedures, consistent with the National Standards for infection prevention and control in community services, published by HIQA, are implemented by staff.

Jan 31 **Person-centred Care Planning**

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

Feb 1 **Subcutaneous Administration of Fluids** *(in person)*

This programme will educate participants in the administration of fluids by the subcutaneous route. It will cover topics such as accountability, indications for subcutaneous infusion, suitable sites and identification of fluids most commonly used. Calculation of the rate of infusion, the principles of an aseptic technique and complications which could occur before, during or after the procedure will be explored.

Feb 1 **Tools for Safe Practice** *(free for INMO members)*

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

Feb 2 **Understanding and Developing Care Plans for Nurses and Midwives**

This 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 3 **Paediatric Asthma – Understanding the Basics**

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

Feb 9 **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.

Feb 15 **Introduction to Positive Behaviour Support**

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

Feb 15 **Best practice for Clinical Audit for Nurses and Midwives**

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

Feb 17 **The Know How of Inhaler Technique**

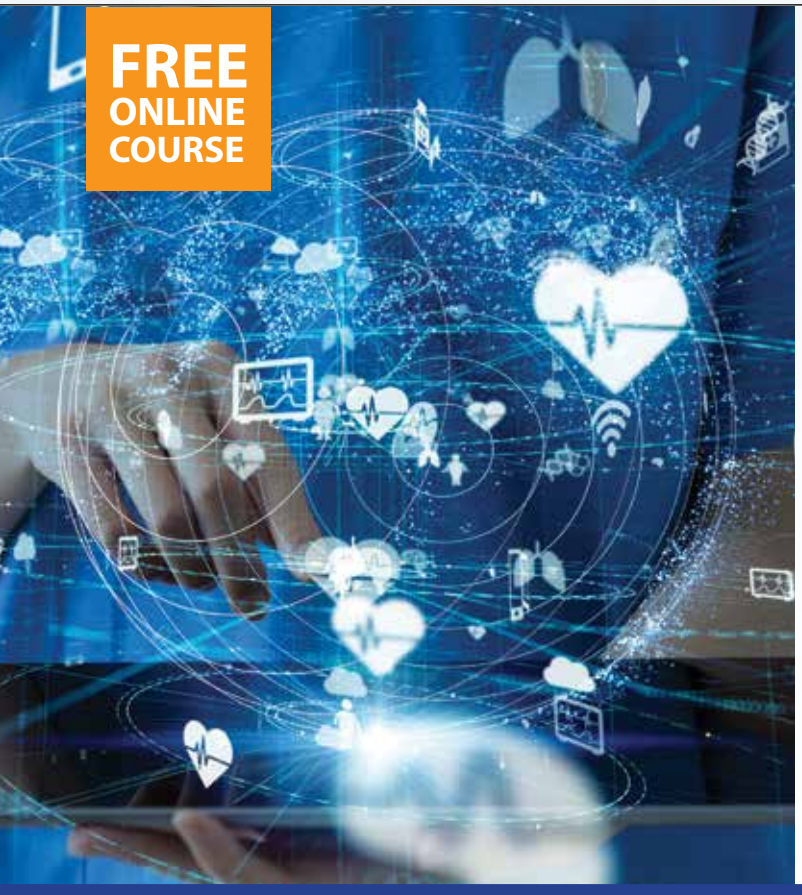
This short programme will address issues around inhaler technique. The programme will introduce nurses and midwives to current best practice in relation to inhaler technique and assist in the understanding of the role of inhaled medication with the correct use of inhalation devices.

Feb 22 **Infection Control Risk Register: Regulation 27; Development and Review**

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

Mar 1 **Phlebotomy**

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



INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

TOOLS FOR SAFE PRACTICE

FOR NURSES AND MIDWIVES

Friday, 2 December 2022

Online from 10.00am - 1.00pm

Practical advice on:

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

3
NMBI CEUS

HOW TO BOOK

Email: deborah.winters@inmo.ie or Tel: 01 6640618 with the following information;

☑ INMO Number | ☑ Email | ☑ Mobile Number

Latest nursing and midwifery research

This month, the INMO library highlights some Irish and international research in nursing and midwifery

Covid-19

- King M, Farrington A, Donohue G, McCann E. Psychological Impact of the Covid-19 Pandemic on Mental Health Nurses. Issues in Mental Health Nursing. 2022 Apr; 43(4): 300-307
- O'Reilly S, Murphy V, Mulroe E, Tucker L, Carragher F, Marron J, et al. The SARS-CoV-2 Pandemic and Cancer Trials Ireland: Impact, Resolution and Legacy. Cancers. 2022 May ;14(9)
- Sweeney MR, Boilson A, White C, Nevin M, Casey B, Boylan P, et al. Experiences of residents, family members and staff in residential care settings for older people during Covid-19: A mixed methods study. Journal of Nursing Management. 2022 May; 30(4): 872–82
- Carbia C, García-Cabrerizo R, Cryan JF, Dinan TG. Associations between Mental Health, Alcohol Consumption and Drinking Motives during Covid-19 Second Lockdown in Ireland. Alcohol & Alcoholism. 2022 Mar; 57(2):211–8

Nursing

- Ryder M, Gallagher P. A survey of nurse practitioner perceptions of integration into acute care organisations across one region in Ireland. Journal of Nursing Management (John Wiley & Sons, Inc). 2022 May; 30(4): 1053–60
- Dockery F, Glynn A, Franks K, Carey JJ, O'Gradaigh D, Kenny P, et al. Fracture liaison services in Ireland—how do we compare to international standards? Osteoporosis International. 2022 May ;33(5): 1089–96

Midwifery

- Camacho EM, Whyte S, Stock SJ, Weir CJ, Norman JE, Heazell AEP. Awareness of fetal movements and care package to reduce fetal mortality (AFFIRM): a trial-based and model-based cost-effectiveness analysis from a stepped wedge, cluster-randomised trial. BMC Pregnancy & Childbirth. 2022 Mar 22; 22(1): 1–10
- Doherty J, O'Brien D. A participatory action research study exploring midwives' understandings of the concept of burnout in Ireland. Women & Birth. 2022 Mar; 35(2): 63–71
- McDermott O, Ronan L, Butler M. A comparison of assisted human reproduction (AHR) regulation in Ireland with other developed countries. Reproductive Health. 2022 Mar 5 ;19(1):1–13
- Ryan M, Nolan A, Vallières F. Lifting the cloak of secrecy: Experiences of providing crisis pregnancy counselling in a changing legislative context in Ireland. Counselling & Psychotherapy Research. 2022 Mar; 22(1): 22–31

Older people

- O'Donnell P, Hannigan A, Ibrahim N, O'Donovan D, Elmusharaf K. Developing a tool for the measurement of social exclusion in healthcare settings. International Journal for Equity in Health. 2022 Mar 15; 21(1): 1–14
- Kodate N, Donnelly S, Suwa S, Tsujimura M, Kitinoja H, Hallila J, et al. Home-care robots – Attitudes and perceptions among older people, carers and care professionals in Ireland: A questionnaire study. Health & Social Care in the Community. 2022 May ;30(3):1086–96

Intellectual disability

- Doyle A, O'Sullivan M, Craig S, McConkey R. Predictors of access to healthcare professionals for people with intellectual disability in Ireland. Journal of Intellectual Disabilities. 2022 Mar; 26(1): 3–17

General practice

- McDonnell T, Nicholson E, Bury G, Collins C, Conlon C, Denny K, et al. Policy of free GP care for children under 6 years: The impact on daytime and out-of-hours general practice. Social Science & Medicine. 2022 Mar; 296: N.PAG

Travellers

- O'Neill E, Abdul-Razak N, Anastasova Z, O'Callaghan C. Case series: Psychosocial challenges of female youth within the Irish Travelling community. International Journal of Social Psychiatry . 2022 May; 68 (3): 681–5
- Quirke B, Heinen M, Fitzpatrick P, McKey S, Malone KM, Kelleher C. Experience of discrimination and engagement with mental health and other services by Travellers in Ireland: findings from the All-Ireland Traveller Health Study (AITHS). Irish Journal of Psychological Medicine. 2022 Jun; 39 (2): 185–95
- McKey S, Quirke B, Fitzpatrick P, Kelleher CC, Malone KM. A rapid review of Irish Traveller mental health and suicide: a psychosocial and anthropological perspective. Irish Journal of Psychological Medicine. 2022 Jun; 39(2): 223–33
- Keane E, Moore N, Leamy B, Scally A, McEntee MF. Identifying barriers to Irish traveller women attending breast screening. Radiography. 2022 May; 28(2): 348–52

Contact the Library

If you require any assistance to access www.nurse2nurse.ie or would like to make an appointment to visit in person, you can contact us at library@inmo.ie or Tel: 01 6640614/25. Opening hours: Monday to Thursday, 8.30am-5.00pm; Friday, 8.30am-4.30pm.

Online – Introduction to Effective Library Search Skills

Next course date: Wednesday, December 17, 2022

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

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

INMO Professional

RCM i-learn

THE ROYAL COLLEGE OF MIDWIVES

Neonatal infection

This i-learn module from the RCM will give midwives a deeper understanding of neonatal infection and how to identify risk factors

NEONATAL infection is a significant cause of mortality and morbidity in newborn babies and accounts for 10% of all neonatal mortality. Infection can lead to life-threatening sepsis. Without quick treatment, sepsis can lead to serious complications including organ failure and potential risk of death.

Early onset neonatal sepsis is persistently associated with poor outcomes.[1] Survivors of neonatal sepsis are at risk of poor growth and a poor neurodevelopmental outcome.[2]

This module aims to provide a general overview of neonatal infection and some specific examples of infections and their causative micro organism. Not all infections will be covered although two further modules are available on RCM iLearn: Group B Strep and Cytomegalovirus.

This module will take approximately one hour to complete.

Vital knowledge

It is imperative that midwives and maternity staff are able to identify potential risk factors and recognise the signs of infection in the newborn baby as early as possible so that appropriate management is undertaken and complications are avoided.

Role of the midwife

Infection can cause a range of symptoms, which in some cases can be life-threatening and the neonate is particularly predisposed to infection due to immaturity of the immune system.

The midwife has a key role in assessing any woman and neonate in their care for risk factors for infection and appropriate management should infection occur.

Thorough clinical assessment for early-onset neonatal infection is an ongoing process that should begin before the baby is born and continue until 72 hours after birth. It includes identifying whether there are any risk factors or clinical markers for infection and performing a physical examination of the baby, including an assessment of the vital signs if any are identified.

During labour, any risk factors should be identified and any new risk factors, such as fever or the development of chorioamnionitis, monitored. After birth, if any risk factors for infection or any clinical markers are present, a careful assessment should be performed, including vital signs – heart rate, pulse, respiratory rate and oxygen saturation levels. The maternal and neonatal history should also be reviewed.

Prior to discharge, if there have been any concerns about early-onset neonatal infection, midwives can provide parents with education about possible treatment and further management.

If a baby has been treated for suspected or confirmed early-onset infection, the parents should be informed about potential long-term effects of the baby's illness and likely patterns of recovery. If no problems are anticipated, reassurance can by given and any parent concerns can be addressed when providing information and planning follow-up.

Learning outcome

When you have completed this module, and the activities included, you will have a deeper understanding of:

- The incidence and potential impact of neonatal infection on future outcomes of the baby
- The underpinning anatomy and physiology of immunity and why the neonate is more predisposed to infection than older children and adults
- How to classify neonatal infection depending on the timing, location, specific pathogen and route of transmission.
- How to recognise the signs of infection including red flags.
- The different types of infection that may present in the neonatal period
- The principles of managing neonatal infection according to guidelines.
- The role of the midwife in recognising and managing neonatal infection within their scope of practice.

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1.Bedford Russell AR and Kumar R (2014). Early onset neonatal sepsis: diagnostic dilemmas and practical management. Archives of Disease in Childhood Fetal Neonatal Edition, 100, F350 – F354

2. Walker O, Kenny CB and Goel N. (2019). Neonatal sepsis. Paediatrics and Child Health, doi:10.1016/j.paed.2019.03.003

Spotlight on leadership

Situational leadership

IN THIS instalment in our leadership series, we focus on situational leadership. This article provides an overview of the situational leadership model, the styles and development levels associated with it and how it can be applied in the healthcare setting.

The important role that context and situation play in leadership behaviour and decision-making emerged in the 1950s. Tannenbaum and Schmidt[1] emphasised how situational pressures influence leaders' responses and decisions. This approach has been used to understand leadership responses to 'tame' and 'wicked' problems.[2] A situation with certainty about solving a problem requires a different leadership style than a critical situation or one with no solution (wicked problem).

Grint and Holt[3] described a wicked problem as the land of leadership, a tame problem as the land of management and a critical problem as the land of the commander. This approach has been used to understand leaders' and followers' relationships, behaviours and interactions in the changing healthcare context.

Originally developed by Paul Hersey and Ken Blanchard in the 1960s,[4] this leadership theory evolved and was further refined over the next two decades to become situational leadership. The central premise of situational leadership is that there is no single style of leadership that trumps another. Instead, the style of leadership used depends on the situation or context in which leaders find themselves. The leader must be able to adapt and become flexible, responding to the needs of followers or employees as required to ensure that they are effective in their role.

Blanchard's model of situational leadership, entitled SLII,[5] describes a framework which proposes four leadership styles representing different levels of supportive and directive behaviours, namely:

- Directing (S1; high directive and low supportive behaviours)
- Coaching (S2; high directive and high supportive behaviours)
- Supporting (S3; low directive and high supportive behaviours)
- Delegating (S4; low directive and low supportive behaviours).[5]

These leadership styles are used in conjunction with follower development levels on specific tasks or situations. The framework proposes that how each leadership style is used depends on the follower's development level. The framework defines four follower development levels as:

- D1 - Enthusiastic beginner
- D2 - Disillusioned learner
- D3 - Capable, but cautious, contributor
- D4 - Self-reliant achiever.[6]

A leader must match their style to the situation or task and the development level of the follower. Doing so will allow for "greater performance and satisfaction from their followers".[5]

The development levels are on a continuum; therefore, followers move back and forth across this continuum, depending on a particular task or situation. For example, if a follower is in D1, they will require a leader who will provide a style of leadership which is high directive and low supportive (S1). Similarly, if the follower is in D4, the leader must use a leadership style which is low directive and low supportive (S4).

A key strength of the situational leadership model is that it is practical and in theory can be easily applied across many settings. Also, because of the flexible nature of the model, it allows leaders to focus on employees, recognising that they may be at different levels of expertise depending on the task. It, therefore, can allow for greater employee recognition and skills development.[7]

However, there are critics of situational leadership. Northouse outlines several criticisms of the model, including a lack of evidence to underpin the model's assumptions, clarity over the conceptualisation of the model's follower development levels and how the model fails to take into account critical demographic characteristics that can impact the leader/follower dynamics.[7]

Such demographics include gender, age and education level. Also, Graeff found the situational leadership model has the potential to encourage a leader to remove themselves from certain situations or avoid conflict.[8]

There is limited research on how situational leadership can impact nursing, midwifery and the broader health care environment. Focusing on the nursing home setting, Lynch et al identified how situational leadership has the potential to affect patient-centred care positively and encourages continuous learning and reflective practice.[9] The authors found that although there is potential for this model in the broader healthcare context, more research is needed.

However, the Covid-19 pandemic has brought situational leadership into focus more recently. One study found that the model was used effectively to redeploy academic hospital staff who were not engaged in clinical work during the pandemic.[10] Another study found that situational leadership can effectively respond to a crisis such as a pandemic. This research found that situational leadership required leaders to thoroughly assess each situation or problem, using multiple leadership styles to address each situation differently.[11]

Although more research is required to fully understand how situational leadership can be applied in healthcare settings, the model does lend itself to particular situations or contexts that may be useful for nurses and midwives to use as part of their leadership toolbox.

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

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

References on request by email to: nursing @medmedia.ie (Quote Pitman S and Adams N. WIN 30 (9): 42)

A column by Maureen Flynn

Quality & Safety

Nurses and midwives and the Spark Innovation Programme

EMPATHY, observation, listening, relationship, human experiences, meaning and connections are intrinsic to our practice. Innovation is not a new concept to us. Nurses and midwives nationwide are engaged in innovative activities on a daily basis; activities motivated by the desire to improve patient care outcomes. This month we are proud to share with readers a snapshot of the nursing and midwifery contribution to the HSE's Spark Innovation Programme.

Spark Innovation Programme

'Spark' is a frontline staff-led initiative that seeks to support, promote and recognise innovation amongst healthcare staff. The HSE's Office of the Nursing and Midwifery Services Director (ONMSD) commenced a collaboration with the spark programme in 2019. This collaboration enables nurses and midwives to participate in Spark programmes and events.

Through pursuing three strategic aims spark nurtures innovation and change. These are: to engage and empower frontline staff; to create a supportive ecosystem for health innovators; and to develop systematic capability.

Innovation and design principles are undoubtedly a departure from the day-to-day clinical roles that most in the HSE might be used to. Spark operates under seven pillars to move to a future in innovation:

- *Engagement*: providing multimodal engagement opportunities for an innovation collective across the health service (twitter/newsletters/workshops etc)
- *Initiatives*: creating opportunities to develop skills, secure micro funding, access mentorship and embed innovation, eg. Spark seed, hospital/ community innovation fund
- *Design*: implementing user-informed change and innovation (design weeks/ bootcamps/ design expertise engagement)
- *Network*: gathering and connecting internal and external partners (promoting

successful innovation projects)
- *Research*: contributing to research in the frontline innovation space both nationally and internationally
- *Pioneering*: leading the way with new product and services and ways of working through pilots and validation studies
- *Professional development*: developing staff capability for agency and impact.

Benefits and outcomes

The nursing and midwifery contribution to healthcare innovation is seldom publicised or shared. For the past two years the spark team has captured the nursing and midwifery contribution in an annual report for 2020 and 2021. The reports set out the number of nurses and midwives applying for Spark seed, Spark ignite, Spark Covid call and design workshops. They provide an overview of the successful ideas funded, reflections, case studies and testimonials.

Many of these initiatives have resulted in significant improvements in the health of patients, populations and health systems. You can find the 2021 annual report of the nursing and midwifery contribution to the spark innovation programme at: **shorturl.at/stHPR**

Innovation fellow

The ONMSD is piloting an exciting interim role for nurses and midwives creating a one-year national nursing and midwifery innovation fellowship – this test of concept commenced in April 2022. The fellowship in innovation gives a clinical nurse or midwife the opportunity to develop their innovation and leadership skills and shape the spark programme.

Amy Carroll is the current Nursing and Midwifery Fellow (2022 to 2023). A midwife/clinical placement co-ordinator based in Kilkenny, she started in the role in April 2022. One of her core goals is to ensure that the reality and challenges specific to nursing and midwifery are kept at the forefront when planning Spark initiatives. She provides tailored support, practical guidance on implementation and measurement of success, and promotion of projects.

She would love to hear from you and can be contacted by email to: Amy.carroll1@hse.ie

Get involved

The spark programme urges all nurses, midwives, doctors, and health and social care professionals who have problem solving mind, a desire to learn about design and innovation and –more than anything – are excited about seeing their ideas come to fruition, to get involved as we want to help navigate your problem solving journey.

When you next have an inspiration or idea for change please get in touch with the Spark team. You can read further about the initiatives here: **shorturl.at/hiKL6** and you can follow the Spark team on twitter @ProgrammeSpark

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

Acknowledgements:
Thank you to the Spark programme team and all the nurses and midwives who are taking their ideas for change forward with support from Spark events and resources. Particular thanks to Amy Carroll, nursing and midwifery spark innovation fellow for collaboration in writing this column

INMO Professional

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- **Hybrid Higher Diploma in Children's Nursing Programme**
- **All-Island Congenital Heart Disease (CHD) Network**
- **Irish Paediatric Acute Transport Service (IPAT)**
- **Non Accidental Injury – ED Nursing Perspective**

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NEW

INMO Section Advanced Nurse/Midwife Practitioner Clinical Nurse/Midwife Specialist

Following the recent International ANP Conference, and the subsequent heightened interest amongst our members, we are seeking to establish a national nursing and midwifery networking group for ANP/CNS members.

This forum will facilitate colleagues from across the country to link with each other for specialised networking, information sharing and above all else support for each other in these roles.

Please send an expression of interest to jean.carroll@inmo.ie, including your INMO membership number.

Preparing for your clinical placement

Róisín O'Connell offers some practical tips on how to get the most out of your clinical placement and discusses the available support

AS THE academic year progresses, many first-year students will be preparing for their first clinical placement. While going on your first placement can be an exciting experience, as you will finally be able to put what you have been learning in the classroom into practice, it is normal to feel a bit nervous as well. In this article I will offer some tips to help you to prepare for your first placement.

Preparation

Put your best foot forward. First impressions are important so make sure that you are well rested and punctual for your first day of placement. Plan your route to your placement site and remember to factor in time for traffic, difficulty finding a parking space or a late bus. It may be worth packing a lunch the night before and bringing a bottle of water for the first day; you can see what the canteen facilities are like after that when you are under less pressure.

The hallmark of a good nurse or midwife is to always have a pen, so be sure to bring a spare. Make sure that you know what your higher education institute (HEI) and clinical placement site's uniform policy is and adhere to it closely. It is also important to be familiar with the local policy regarding sick leave in case you need to miss a placement day.

Learning on placement

While you will have learned a lot during your time in college, there will be a significant amount of information to take in while you are on placement. Don't be afraid to ask your preceptor questions and to take the initiative of asking to accompany them if they are going to perform a task you would benefit from observing.

You will also have a clinical placement co-ordinator (CPC) assigned to you who can answer any questions you might have as well. It is important to always have a small notebook with you in your pocket so that you can write down unfamiliar terms or medications that you can look up later. This is something that I found extremely useful when I was a student.

Many students find that protected reflective time (PRT) is an ideal opportunity to look up new terms you may have heard in handover, or to research different medications, their indications for use and their side effects. All students should have a total of at least four hours per week of PRT, as per the NMBI Nurse/Midwife Registration Programmes Standards and Requirements.

Know the policies and standards

When you are on placement it is important that you are aware of the various policies, guidelines and standards that are relevant to you as a student nurse or midwife.

HEIs and clinical placement sites will have local policies, but the NMBI sets requirements, guidelines and standards that you must follow. These can be found at: **www.nmbi.ie/Standards-Guidance**

It is vital that you are aware of your code of conduct, the scope of practice, and domains of competence while on placement. Additionally, your college and clinical placement site will likely inform you of their social media policy, but it is worth bearing in mind that the NMBI also has a guidance document, which is available at the web address above.

Seeking support on placement

While the support of the CPC and the preceptor in the clinical placement site are readily accessible, it can be easy to forget about other means of support available to you. Some students can feel isolated, overwhelmed or anxious during clinical placement blocks, as they feel removed from normal student life.

This is likely to happen more often as some HEIs take a blended approach to learning. Remember that while you are on placement you remain a student of your HEI and can avail of the support it offers, including health services, counselling services and guidance from your link lecturer or personal tutors.

In addition to support offered by your HEI, INMO members also have access to a 24-hour counselling helpline service, details available at: **www.inmo.ie/membership_benefits**

It is also important to keep in touch with your family and friends while on placement, as it really does make a difference – especially if you are feeling lonely.

Finally, remember that the INMO is here to support you when you are on clinical placement. If you are experiencing issues during your placement or have a question, do not be afraid to get in touch.

It is important that each class has an INMO rep who is connected with me, if your group does not have one then please discuss this and nominate one person to get in touch.

The very best of luck on your placement.

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

Time of fear

Pregnancy is a time of increased vulnerability to domestic abuse and healthcare workers who care for pregnant women need to recognise the signs, writes **Sarah Benson of** Women's Aid

IT SHOULD be a time full of hope, but pregnancy can leave some women more vulnerable. Global research shows that domestic abuse during pregnancy is more common than pre-eclampsia and gestational diabetes. In Ireland, one in eight women suffer domestic abuse during pregnancy. In 2021, 152 women told Women's Aid that they were abused while pregnant and 41 women suffered a miscarriage because of the abuse.

This is only the tip of the iceberg however. One in four women in Ireland experience some form of domestic abuse and unfortunately, domestic abuse does not stop in pregnancy. Every year, the Women's Aid 24-hour national freephone helpline **1800 341900** and face-to-face support services support hundreds of women who are coercively controlled, beaten and raped while they are pregnant.

We also hear from pregnant women whose abuser deliberately targets their stomach, women who are sexually assaulted following childbirth and women who are beaten while holding or trying to protect their baby. Other examples of abuse during the postnatal period include women disclosing that they are not being allowed, or being forced to give up breastfeeding and premature removal of stitches.

The adverse impact of domestic abuse on pregnant women's mental and physical wellbeing is significant and wide ranging. It also directly affects children. Effects include miscarriage, premature birth, delivering a baby with a low birth weight, self-medication with alcohol and/or drugs to cope with the abuse, portpartum depression, stress and anxiety, mother-child bond being negatively affected, and behavioural and emotional problems in children. It extreme cases, domestic abuse can be fatal.

Barriers to seeking help

Pregnant women who experience domestic violence and abuse face a range of barriers towards help-seeking and disclosure during a vulnerable and high-risk period. In addition to concerns about privacy, confidentiality and fear of the abuser, women are often not fully aware of what constitutes domestic abuse, including coercive control, or their support or legal options.

For more vulnerable groups, communication issues like language and interpretation are fundamental barriers. Disclosing abuse is a complicated decision. Women fear that ending the abuse will cause them to lose social (family, friends) and financial support, or become entangled in court disputes over custody, domestic violence legal orders and child maintenance. At the point of pregnancy, women may have invested heavily in their relationship and may already have dependent children. It is important for professionals working with victims of abuse to understand that while women may want to change their situation, their ability may be affected by their concerns and lack of resources.

Indicators of domestic abuse in pregnancy

While pregnancy may be a particularly vulnerable time for women in abusive relationships, it also offers healthcare professionals a key opportunity to identify victims and support them appropriately, due to the routine nature of antenatal and postnatal care. Indicators of domestic abuse relevant to maternity care, include:

Case study

Like so many women, Aisling* met a man she thought was perfect for her. Mike played the role of the perfect gentleman and she was swept off her feet. At 24, she fell in love and, like so many of us, hoped for her fairytale ending. Four years later, she married Mike and believed she had found it. Her family and friends adored him too and Aisling was excited about their future together.

Sadly, not long into her marriage, Mike's behaviour changed overnight, his true colours came out and she found herself trapped in an abusive relationship with no idea how to set herself free. Aisling's world came crashing down and she felt powerless. She feared telling anybody the truth because she knew that everyone thought the world of Mike and worried that she would not be believed.

Aisling told us: "When I was pregnant, he became more aggressive and violent. One morning, I was in the bathroom being sick and he came in and started yelling. He told me this pregnancy had made me ignore him and that he was sick of me being sick all the time. He picked up the towel and started hitting me with it. I pleaded with him to stop.

"Another time, when I was five months pregnant, he began forcing me to have sex with him. I tried to get away from him and fell on the floor. He started kicking me in the back, I was so frightened I was trying to hide my stomach, I was so worried about the baby. I had bruises all over my back and was so sore from where he had kicked me. Later that day, I started to bleed. He took me to the hospital and, crying, he told staff that I'd been in a car crash. And how scared he was that I was going to lose our baby.

"Later, when he had gone home for the night, I talked to a midwife again. I don't know how, but suddenly I found myself blurting out 'I wasn't in a car crash'. She was amazing. She just listened and held my hand while I spoke. She told me that I should talk to the social worker, who then put me in touch with Women's Aid. It was so good to talk to someone confidentially, who didn't tell me what to do, but who confirmed what I knew – that what Mike was doing was wrong and that I shouldn't have to experience these things. Orla from Women's Aid supported me, helping me get legal protection and, when I was ready, she also came to court with me and helped me secure a barring order against Mike."

No longer alone

Thanks to Women's Aid support services, Aisling was able to find the courage and support she needed to leave years of cruelty and abuse behind her. It's not quite over yet, but she is on the path to being free and safe. She still needs to face Mike in court to sort out child custody and access arrangements, but she is no longer doing it alone. As Aisling said: "I have an army beside me. An army of family, Women's Aid and invisible friends, advocates and kind people who support their crucial services."

**Name and some details have been changed to protect identity*

- Late booking and/or poor or non-attendance at antenatal clinics
- Repeat attendance at antenatal clinics, the GP surgery or emergency departments (ED) for minor injuries or trivial or non-existent complaints
- Unexplained admissions
- Non-compliance with treatment regimens/early self-discharge from hospital
- Repeat presentation with depression, anxiety, self-harm and psychosomatic symptoms
- Injuries that are untended and of several different ages, especially to the neck, head, breasts, abdomen and genitals
- Poor obstetric history, including repeated miscarriage or terminations of pregnancy, stillbirth, or preterm labour, preterm birth, intrauterine growth restriction/low birth weight, unplanned pregnancy
- The constant presence of the partner at examinations, who may be domineering, answer all the questions for her and be unwilling to leave the room
- The woman appears evasive or reluctant to speak or disagree in front of her partner
- A partner insisting on acting as the translator for a pregnant woman for whom English is not a first language.

How you can help

If any healthcare professional is worried about a patient in their care or if a woman discloses abuse, they should listen to what she has to say, believe her if she says she is experiencing abuse, and support her on her journey to safety. The key step to take is to refer the woman to the hospital's medical social work team and the Women's Aid freephone helpline **1800 341900.**

Training, awareness and referral

For many years, Women's Aid has had excellent contact with staff in maternity hospitals. We are frequently invited to deliver training or awareness talks to frontline professionals working in maternal and neonatal health services. Through these many engagements and discussions with frontline staff, and our own services, we have long been aware of the vulnerability and particular risks to pregnant women who are subjected to abuse. In addition, we have gained insight into midwives and other hospital staff's experiences around routine enquiry, and their appreciation for training and support around the complex societal issue of domestic violence.

Innovative partnership

As a result of this experience and informed by global and national research and in line with the Maternity Strategy 2016-2026, Women's Aid saw the need to offer a more dedicated resource to support the midwives, doctors, nurses and social workers who care for pregnant women. Thus, in 2021, Women's Aid and four of Ireland's leading maternity hospitals began an innovative partnership to enhance the support for abused pregnant women who are accessing maternity services as well as women contacting Women's Aid for support. This partnership also supports staff who may be subjected to abuse.

Our partners are The Coombe Women and Infants University Hospital, The Rotunda Hospital, The National Maternity Hospital and Ireland South Women and Infants Directorate (primarily Cork University Maternity Hospital). Over the past year we have worked closely together to develop domestic abuse training and create unique domestic abuse and pregnancy awareness resources for hospital staff and patients. Women's Aid has also employed a dedicated domestic abuse support worker who is assigned to the three Dublin maternity hospitals.

This year, the International '16 Days of Action' runs from November 25 to December 10 and the partnership will continue to raise awareness on pathways into specialist services and on the links between domestic abuse and maternal health to ultimately create hospital environments that are visibly disclosure friendly.

Women's Aid is also being supported by the HSE's National Women and Infant Health Programme (NWIHP) to provide training to maternity care staff on domestic abuse awareness. The training is designed to build capacity so that staff are empowered to ask women questions regarding potential domestic abuse, and to respond safely and appropriately, including with information about the specialist domestic abuse services available.

The training is framed around the three Rs – Recognise, Respond and Refer. Training is being delivered online in half-day sessions to multidisciplinary groups and is being rolled out to the six hospital groups. Women's Aid aims to target more than 1,000 staff for the training over the course of the next year.

Together Women's Aid and maternity and healthcare institutions and staff can work towards offering women and their children the support they need in a safe environment and empower women to disclose abuse, seek help and ultimately become free from abuse. This work will continue until every woman is safe in her home and in her relationship and until there is zero tolerance of all forms of male violence against women.

More information

If you would like to learn more about this work and this year's '16 Days of Action' Awareness Campaign contact info@womensaid.ie If you or someone you know is experiencing domestic abuse, you can call the Women's Aid 24-hour national freephone helpline at Tel: **1800 341 900** Or use the instant message support service on: **www.womensaid.ie** (open mornings and evenings, seven days a week).

Sarah Benson is the chief executive of Women's Aid

***A time of hope can also be a time of fear**: Friday, November 25 is the United Nations Day Opposing Violence against Women and in Ireland Women's Aid and four leading maternity hospitals (see below) are working in partnership to listen, believe and support women subjected to domestic abuse. Pictured are staff from the National Maternity Hospital, Dublin at an information desk in the hospital*

National Strategy on Domestic, Sexual and Gender-Based Violence

LED by the Department of Justice, the government is currently finalising the 'Third National Strategy to combat Domestic, Sexual and Gender-Based Violence', which will place a priority on prevention and reduction, and will include a National Preventative Strategy.

The INMO made a substantial submission to the public consultation process on this strategy in June 2021, in which it stated that: "Dedicated training and support should be made available to all healthcare professionals, including nurses and midwives, to assist them in identifying and supporting those who are the victim of domestic and gender-based violence."

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LIVE ONLINE EVENTS

VISIT OUR WEBSITE

ONLINE
Competency based interview preparation

Tuesday, 29 November 2022

Time: 10am - 1pm

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

3 NMBI CEUS

Fee: €30 INMO members;
€65 Non members

ONLINE
Introduction to management and leadership skills

Wednesday, 7 December 2022

Time: 10.00am - 1.00pm

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

3 NMBI CEUS

Fee: €30 INMO members;
€65 Non members

IN PERSON
Retirement Planning Seminar

Thursday, 26 January 2023

Time: 10.00am - 1.00pm

This seminar is an in person event with speakers on the day to ensure you are fully prepared for a secure retirement.

- Superannuation and your entitlements.
- Options for drawing down your AVC at retirement.
- Should you consider a lump sum AVC before retirement?
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Menopause awareness

The Department of Health has launched a one-stop-shop for menopause information alongside a new awareness campaign

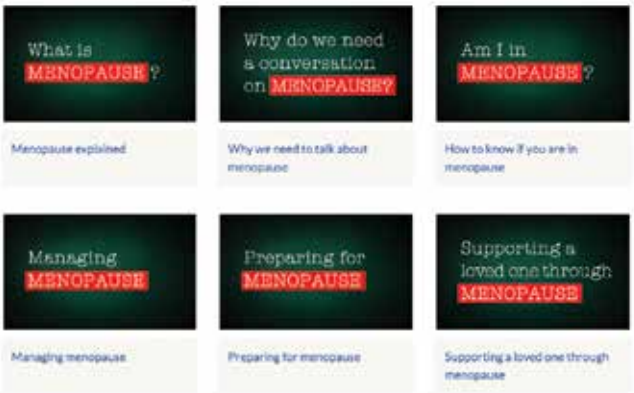
MINISTER for Health Stephen Donnelly has launched a government awareness campaign for menopause. The campaign is a direct response to the demand from Irish women for greater knowledge and understanding of menopause, as well as better access to accurate information and support so that they can actively manage their experience. It aims to increase awareness of menopause and the symptoms associated with it and encourage open conversation to reduce the stigma associated with this phase of life.

New research commissioned by the Department of Health to inform the campaign has highlighted that:

- Three-quarters of women over the age of 35 have either entered perimenopause (19%), are in menopause (18%) or have completed menopause (37%)
- Women in menopause report experiencing up to seven symptoms at any given time
- 17% of women experiencing menopause have severe symptoms
- 52% of women currently in menopause describe it as a negative experience
- 91% of women currently in menopause say they are experiencing constant or occasional symptoms
- More than half of Irish women report fatigue, lack of energy, insomnia, 'brain fog', changes in weight or body shape, and joint pain – as well as hot flushes and changes in periods
- 86% of women say that menopause can have a big impact on their everyday lives
- 28% of women in menopause say they would be happy to talk about it to their manager at work.

The nationwide campaign includes a 30-second advertisement in national and local radio, print ads in national newspapers and magazines, out-of-home advertising on digital displays and bus shelters nationwide, along with ads on digital and social media.

The Department of Health has developed **gov.ie/menopause**, a one-stop shop for information about menopause and menopause symptoms, advice on proactive management, how to support someone going through menopause and links to appropriate clinical expertise.



From gov.ie/menopause information resource showing some of the information available

Speaking at the launch, Mr Donnelly said that one of his main objectives as Minister for Health has been to improve access to healthcare for women in Ireland. He said that he and his department, alongside the HSE, had worked hard to deliver services and supports for women experiencing perimenopause and menopause.

"There are now four menopause clinics providing treatment for the 25% of women who need medical management of their menopause symptoms. Two further clinics are due to open before the end of the year.

"While menopause affects half of our population directly, all of us know someone going through it, be it a family member, a friend or a colleague. This campaign and website will empower everyone to open up the conversation around menopause and to eradicate any stigma or secrecy that's associated with it."

Chief nursing officer Rachel Kenna said that the research conducted for this campaign painted an informative portrait of what menopause experience is like for women in Ireland today.

"We know that women are dealing with multiple symptoms, not just temperature regulation and menstrual changes most commonly associated with menopause, but also fatigue, joint pain, insomnia, itchy skin and brain fog, among others. This campaign provides information for those experiencing perimenopause and menopause, helping them to recognise their symptoms and to feel enabled to seek the support they need.

"The cohort of women going through menopause may also be dealing with stressors associated with childcare, elderly parents and work. It is important that they take time for self care and are supported by their partners, families, friends and colleagues in doing so."

Dr Deirdre Lundy, clinical lead at the National Maternity Hospital's Complex Menopause Service, said that while most patients who are troubled by menopause symptoms are able to receive advice and treatment in the community through their GP, practice nurse or family planning clinic, unfortunately, those with certain medical conditions, such as thrombosis, cardiovascular disease, cerebrovascular disease, hormone sensitive cancers, etc are advised to be seen by a menopause specialist.

"I lead one of these complex menopause services and I am delighted to see more specialist menopause clinics opening around the country," she added.

Dr Deirdre Collins, GP and board member of the Irish College of General Practitioners (ICGP), said that GPs were at the forefront of menopause care, as part of the continuity of care delivered within general practice.

"The ICGP has published a comprehensive new guide for the management of Menopause in General Practice, which will guide GPs from the first consultation right through perimenopause and the menopause. This guide is a milestone in the management of menopause in general practice. It includes information on diagnosis, lifestyle interventions, prescribing of HRT and, importantly, alternative options to HRT as well as specific advice for women with a history of breast cancer."

Novartis Rheumatology and Dermatology Nurses Collaborative Forum

Pictured at the recent Rheumatology and Dermatology Nurses Collaborative Forum hosted by Novartis were (l-r): *Amanda Walsh, Anita Flynn and Gaynor Barry*

Also pictured at the Forum were (l-r): *Dervila Treacy, Simon Crouch and Paula Keenan*

Also pictured were (l-r): *Deirdre Kennedy, CM Losames, Mai McManus and Christina O'Rourke*

Also pictured were (l-r): *Clara Bannon and Kate Tyaransen*

Also pictured were (l-r): *Sinéad Fitzgerald and Carmel O'Connell*

Also pictured were (l-r): *Patricia O'Neill, Paula Dreelan, Amrit Kaur, Jackie Healy and Marie O'Connor*

Also pictured were (l-r): *Cathal McDermott, Madeline O'Neill, Patricia Minnock, Clara Bannon and Jamie Early*

Also pictured were (l-r): *Ruth McCarthy and Éadaoin Redmond*

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Fast and significant improvement in **quality of life[4,9]**

With **The Complete Cosentyx Approach™**, you can address the underlying cause of the disease and **decrease systemic inflammation[2]**

ABBREVIATED PRESCRIBING INFORMATION
Please refer to the Summary of Product Characteristics (SmPC) before prescribing.
COSENTYX (secukinumab)
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 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); 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; 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. *Pediatric 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. *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. *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. *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, tinea pedis 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 and inflammatory bowel disease. *Rare (≥1/10,000 to <1/1,000)*; Anaphylactic reactions, exfoliative dermatitis and hypersensitivity vasculitis. 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:** June 2022. 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 of the medicinal product is important to Novartis and the HPRA. It allows continued monitoring of the benefit/risk profile of the medicinal product. All suspected adverse reactions should be reported via HPRA Pharmacovigilance, website www.hpra.ie. Adverse events could also be reported to Novartis preferably via www.report.novartis.com or by email: drugsafety.dublin@novartis.com or by calling 01 2080 612.

* The Complete Cosentyx Approach™ is defined as efficacy in both skin and persistent psoriasis manifestations in nails, scalp, palms,and soles, as well as psoriatic arthritis; controls irreversible structural damage (PsA) and improves quality of life. PsA = psoriatic arthritis.[10]

References: 1. Duffin KC et al. 2018 Las Vegas Dermatology Seminar. 1-3 November 2018; Las Vegas, NV, USA. Poster. **2.** Krueger J et al. 24th World Congress of Dermatology. 10-15 June 2019; Milan, Italy. Poster 505. **3.** Langley RG et al. *N Engl J Med.* 2014;371(4):326-338. **4.** Bissonnette R et al. *J Eur Acad Dermatol Venereol.* 2018;32(9):1507-1514. **5.** Reich K et al. 2017 Winter Clinical Dermatology Conference. 13-18 January 2017; Kohala Coast, HI, USA. Poster. **6.** Reich K et al. 3rd Inflammatory Skin Disease Summit. 12-15 December 2018; Vienna, Austria. Poster LB 6. **7.** Novartis data on file. CAIN457F2342 (FUTURE 5): Week 104 Interim Report. May 2019. **8.** Baraliakos X et al. *Ann Rheum Dis.* 2020;0: 1-9. **9.** Strober B et al. *J Am Acad Dermatol.* 2017;76(4):655-661. **10.** Cosentyx SmPC, available at www.medicines.ie [accessed November 2021].

NOVARTIS

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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.

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

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

Breastfeeding rates in Ireland finally increasing

During national breastfeeding week last month, the department of health said rates were up by 5% between 2019 and 2021

ACCORDING to new HSE figures, there was a 5% increase in the number of babies breastfed at the time of their first public health nurse visit between 2019 and 2021, a rise to 59%.

The HSE pointed to the recruitment of 20 additional infant feeding and lactation posts within nursing and midwifery services, which aim to support breastfeeding parents. While midwives are the first to assist with breastfeeding, should mothers need more specialist support the HSE said that all 19 maternity hospitals now have a specialist lactation support service available.

More infant feeding/lactation posts are being recruited to ensure nationwide availability within primary care services. Some 110 breastfeeding groups have now resumed meeting in person providing important peer-to-peer support for parents on their breastfeeding journey.

Laura McHugh, HSE national breastfeeding co-ordinator, spoke about the importance of this support being available: "While breastfeeding rates are increasing around the country, we want to continue to build on this progress by supporting every parent who may need help on their breastfeeding journey. I welcome our colleagues taking up the new infant feeding and lactation roles around the country, and although not everyone will need their services, their support will make a big difference for parents who do."

According to the HSE, approximately 60% of babies are breastfed in the first week of life and Anne O'Malley, a PHN at Community Healthcare Dublin North City and County, said that "every breastfeed makes a difference" because any amount of breast milk is beneficial for mother and baby.

"If a mother can breastfeed for a short amount of time it will be helpful and the longer you breastfeed the greater protection for mother and baby. We want every mother to know about all the free support available to help her to breastfeed for longer if she wishes," added Ms O'Malley.

Marking National Breastfeeding Week were Orla Gleeson with baby Ailbhe, Emma Taaffe with baby Oisín, and HSE public health nurse Catherine Ott, pictured at Carlton Hall Breastfeeding Support Group in Marino, Dublin. The HSE is encouraging parents to take up free expert help if needed

Picture: Mark Stedman

Meanwhile the Coombe Women & Infants University Hospital has established a dedicated team of midwives sharing responsibility to protect, promote and support breastfeeding at the hospital. The Coombe also provides access to excellent antenatal education and lactation experts during pregnancy and post-birth, as well as online educational videos on breastfeeding, freely available in their Breastfeeding Library.

Midwives who are fully trained or are currently in training in the International Board Certified Lactation Consultant (IBCLC) accreditation are incorporated in the hospital's breastfeeding support programme to develop their own skills, while providing continuity of care to mothers post-partum. In addition to postnatal midwifery, specific lactation support midwives rotate across three designated post-partum wards in the Coombe to provide further support, targeted at encouraging breastfeeding and ensuring comfortable breastfeeding for both mother and baby.

According to the hospital, the benefits of the recently developed service have already been noted by participants, with mothers citing a greater understanding of how they can breastfeed their baby and community midwives noticing more confidence in breastfeeding among mothers.

This team of midwives is supported and mentored through study days by the clinical midwife specialists (CMS) at the hospital. Additional support for midwives undertaking further IBCLC training in breastfeeding is included in the group, with dedicated study days set aside to support midwives in training alongside mentorship from CMSs.

Speaking about these developments at the Coombe, CMS Mary Toole said that breastfeeding was incredibly important to the growth, protection and development of babies, as it provides complete nutrition for a baby. "Many mothers are keen to breastfeed but can be uncertain as to the best ways to do so comfortably and properly. Our dedicated team of lactation consultants and midwives is working to ensure that mothers leave hospital with a stronger awareness of how they can have a comfortable breastfeeding experience, while we are continuing to upskill our midwives in training to provide lactation support.

"We hope that our extra resources pave the way for encouraging more mothers to try breastfeeding and remind parents of our further range of supports focused on breastfeeding and postpartum care freely available on our website."

Prof Michael O'Connell, master at the hospital, added that breastfeeding played an important role in the life of both the mother and the baby.

"Not only does it strengthen the immune system, but it also develops a deep-rooted bond between mother and child, which is why breastfeeding is a priority throughout all aspects of care we provide. We hope this new resource provides some additional support to parents and mothers at every stage of their breastfeeding journey," he added.

Update on diagnosis and staging of patients with prostate cancer

Recent updates to the NCCP's prostate cancer guidelines are aimed at improving the quality of care delivered to patients

THE National Cancer Control Programme (NCCP) has updated its guidelines on diagnosis and staging of patients with prostate cancer, developed in collaboration with clinicians, patient representatives and key stakeholders by a multidisciplinary Guideline Development Group.[1] These updated guidelines now supersede the recommendations in the radiology and diagnosis sections within the *National Clinical Guideline No. 8 Diagnosis, Staging and Treatment of Patients with Prostate Cancer* (2015).

Assessment

A prostate assessment consists of four parts: clinical history, a digital rectal examination (DRE), urinalysis (UA/MSU) and prostate-specific antigen (PSA) blood test.

Risk stratification

The NCCN prostate cancer risk stratification is as follows:

- *Very low risk group:* Has all of the following – cT1c, Grade Group 1, PSA < 10µg/L, fewer than three prostate biopsy fragments/cores positive, ≤ 50% cancer in each fragment/core, PSA density < 0.15ng/mL/g
- *Low risk group:* Has all of the following but does not qualify for very low risk – cT1-cT2a, Grade Group 1, PSA < 10µg/L
- *Intermediate risk group:* Has all of the following – no high-risk group features, no very high-risk group features, has one or more intermediate risk factors (IRF) (cT2b–cT2c, Grade Group 2 or 3, PSA 10-20µg/L)
- *Favourable intermediate risk group:* Has all of the following – 1 IRF, Grade Group 1 or 2, < 50% biopsy cores positive (eg. < 6 of 12 cores)
- *Unfavourable intermediate risk group:* Has one or more of the following – 2 or 3 IRFs, Grade Group 3, ≥ 50% biopsy cores positive (e.g. ≥ 6 of 12 cores)
- *High risk group:* Has no very high-risk features and has exactly one high-risk feature – cT3a OR Grade Group 4 or Grade Group 5 OR PSA > 20µg/L
- *Very high risk group:* Has at least one of the following – cT3b-cT4, Primary Gleason pattern 5, two or three high risk features, > 4 cores with Grade Group 4 or 5.

Summary of recommendations

For men with suspected prostate cancer referred from a urologist, a multiparametric MRI is recommended before a prostate biopsy. If a mpMRI indicates that a biopsy is not needed, then the patient will avoid discomfort associated with a biopsy and possible side-effects (such as sepsis and scar tissue). In addition, mpMRI-directed biopsy pathways tend to detect fewer instances of clinically insignificant cancer than biopsies do, so some patients will avoid the stress and anxiety of a diagnosis of clinically insignificant cancer. If the patient is not a suitable candidate for an mpMRI, then a systematic prostate biopsy should be offered as a first-line test.

An abnormal MRI finding is defined using the PI-RADS scoring system for prostate MRI interpretation. A biopsy is recommended in patients with focal lesions graded PI-RADS 4 and 5. This includes a systematic biopsy and targeted biopsy of focal lesions. In cases with focal lesions graded PI-RADS 3, a biopsy can be considered. Patients with PI-RADS ≤ 3 are at low risk of clinically significant prostate cancer however additional risk stratification may be used in determining the need for a biopsy

In men with abnormal MRI findings, a targeted biopsy of focal lesions should be performed using either MRI (guided) transrectal/transperineal US fusion or cognitive registration biopsy. The guidelines pointed out that targeted biopsies should only be performed in a high volume centre by appropriately trained professionals. A minimum number of 12 cores should be taken for a systematic biopsy.

For men being investigated for prostate cancer without an MRI targetable lesion, omitting a biopsy should be considered, following the shared decision-making model. For those with a negative MRI (PI-RADS 1 or 2) and a high clinical suspicion of prostate cancer, a systematic prostate biopsy is recommended. In those with a negative MRI who do not proceed to biopsy, PSA should be monitored regularly at six months and then annually.

In men with favourable intermediate risk prostate cancer who have had a pre-biopsy MRI the use of further staging scans is not recommended. In those with unfavourable intermediate risk, routine use of further staging scans is not recommended. However a clinician may decide to do further staging investigations if there are clinical features that may increase a patient's individual risk following discussion at an multidisciplinary team (MDT) meeting.

In men with high-risk prostate cancer who are suitable for definitive treatment, PSMA (prostate-specific membrane antigen) PET-CT should be considered for primary staging. If PSMA PET-CT is not available within four weeks then conventional imaging, including an isotope bone scan, CT and MRI prostate (in those who have not had one to date) should be performed as an alternative with a view to proceeding to treatment.

In men with a biochemical recurrence of prostate cancer following primary treatment (surgery or radiotherapy), PSMA PET-CT should be considered if it will influence patient management following discussion at an MDT meeting. The timeframe to PSMA PET-CT will vary with different clinical circumstances and should be determined by the MDT. If PSMA PET-CT is not available within the timeframe recommended, then conventional imaging including an isotope bone scan, CT and MRI should be performed with a view to proceeding to treatment.

The guidelines recommend that all patients with suspected prostate cancer should have access to a clinical nurse specialist or advanced nurse practitioner, who, along with the urologist, should explain clinically significant and insignificant prostate cancer to patients. The team should also be available to patients to explain any necessary diagnostic tests and their results.

– Tara Horan

Reference

1. HSE National Cancer Control Programme. National Clinical Guideline Diagnosis and staging of patients with prostate cancer, 2022 (June)

The Pelgraz® Patient App

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Abbreviated Prescribing Information
Please refer to the Summary of Product Characteristics (SmPC) before prescribing **Pelgraz▼**(pegfilgrastim) **6 mg solution for injection in pre-filled injector. Presentation:** Each pre-filled injector contains 6 mg of pegfilgrastim* in 0.6 mL solution for injection. The concentration is 10 mg/mL based on protein only**. *Produced in *Escherichia coli* cells by recombinant DNA technology followed by conjugation with polyethylene glycol (PEG). ** The concentration is 20 mg/mL if the PEG moiety is included. **Indications:** Reduction in the duration of neutropenia and the incidence of febrile neutropenia in adult patients treated with cytotoxic chemotherapy for malignancy (with the exception of chronic myeloid leukaemia and myelodysplastic syndromes). **Dosage and Administration:** Pelgraz therapy should be initiated and supervised by physicians experienced in oncology and/or haematology. Posology: One 6 mg dose (a single pre-filled injector) of Pelgraz is recommended for each chemotherapy cycle, given at least 24 hours after cytotoxic chemotherapy. Safety and efficacy of Pelgraz in children and adolescents has not yet been established and no recommendation on a posology can be made. No dose change is recommended in patients with renal impairment, including those with end-stage renal disease. **Method of administration:** Pelgraz is for subcutaneous use. The injections should be given subcutaneously into the thigh, abdomen or upper arm. See SmPC for instructions on handling of the medicinal product before administration. **Contraindications:** Hypersensitivity to pegfilgrastim or any of the excipients in Pelgraz. **Warnings and precautions:** To improve the traceability of biological medicinal products, the trade name of the administered product should be clearly recorded. The long-term effects of pegfilgrastim have not been established in acute myeloid leukaemia (AML); therefore, it should be used with caution in this patient population. Granulocyte-colony stimulating factor (G-CSF) can promote growth of myeloid cells *in vitro* and similar effects may be seen on some non-myeloid cells *in vitro*. The safety and efficacy of pegfilgrastim have not been investigated in patients with myelodysplastic syndrome, chronic myelogenous leukaemia, and in patients with secondary AML; therefore, it should not be used in such patients. Particular care should be taken to distinguish the diagnosis of blast transformation of chronic myeloid leukaemia from AML. The safety and efficacy of pegfilgrastim administration in *de novo* AML patients aged < 55 years with cytogenetics t(15;17) have not been established. The safety and efficacy of pegfilgrastim have not been investigated in patients receiving high dose chemotherapy. This medicinal product should not be used to increase the dose of cytotoxic chemotherapy beyond established dose regimens. Pulmonary adverse reactions, in particular interstitial pneumonia, have been reported after G-CSF administration. Patients with a recent history of pulmonary infiltrates or pneumonia may be at higher risk. The onset of pulmonary signs such as cough, fever, and dyspnoea in association with radiological signs of pulmonary infiltrates, and deterioration in pulmonary function along with increased neutrophil count may be preliminary signs of Adult Respiratory Distress Syndrome (ARDS). In such circumstances pegfilgrastim should be discontinued at the discretion of the physician and the appropriate treatment given. Glomerulonephritis has been reported in patients receiving filgrastim and pegfilgrastim. Generally, glomerulonephritis resolved after dose reduction or withdrawal of filgrastim and pegfilgrastim. Urinalysis monitoring is recommended. Capillary leak syndrome has been reported after G-CSF administration and is characterised by hypotension, hypoalbuminaemia, oedema and haemoconcentration. Patients who develop symptoms of capillary leak syndrome should be closely monitored and receive standard symptomatic treatment, which may include a need for intensive care. Generally asymptomatic cases of splenomegaly and cases of splenic rupture, including some fatal cases, have been reported following administration of pegfilgrastim. Spleen size should be carefully monitored (e.g. clinical examination, ultrasound). A diagnosis of splenic rupture should be considered in patients reporting left upper abdominal pain or shoulder tip pain. Treatment with pegfilgrastim alone does not preclude thrombocytopenia and anaemia because full dose myelosuppressive chemotherapy is maintained on the prescribed schedule. Regular monitoring of platelet count and haematocrit is recommended. Special care should be taken when administering single or combination chemotherapeutic medicinal products which are known to cause severe thrombocytopenia. Sickle cell crises have been associated with the use of pegfilgrastim in patients with sickle cell trait or sickle cell disease. Therefore, use caution when prescribing pegfilgrastim in patients with sickle cell trait or sickle cell disease, monitor appropriate clinical parameters and laboratory status and be attentive to the possible association of this medicinal product with splenic enlargement and vasoocclusive crisis. White blood cell (WBC) counts of 100 x 10^9 /L or greater have been observed in less than 1% of patients receiving pegfilgrastim. No adverse reactions directly attributable to this degree of leukocytosis have been reported. Such elevation in WBCs is transient, typically seen 24 to 48 hours after administration and is consistent with the pharmacodynamic effects of this medicinal product. Consistent with the clinical effects and the potential for leukocytosis, a WBC count should be performed at regular intervals during therapy. If leukocyte counts exceed 50 x 10^9 /L after the expected nadir, this medicinal product should be discontinued immediately. Hypersensitivity, including anaphylactic reactions, have been reported with pegfilgrastim. Permanently discontinue pegfilgrastim in patients with clinically significant hypersensitivity. Do not administer pegfilgrastim to patients with a history of hypersensitivity to pegfilgrastim or filgrastim. If a serious allergic reaction occurs, appropriate therapy should be administered, with close patient follow-up over several days. Stevens-Johnson syndrome (SJS), which can be life-threatening or fatal, has been reported rarely in association with pegfilgrastim treatment. If the patient has developed SJS with the use of pegfilgrastim, treatment must not be restarted at any time. As with all therapeutic proteins, there is a potential for immunogenicity. Rates of generation of antibodies against pegfilgrastim is generally low. Binding antibodies do occur as expected with all biologics; however, they have not been associated with neutralising activity at present. Aortitis has been reported after filgrastim or pegfilgrastim administration in healthy subjects and in cancer patients. The symptoms experienced included fever, abdominal pain, malaise, back pain and increased inflammatory markers (e.g. C-reactive protein and WBC count). In most cases aortitis was diagnosed by CT scan and generally resolved after withdrawal of filgrastim or pegfilgrastim. The safety and efficacy of Pelgraz for the mobilisation of blood progenitor cells in patients or healthy donors has not been adequately evaluated. Increased haematopoietic activity of the bone marrow in response to growth factor therapy has been associated with transient positive bone-imaging findings. This should be considered when interpreting bone- imaging results. This medicinal product contains 50 mg sorbitol in each unit volume, which is equivalent to 30 mg per 6 mg dose. Pelgraz contains less than 1 mmol (23 mg) sodium per 6 mg dose, that is to say essentially 'sodium-free'. The needle cover contains dry natural rubber (a derivative of latex), which may cause allergic reactions. **Pregnancy and Lactation:** Pegfilgrastim is not recommended during pregnancy and in women of childbearing potential not using contraception. A decision must be made whether to discontinue breastfeeding or to discontinue/abstain from pegfilgrastim therapy taking into account the benefit of breastfeeding for the child and the benefit of therapy for the woman. **Adverse Events include: Adverse events which could be considered serious include: Common:** Thrombocytopenia. **Uncommon:** Sickle cell crisis, capillary leak syndrome, glomerulonephritis, hypersensitivity reactions (including angioedema, dyspnoea, anaphylaxis), splenic rupture (including some fatal cases), Sweet's syndrome (acute febrile dermatosis), pulmonary adverse reactions including interstitial pneumonia, pulmonary oedema and pulmonary fibrosis have been reported. Uncommonly cases have resulted in respiratory failure or ARDS which may be fatal. **Rare:** Aortitis, pulmonary haemorrhage, Stevens-Johnson syndrome. **Other Very Common adverse events:** Headache, nausea, bone pain. **Other Common adverse events:** Leukocytosis, musculoskeletal pain (myalgia, arthralgia, pain in extremity, back pain, musculoskeletal pain, neck pain), injection site pain, non-cardiac chest pain. See SmPC for details of other adverse events. **Shelf Life:** 3 years. Store in a refrigerator (2°C – 8°C). Pelgraz may be exposed to room temperature (not above 25°C ± 2°C) for a maximum single period of up to 72 hours. Pelgraz left at room temperature for more than 72 hours should be discarded. Do not freeze. Accidental exposure to freezing temperatures for a single period of less than 24 hours does not adversely affect the stability of Pelgraz. Keep the container in the outer carton in order to protect from light. **Pack Size:** One prefilled injector with one alcohol swab, in a blistered packaging. **Marketing Authorisation Number:** EU/1/18/1313/002. **Marketing Authorisation Holder (MAH):** Accord Healthcare S.L.U, World Trade Center, Moll de Barcelona, s/n, Edifici Est, 6a planta, Barcelona, 08039 Spain. **Legal Category:** POM. Full prescribing information including the SmPC is available on request from Accord Healthcare Ireland Ltd, Euro House, Little Island, Co. Cork, Tel: 021-4619040 or www.accord-healthcare.ie/products. **Adverse reactions can be reported to Medical Information at Accord-UK Ltd. via E-mail:** medinfo@accord-healthcare.com **or Tel:** +44(0)1271385257.
Date of Generation of API December 2019. IE-01454

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Adverse events should be reported. Reporting forms and information can be found on the HPRA website (www.hpra.ie), or by e-mailing medsafety@hpra.ie. Adverse events should also be reported to Medical Information via email; medinfo@accord-healthcare.com or tel:0044 (0) 1271 385257

May 2020. IE-01429

Supporting patients following bladder cancer surgery

Nurses have an important role to play in both psychologically and physically supporting patients who undergo ileal conduit formation due to bladder cancer, write **Breege Donegan** and **Liz Kingston**

GLOBALLY, bladder cancer is the most commonly occurring cancer of the urological system and the ninth most common cancer overall.[1,2] It is the second most prevalent urological cancer in the UK[3] and approximately 470 people receive a diagnosis of bladder cancer in Ireland every year.[4]

Bladder cancer treatment very often involves ileal conduit (IC) formation, which greatly affects quality of life. Quality of life is affected by this invasive life changing procedure. Nurses, in particular, are instrumental in educating patients and their families in the daily management of their new IC.[7]

Quality of life

The World Health Organization defines quality of life as a person's perception of their life, regarding their goals, standards and concerns, in consideration of the values and culture of where they live. Quality of life can be affected by individuals' psychological and physical health, environment, social support and personal beliefs.[5] Therefore, if a person experiences a deterioration in their health condition, for example, following cystectomy and IC formation, this can greatly affect various aspects of their life, leading to a suboptimal quality of life.[6]

This article highlights how the formation of an IC can affect a person's quality of life, in terms of their physical and psychological health, their social relations, their ability to return to work and their level of independence. The nursing profession is ideally placed to address quality of life issues among patients and to enable and support patients in adjusting to their IC.

Nursing interventions for IC management should incorporate education and support for body image perception, social distress, sexual wellbeing and returning to work, with the ultimate goal of empowering patients and improving patient outcomes and their overall quality of life.

Physical health and appearance is altered by the formation of an IC, and many patients experience functional impairments of various bodily systems as well as sensory changes, such as pain.[1,8,9,10,11,12]

Sleep patterns can be particularly affected. The presence of an IC negatively impacts sleep quality and overall quality of life.[1,8,13] Nursing advice regarding sleep hygiene should include information and support around the advantages of using a night drainage bag system and the positive impact this can have on improving quality of life postoperatively.

Psychological health is often negatively affected by the formation of an IC and this appears to impact on women more frequently than men.[14] The formation of an IC negatively affects body image immediately after surgery[12,13] and in the long-term with many attempting to conceal stomas.[12,13,15]

Quality of life would improve if patients were sufficiently psychologically supported in ways that would help them become independent in managing their stoma and adapting to their new situation.[9]

The lack of focus on the effects of a bladder cancer diagnosis on quality of life suggests the need for further research to explore the relationship between diagnosis, quality of life and coping. Qualitative research may be more conducive to eliciting such expressions of fears or concerns of recurrence as quantitative studies can limit respondents' potential to express their true anxieties or worries.

Social relations are negatively affected by having an IC in terms of personal relationships, social support and sexual activity.[1,8,10] Results suggest that strong social and family support is vital to ensuring optimal health following IC formation.[9] Changes to family life, socialising, avoiding communication and limiting or avoiding taking part in leisure or social activities were significant challenges reported by those living with an IC.

Issues regarding sexual functioning are associated with higher levels of distress, depression, anxiety and a poorer overall quality of life.[15,16] Unfortunately, those who undergo IC formation receive little or no professional help or support regarding sexual functioning.[17,18]

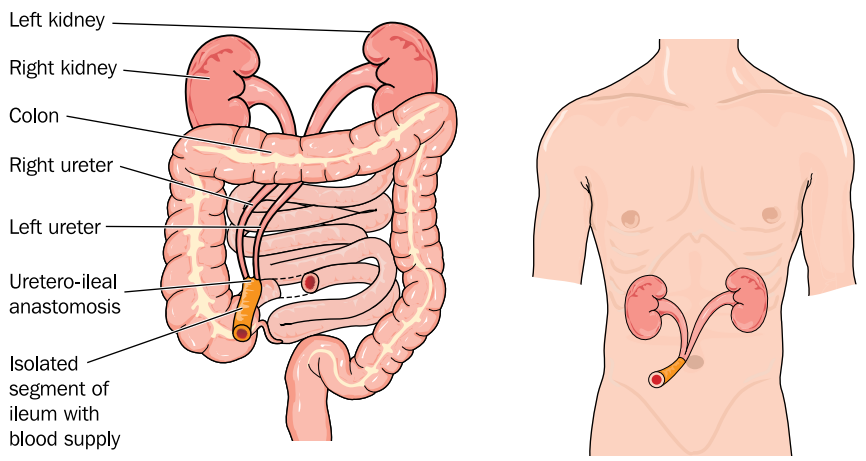
Role of the nurse

Greater awareness is needed among nurses of the importance of intimacy and sexual relationships in maintaining a good quality of life.[15,19] Nurses can open the conversation and allow the patient to feel comfortable and safe in raising these concerns. Adopting a multidisciplinary, interprofessional approach to this aspect of quality of life could prove useful.

As far back as 1990, most patients' level of independence and work capacity was negatively affected following an IC formation.[20] A review at this time identified that many respondents either left their jobs or reduced their working hours for reasons such as needing to care for the stoma, fears about concealment of the stoma and concerns about leakage and odour suggesting that little progress in improving quality of life related to work capacity has occurred over three decades.[8,9,10]

Participating in work is an important factor in achieving a satisfactory quality of life overall,[9] yet reported rates of those

Figure: Ileal conduit formation following full or partial bladder removal



continuing in employment post-operatively are low.[9,10] Nurses are well placed to support and educate patients so that they will have the necessary information and skills to adjust to this life-changing situation. Ideally, patient education begins on admission to hospital and continues throughout the patient's hospital stay. Nursing interventions may include referral to occupational therapists and physiotherapists for review and assisting patients further in their endeavours to return to optimal health and return to employment.[21]

Patients' environment, education, training and skill development is instrumental in promoting optimal health and gaining independence among patients.[1,9] Stoma care education is especially important and nurses play a vital role in assisting patients in becoming independent, adapting to life after a radical cystectomy and IC formation.[22,23] Lack of education and training negatively affects patients' abilities to care for their stoma independently[16] which negatively affects their psychological health and social relations.[1]

Conclusion

Key aspects of quality of life can be negatively affected by living with an IC. There is little focus on sexual wellbeing after this surgery, with much of the research focusing on the physical rather than the psychological or social impact.[15,19] Further research that focuses specifically on holistically addressing this important aspect of quality of life is needed.

Further qualitative research, capturing and analysing the patient narrative of living with an IC and its impact on quality of life, is warranted. This would strengthen the evidence base and enable the delivery of patient focused, holistic and appropriate healthcare based on patients' own perceptions of their needs, with the ultimate goal of improving quality of life outcomes following this life-altering surgery.

Nurses have an important role to play in supporting these patients both psychologically and physically.[24] Clinical nurse specialists and advanced nurse practitioners, who are specially trained in this field, are ideally placed to provide support and education [25] as well as referral to appropriate services if necessary. [21]

Competent nursing care that addresses psychological wellbeing as well as physical health is essential to good recovery, adjustment to living with an IC and to long-term acceptance[21] potentially leading to improved patient outcomes and quality of life.

Breege Donegan is a registered nurse and BioInnovate Fellow at the University of Galway and Liz Kingston is a registered nurse and senior lecturer at the University of Limerick

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Management of pleural disease – a new subspecialty

A team from Galway University Hospital gives an overview of the management options and associated complications of pleural disease

MANAGEMENT of pleural disease is an evolving and growing subspecialty within respiratory medicine. It includes the management of pneumothoraces, pleural infection and the assessment/management of benign and malignant pleural effusions. In addition, but to a lesser extent in the Irish setting, it includes primary malignancy of the pleural space.

Often, these conditions require an intervention such as diagnostic thoracentesis, therapeutic thoracentesis, intercostal chest drain insertion and medical or surgical thoracoscopy/video assisted thoracoscopy (VATS).[1] Cancer commonly manifests as pleural effusions, frequently caused by the spread of cancer to the pleural space. All cancers have been known to metastasise to the pleura but it is most commonly associated with breast cancer, lung cancer and lymphoma.[2]

Malignant pleural effusions (MPEs) always represent advanced disease and are frequently associated with a poor prognosis. Recurrent malignant effusions result in burdensome respiratory symptoms and have a significantly negative affect on quality of life for cancer patients. Therefore, rapid pathways to allow assessment, investigation and management can offer significant benefits to patients with advanced malignancy ensuring independence and access to ambulatory care.

The management of recurrent malignant effusions has evolved over the past decade with the emergence of indwelling pleural catheters (IPCs) now occupying a central role in the management of MPE. An alternative approach to management uses talc, either as a talc slurry via a chest drain or as a talc poudrage, at the time of thoracoscopy/VATS. However, in contrast to talc pleurodesis, the use of an IPC is associated with fewer hospital days from treatment to death.[3]

The ongoing AMPLE-3 trial will compare outcomes in MPE management with IPC versus VATS. The primary outcome will determine the number of repeat procedures required at 12 months with secondary outcomes being the impact on hospital stay and quality of life.[4]

Management options

Patients with MPEs may experience severe dyspnoea, coughing and chest pain, which negatively affects their quality of life.[5] The management of pleural effusions will depend on the underlying cause and the patient presentation. Reasons for pleurodesis via a chest drain or thoracoscopy versus IPC insertion is dependent on clinical factors. These include the presence of expandable lung following drainage and the patient/clinician's preferences and experience.

The insertion of an IPC is symptom driven but additional factors must be considered. These include the patient's performance status, their expected survival, their lung expansion and symptomatic improvement following previous pleural interventions. While complications with an IPC insertion are rare, they do occur in some 2.8-6% of procedures.[3]

An IPC can be inserted as an ambulatory day-case procedure reducing the need for prolonged hospital stays. IPC insertion offers patients and their families independence as they can perform drainages in their own time and in their own homes.[6] IPC insertion decreases the risks associated with repeated pleural aspirations. It also lessens hospital admissions and offers patients improved quality of life.[6]

Barriers and complications

Procedure-related complications are generally acute with the same profile and frequency of other more standardised pleural interventions. These may include pneumothorax, subcutaneous emphysema, bleeding and infection.[1,7]

Pneumothorax is rare with IPC insertion and the chest radiograph features as seen post insertion are a manifestation of an underlying trapped lung and so called pneumothorax *ex-vaceo*.

IPC complications

- Blockage
- Site infection
- Catheter fracture
- Loculations
- Chest pain
- Catheter migration
- Pleural infection
- Seed metastasis

Localised skin infection at the exit site of the IPC, cellulitis, tunnel infection and empyema are the most common infections reported in IPCs.[7] In general, cellulitis can be managed with oral antibiotic treatment in the outpatient setting.

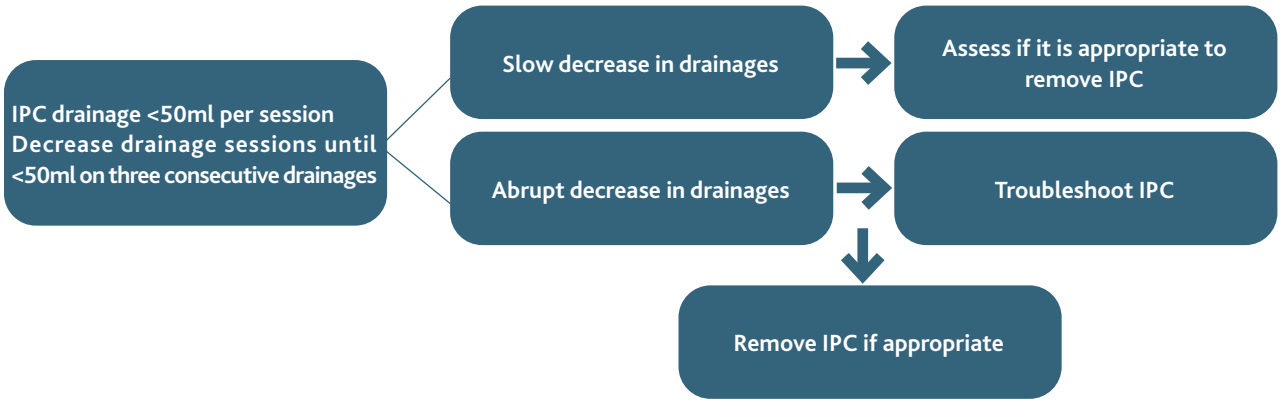
An empyema will require intensive drainage and antibiotic treatment. If this fails, removal of the IPC and insertion of a chest drain is recommended.[7] Tunnel infections manifest in swelling, hardening of the soft tissue and tenderness extending beyond 2cm from the drain insertion site.[7]

Tract metastases are a rare complication and occurs when cancer cells travel along the subcutaneous tract established by the catheter. They occur in less than 5% of cases and are more commonly associated with mesothelioma.[1] There is no longer a role for prophylactic tract radiotherapy.[8]

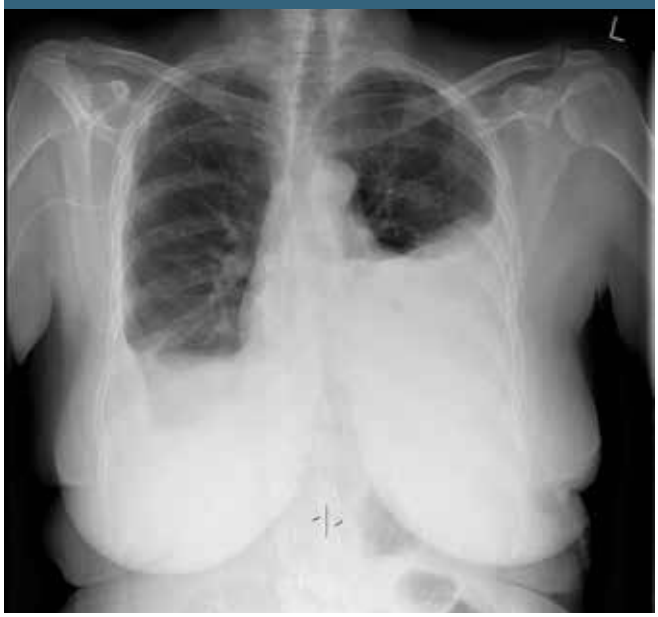
Loculations occur in 14% of patients. The build-up of fibrinous materials causes pocketing and loculations that inhibit the removal of fluid. Fibrinolytic therapy may be used for symptomatic relief, though the effect may be temporary.[6]

A non-draining IPC may be indicative of pleurodesis or drain blockage/associated complication. Therefore, a comprehensive patient review should be undertaken to include symptom assessment and chest imaging particularly if drainage ceases

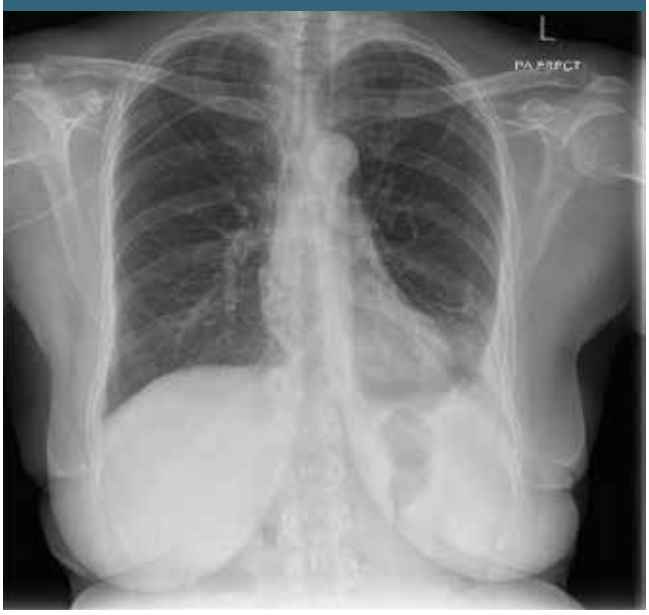
Algorithm for IPC removal



Pre-IPC insertion



Post-IPC insertion



suddenly. However, the listed complications above are infrequent and removal of IPCs secondary to these occurs in less than 10% of patients.[4]

Definitive management of malignant pleural effusions (MPEs) can have a significant positive impact on the patient's symptom burden. It's feasible that in the future, fresh cutting edge methods will be created to enhance the quality of life for individuals with MPEs.

ANP role in IPC

Advanced nurse practitioners (ANP) are in a prime position to play a pivotal role as a case worker in the management of IPCs. This is through education, clinical review and drain management. Therefore, their influence can help to minimise the risk of infections and IPC complications. IPC drainages are typically performed by carers and education requires a multifaceted approach.

The ANP supports patients and carers by providing educational packs, videos and practical demonstrations. The ANP's goal is to ensure a streamlined and stress free experience for the patient and carers.[2,6] These patients require regular follow up, even in the absence of catheter related concerns, frequency of follow up is determined on an individual basis.[3]

The ANP becomes the point of the contact for all patients, with reviews being carried out in person or via virtual platforms. Virtual platforms may include apps that allow the patient or carer to input data in real time and generate a report to their healthcare provider.

An IPC for the management of recurrent MPEs can support patient goals, including shorter hospital stays, ambulatory care and ensuring good symptom management in the community, especially at end of life.[6]

Helen Mulryan and Donna Langan are advanced nurse practitioners and Derek Nash (locum) and David Breen are respiratory consultants at Galway University Hospital

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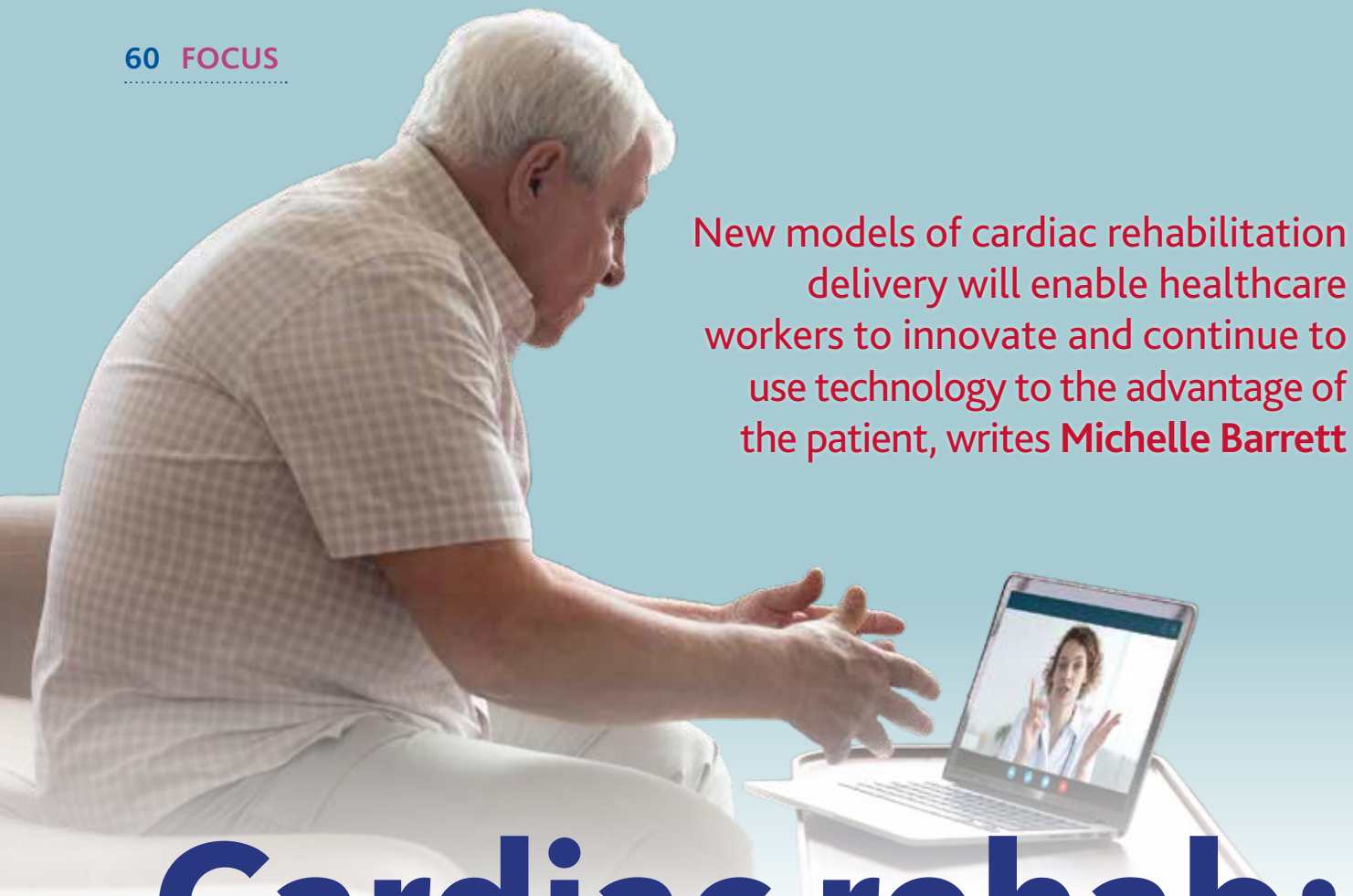


New models of cardiac rehabilitation delivery will enable healthcare workers to innovate and continue to use technology to the advantage of the patient, writes **Michelle Barrett**

Cardiac rehab: The future is hybrid

COVID-19 affected all aspects of life in Ireland. As a result of the pandemic, all but strictly necessary hospital visits were halted while most scheduled hospital admissions and outpatient activities were cancelled or postponed. The restrictions had an immediate and dramatic impact on cardiac rehabilitation (CR), which has traditionally been provided in group-based outpatient clinics in hospitals and community settings. Similar affects were felt on a global scale with most countries reporting the closure of their CR programmes.[1]

Throughout the pandemic, the health service focus shifted to treating and preventing the spread of Covid-19 infections. For many months CR staff were redeployed to help support testing and tracing services and in providing essential care for Covid-19 patients. As the understanding of Covid-19 deepened and treatment pathways developed, other services including CR resumed. However, the provision of CR services could not revert to the old ways of doing things and CR programmes had to adapt to provide services remotely. Healthcare providers rapidly transitioned to technologically delivered services (telehealth), making it possible for patients to participate in CR from the safety of their own home.

Pandemic accelerated change

While there are a number of definitions of telehealth, it is essentially the delivery of healthcare through technology such as mobile phones or computers. Telehealth encompasses virtual appointments, smartphone apps, remote monitoring as well as online education and use of telephony generally.

Telehealth can provide a high quality service, increase access to care, increase self-awareness and empower patients to manage their chronic conditions.[2] There are also organisational benefits to using telehealth that include a reduction in missed appointments and decreased waiting times.[2]

Prior to the pandemic, Ireland had been relatively slow to adopt telehealth but was forced to reconsider methods of service delivery when face-to-face consultations became impossible. In the past, healthcare has been slow to change and required extensive study over lengthy durations before changes are adopted.[3] However, telehealth is not a new phenomenon and prior to the pandemic has been used successfully in Australia, Canada and the UK.[3] In addition, it has also been widely evaluated and shown to deliver success rates equal to traditionally delivered centre-based CR.[4]

The pandemic led to a rapid expansion of telehealth use within the Irish health services.[5] The health service "underwent probably the most radical transformation in its history" throughout the pandemic with "the adoption of new technology… unprecedented".[5] For example, healthcare providers began using the Attend Anywhere platform, which facilitates live video conferencing across a secure network, while text messaging and phone calls became the default mode of communication between staff and patients.

Interventions that successfully promote patient uptake and adherence include activity self-monitoring, action planning and tailored counselling by CR staff,[6] all of which can be provided using telehealth.

Heart disease and stroke prevention charity Croí pivoted to an online CR

delivery, which required the creation of a new interactive platform. This allowed participants to access their programmes from home and included videos, online resources and live Zoom sessions.

Croí's recent report on the outcomes of their innovative digital programme found it delivered significant improvements for participants.[7] The evaluation showed impressive results, with a 74% uptake and an 84% retention rate, and highlighted that physical activity levels increased almost six-fold while anxiety and depression levels halved.[7]

These results are encouraging. Telehealth could inform and shape services with similar programmes scaled up to provide CR throughout the country. As with all new services, thorough evaluation is needed and specific resources will be required. It will also be important to listen to what patients think of these services as their views will reveal where improvements are required.

Specific considerations in remote CR

In adopting new technologies and integrating telehealth practices into CR, it is important that adequate consideration is given to what works best when providing CR remotely.

Assessment and treatment plans

All CR patients undergo a baseline assessment and receive an individualised treatment plan. Baseline assessment of exercise capacity is crucial to effective, safe delivery of exercise interventions. While the pandemic demonstrated it is possible to perform the initial patient introduction and evaluation remotely when necessary, it may be preferable that this should be centre-based to maximise safety and patient wellbeing. Participants may be more confident after an initial in-person testing and assessment and may be more motivated having met their CR providers.[8]

As telehealth practices evolve, it is important that treatment plans continue to be individualised and include similar content to that provided by centre-based CR. This plan must address lifestyle modification (smoking cessation, nutritional counselling and physical activity) and medical risk factor management (blood pressure, lipids and glucose).

An individualised plan could still be developed using standardised electronic templates that allow option selections or freeform text and then shared electronically with patients. With activity trackers and smartphone apps readily available, exercise can also be prescribed remotely. Patients can exercise at home without specialised equipment, performing squats, sit-to-stands and wall push ups. These exercises can easily be demonstrated using pre-recorded videos which patients can replay as necessary.

Home-based CR plans can be adapted as required but are arguably most suitable for patients at low to moderate risk.[9] With the risk of a serious cardiac event due to exercise extremely rare during CR, many patients can be given exercise programmes to do on their own. However higher risk patients may need supervision in real time, either using live video conferencing or a centre-based programme.[10]

A one-size-fits-all technology solution is unlikely to meet all needs and the available new technologies should be introduced in ways that maximise their potential while being cognisant of their limitations.

Distant, not isolated

Increased reliance on technology comes with a risk of isolation. The pandemic resulted in large scale social distancing, working from home, prohibition of large gatherings and stay at home orders. Social isolation has been associated with anxiety, anger and stress, all of which can lead to unhealthy lifestyles, including reduced physical activity and an unhealthy diet.[1]

Outpatient CR programmes encourage social interaction and motivation, which improves the psychological wellbeing of participants. This may be even more important following the isolation brought by the pandemic. Patients benefit from peer-to-peer encouragement and the camaraderie found in group participation.

Recognising the importance of social connection as an essential part of CR, online group sessions for education and patient support could be offered. However, social connection cannot be entirely addressed by Zoom classes and CR staff will need to carefully consider how this sense of community can be fostered in an online environment. Croí My Sláinte reported participants enjoyed accessing pre-recordings in their own time and then valued coming together in a peer supported environment for an interactive discussion.[7]

While the success of initiatives such as 'Parkrun' and 'Men on the Move' point to the popularity of group based activities, there are some for whom group work is off putting and who may benefit more by exercise undertaken in the privacy and safety of their own home. Technology offers alternatives, not the ultimate solution, and choice is essential.

Integrating online resources

When designing an online programme, healthcare professionals must direct patients to evidence-based information, since there is an abundance of unreliable health information available online. The Irish Heart Foundation (IHF) provides a support line, staffed by specialist cardiac nurses. It also provides downloadable health information booklets as well as counselling and peer support groups. The IHF is committed to providing a website that is user friendly and accessible to the public, regardless of technological ability. The Irish Association of Cardiac Rehabilitation and Croí provide educational videos on essential CR topics on their websites. Incorporating these resources could provide the backbone of a telehealth CR programme.

Increasing access

Telehealth may improve access and participation in CR as can be seen in the Figure. This is important as only a minority of eligible cardiac patients are referred to and complete CR. There are many reasons for this including limited capacity, low referral rates, patient specific factors (age, gender, socioeconomic status) and practical issues.[11] Some of the practical issues identified for low uptake include lack of time to commit to weekly centre-based programmes, exacerbated by long commutes and transportation issues. In this regard the possibilities for telehealth programmes are obvious. Using innovative telehealth, patients who previously would typically not participate may be reached.

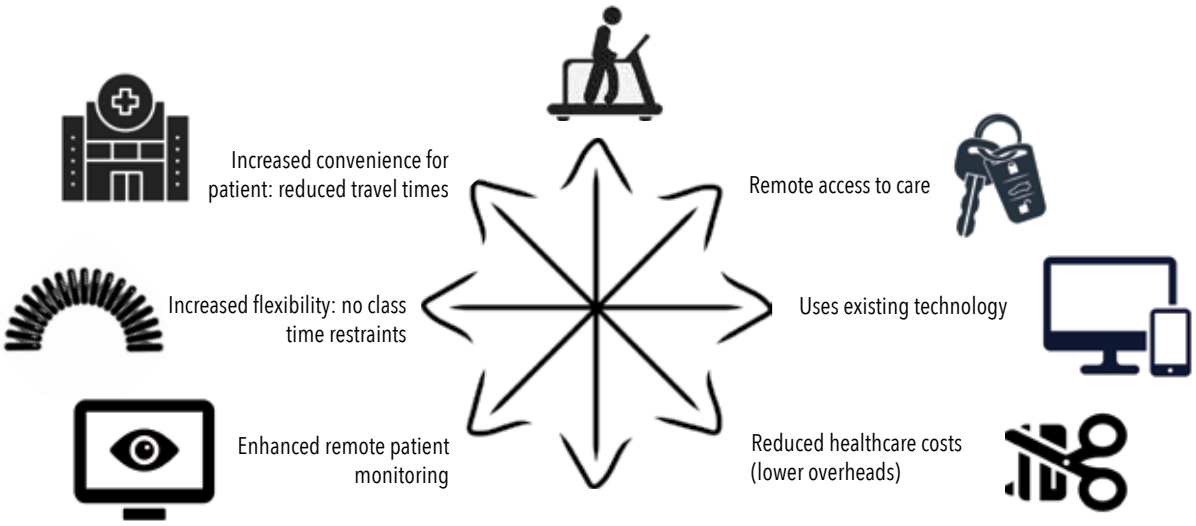
There are currently lengthy waiting lists for CR which causes significant enrolment delays. This is of concern as participants benefit most when CR is initiated early. In June 2021, Dr Angie Brown of the Irish Heart Foundation warned that "Lifesaving rehabilitation for heart patients is at an absolute crisis point in Ireland as no hospital has a full team in place".[12]

The waiting list crisis worsened during the pandemic and was further exacerbated by staffing issues with over 2,800 people waiting for support.[12] With resources stretched and staff capacity low, telehealth can have greater scope to allow more people to access CR programmes. Once the programme is devised, it can scale up to deliver to larger numbers of participants.

Moving Forward

The reluctance to adopt telehealth has been partly due to a belief that patients will not accept this method of healthcare delivery and a perceived lack of patient

Figure: Virtual cardiac rehabilitation advantages [13]



confidence with technology. It was thought that technology may be beyond the reach of much of the older population who were less likely to own a smart phone.[14] However by early 2017, up to 90% of Irish adults had smart phones.[15] If supported, patients of all ages can engage with telehealth if they have access to a device and internet.[7] Older people demonstrated both a willingness to engage with telehealth and indeed even expressed a preference.

The future is hybrid

One learning from the pandemic is that technology can deliver solutions but not all the answers. If healthcare providers become over reliant on telehealth, they may overlook those for whom face-to-face interventions are required. By offering choice to cater for individual preferences and by using hybrid approaches, CR has the potential to engage those previously harder to reach populations without creating new exclusions. In today's always on society, the public want to access at times they chose and in ways that suit them. Therefore, greater flexibility in how CR is delivered should lead to better adherence with more patients empowered to take control of their own care.

Future healthcare providers

Those with the healthcare knowledge today are unlikely to be those who design and maintain the technology needed. When considering how technology is integrated into the day-to-day environment, it will be important to consider who and how material and processes can be adapted as best practice evolves. Redesigning the educational requirements for CR staff needs to be considered for the long-term while current practitioners will need a level of upskilling.

Conclusion

Healthcare providers must respond and adapt to the ever changing environment, although the pace of change in Ireland has lagged behind when it comes to implementing digital strategies. The pandemic forced healthcare providers to reconsider how they deliver CR and drove a rapid exploration of innovative methods and approaches.

Much progress will be lost if healthcare providers revert to old ways of working and they must be enabled to continue to innovate and develop new models of service delivery, making most appropriate and best use of technology. This change in mind set will allow proper consideration of how services can be delivered to a greater number of people needing to access CR in a cost effective manner.

Adopting telehealth approaches could increase capacity in the system, reduce wait times and help address extensive CR waiting lists. CR telehealth is acceptable, effective, feasible and safe. The technology is already available and easily accessible. Indeed, using telehealth practices may overcome some of the existing barriers to participation in CR and offers a unique opportunity to engage CR patients in new ways.

Nevertheless, telehealth should supplement rather than replace old models of care. It cannot and should not be expected to fully replace face-to-face consultations. We must look back at the lessons learned from the pandemic in order to be able to move ahead, improving and adapting life-saving CR services ensuring they are fit for purpose to meet 21st century needs.

Michell Barrett is a cardiology nurse with an MSc in palliative care

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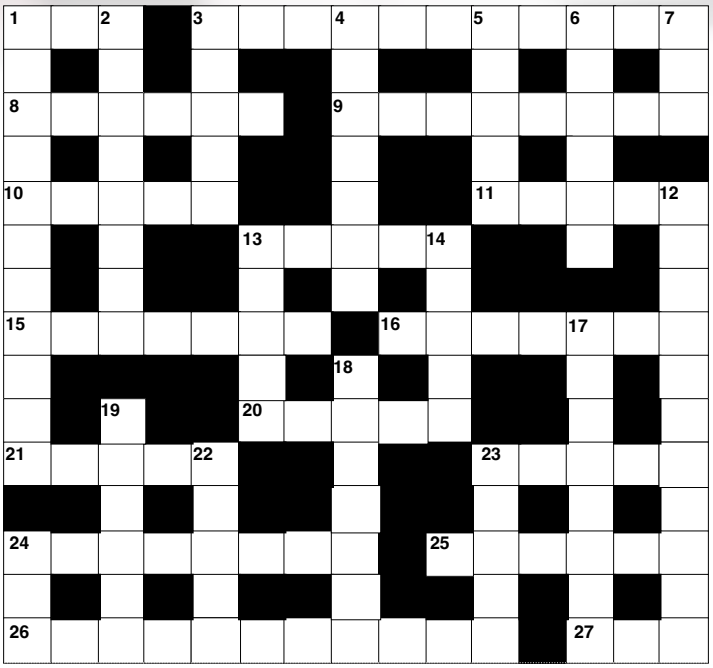
CROSSWORD Competition

Across

1 Cut off a floppy-eared rabbit? (3)
3 Arctic ships, or activities to get the party going (11)
8 She's a man-eating monster (6)
9 Relied (8)
10 Misgiving (5)
11 Small fish usually followed by mackerel (5)
13 Abyss (5)
15 Famous knight from the court of King Arthur (7
16 Pain in the ear makes the goat ail, perhaps (7)
20 Central European - with a money order, by the sound of it (5)
21 Broken piece of pottery (5)
23 Instruction that gets Leonard to play slowly (5)
24 The state capital of Hawaii (8)
25 Musketeer who accompanied Porthos and Athos (6)
26 Let me try Jordan out for an animated cat and mouse pairing (3,3,5)
27 Produce an egg (3)

Down

1 Regard with spiteful aspect (4,7)
2 Country of the Algarve (8)
3 One picture placed inside another (5)
4 Traditional Irish percussion instrument (7)
5 Helps move the beast (5)
6 Put up with, undergo (7)
7 Mr Millar played rugby for Ireland with some classy distinction (3)
12 Composer of the 1812 Overture (11)
13 Mock-Irish word for entertainment and fun (5)
14 Many yearn to abscond from school (5)
17 & 18 Lazier guardsmen suffering with a tonic-clonic episode (5,3,7)
19 Double-sized wine bottle (6)
22 Nobel Laureate Bob uses some trendy language (5)
23 Truck (5)
24 Strike (3)



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You can email your entry to us at **nursing@medmedia.ie** by taking a photo of the completed crossword with your details included putting *'Crossword Competition'* in the subject line. Closing date: **November 28, 2022.**
If preferred you can post your entry to: WIN Crossword, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Dublin A96E096

October crossword solution

Across: 1 Cap 3 Regulations 8 Teacup 9 Grouting 10 Hiked 11 Hindu 13 Ticks 15 Run down 16 Corkage 20 Rooks 21 Epoch 23 Woman 24 Hip flask 25 Iguana 26 Belly button 27 Eat

Down: 1 Catchphrase 2 Plankton 3 & 13d Round tower 4 Urgency 5 Tough 6 Onions 7 Sag 12 Unrepentant 14 Shows 17 Adam's ale 18 Tool kit 19 Compel 22 Hilly 23 Wigan 24 Hob

The winner of the October crossword sponsored by Affordable Live-in Homecare is:
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NEW

INMO Community Intervention Teams National Section

Members who wish to join this recently established national section are asked to please email **membership@inmo.ie**.

For those working in CIT and interested in getting involved please contact: membership@inmo.ie

Strengthening mental health nursing workforce key to improving care

ICN publishes new report on mental health nursing workforce

NURSES form the largest number of providers in mental healthcare services (44%) across the world and are responsible for the delivery and coordination of the majority of patient care. Faced with rising demand for mental health and substance use services, coupled with shortages of nurses, especially those prepared with specialised mental health skills, the International Council of Nurses (ICN) developed a report to assist governments, policy makers, nursing associations, nursing educators and workplaces to review and develop the mental health nursing workforce.

ICN president Dr Pamela Cipriano said the report provided valuable insight: "Too many people are simply unable to get the care and support they need for mental health conditions. The erosion of mental health is considered by many as the flashpoint for the next pandemic, with one in eight people in the world living with a mental health disorder. As nurses form the largest part of the mental health workforce, the key to transforming mental healthcare lies in strengthening the mental health nursing workforce. It's essential to reverse the underinvestment in mental health and substance use services to reduce the disease burden for individuals and restore social and economic stability that has been threatened even more through the pandemic."

To gather the information for this seminal report, the ICN, with the assistance of mental health nursing experts from across the globe, developed a survey which was completed by mental health nurses, specialist mental health organisations, ministries of health and experts in the area of mental health across 44 low-, middle- and high-income countries.

Survey respondents indicated that there are multiple reasons why there are insufficient numbers of mental health nurses, including: poor planning and regulatory environments; limited incentives to pursue a career in mental health; inadequate education preparation; lack of reward; and the lingering stigma attached to mental health.

The report concluded that if mental health needs are to be addressed appropriately, there needs to be targeted strategies and investment in the mental health nursing workforce. The ICN strongly advocates for the investment of further education and professional development in mental health nursing so as to support individuals and communities to achieve the highest attainable standard of health and wellbeing.

INMO launches 2022 'Pink and Blue Power' campaign to raise awareness of breast and prostate cancer among members

INMO Executive Council members at the launch of the 2022 Pink and Blue Power campaign with general secretary Phil Ní Sheaghdha and Cornmarket staff.

The INMO launched its 2022 Pink and Blue Power campaign recently, alongside the Organisation's partners, Cornmarket. Pink and Blue Power – a potentially life-saving breast and prostate health assessment and education programme – was launched in response to a high level of cancer claims, with seven INMO members being diagnosed with breast cancer in 2019. The aim of the campaign is to increase awareness of the signs and symptoms of breast and prostate cancer to promote early intervention, with a once-off clinical physical breast or prostate exam. Where further investigation is required, a referral to a participating private hospital is arranged for a mammogram, ultrasound, MRI and/or biopsy, managed by participating consultants in the Galway Clinic, Beaumont Private Clinic and Bon Secours Private Hospitals in Cork, Galway and Dublin, with up to 18 consultant urologists, radiologists and breast surgeons on the panel.

Breast cancer is one of the most common cancers in Ireland, with one in nine women diagnosed during their life. Some 15% of women diagnosed with breast cancer are aged between 20 and 40 years of age. Prostate cancer is the second most common cancer among men in Ireland, with one in seven men diagnosed with prostate cancer during their life.

Speaking at the launch of the campaign, INMO president Karen McGowan said: "We are delighted to be in a position to offer this free breast and prostate health assessment programme, in association with Cornmarket, to members of the INMO Income Protection Scheme. We are particularly happy to be giving some care back to the carers, our members working on the frontline, with all the associated stresses. We will be inviting members to take part over the coming weeks."

November

Thursday 3
International Nurses Section meeting. 5pm at the Richmond Education and Event Centre

Thursday 10
SALO Networking Group meeting. 12pm at the Richmond Education and Event Centre

Saturday 12
PHN Section webinar. See *page 6* for full details

Monday 14
Nurse Midwife Education Section meeting. Online from 12.30pm

Thursday 17
All Ireland Midwifery Conference in Cavan. See *page 28* for details

Saturday 19
School Nurses Section online meeting. Includes a talk on indemnity cover

Thursday 24
Assistant Directors Section webinar. 11am online

Saturday 26
National Children's Nurses Section webinar. From 11am online

Monday 28
Retired Nurses Section seminar. Richmond Education and Event Centre. Booking essential. Email education@inmo.ie or call 01 6640618/41 to book at a cost of €20

Wednesday 30
CPC Section meeting. Online at 11am

December

Saturday 3
Special Education Nurses Section meeting. 10am online

Saturday 3
Midwives Section meeting. 10am online

Tuesday 6
Orthopaedic Section meeting. 4pm via Microsoft Teams

Saturday 10
PHN Section meeting. 10.30am online

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

INMO Membership Fees 2022

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

Condolences

- INMO membership, staff and management were deeply saddened to hear of the death of popular nurse Devi Prabha Sreeraj who worked in Midland Regional Hospital Portlaoise. We offer our sincere condolences to her family, friends and colleagues at this difficult time. May she rest in peace.
- The INMO would like to offer condolences to Kathleen and Roisín Dalton, INMO members in the Brothers of Charity, Foynes and St John's, Limerick on the death of their father and grandfather Joe O'Connor who died recently in his 93rd year. He will be sadly missed by all in his extended family. May he rest in peace.

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for Nurses

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AGENDA

Hypertension Management

Padraig Denn, CNMIII

Acute Coronary Syndrome – a Case Presentation

Nadeesh Kuvil, CNMII

Atrial Fibrillation – The Importance of Patient Education

Lorena Rosalejos, CNS & Fionnuala Seaver, CNS

Heart Failure – Classifications and Management

Susi Gnanaraj, CNS

Pacing Settings

Ana Laura Correia, Cardiac Physiologist & Tania Silva, Chief 2 Cardiac Physiologist

Q&A and Panel Discussion

Moderated by Tim Rees, CNMII

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Mater Private Network

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

Irish Cancer Society Night Nurses

The Irish Cancer Society are seeking Registered General Nurses who can provide a minimum of 6 nights per month and have some palliative experience. Training will be provided.

- Job description on **www.cancer.ie**
- Email CV to **recruitment@irishcancer.ie**
- Informal enquiries to Amanda on 01-231 0532

Irish Cancer Society

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

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