€5.75 Vol 26 No 3 April 2018

WIN

World of Irish Nursing & Midwifery

INMO
Journal of the
Irish **Nurses** and
Midwives Organisation

Latest INMO CPD education programme
page 29

ED crisis continues to deepen
page 8

Your photos: Commuting in the snow
page 8,11

Mandatory reporting of abuse
page 25

CPD: Treating burns
page 37

Members deliver

24/7 cover continues throughout red alert

NEWS & VIEWS

FEATURES

CLINICAL

LIVING

JOBS & TRAINING

WIN – World of Irish Nursing & Midwifery is distributed by controlled circulation to **more than 35,000** members of the INMO. It is published monthly (10 issues a year) and is registered at the GPO as a periodical. Annual Subscription: €155 incl. postage paid. Editorial Statement: *WIN* is produced by professional medical journalists working closely with individual nurses, midwives and officers on behalf of the INMO. Acceptance of an advertisement or article does not imply endorsement by the publishers or the Organisation.

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

(ISSN: 2009-4264)
Volume 26 Number 3
April 2018

WIN,
MedMedia Publications,
17 Adelaide Street,
Dun Laoghaire,
Co Dublin.
Website: www.medmedia.ie

medmedia publications

Editor Alison Moore
Email: alison.moore@medmedia.ie
Tel: 01 2710216

Production & news editor Tara Horan

Sub-editor Fodhla McCarthy

Designers Fiona Donohoe, Paula Quigley

Commercial director Leon Ellison
Email: leon.ellison@medmedia.ie
Tel: 01 2710218

Publisher Geraldine Meagan

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

INMO
Irish Nurses and Midwives Organisation

Editor-in-chief: Phil Ní Sheaghdha

INMO editorial board:
Martina Harkin-Kelly; Mary Leahy; Margaret Frahill; Frances Cullen; Kay Garvey; Mary Gorman; Karen McGowan

INMO editor: Ann Keating
Email: ann.keating@inmo.ie

INMO editorial assistant: Freda Hughes

INMO photographer: Lisa Moyles

INMO correspondence to:
Irish Nurses and Midwives Organisation,
Whitworth Building,
North Brunswick Street,
Dublin 7.
Tel: 01 664 0600
Fax: 01 661 0466

Email: inmo@inmo.ie
Website: www.inmo.ie

www.facebook.com/irishnursesandmidwivesorganisation

twitter.com/INMO_IRL

Our fortitude must not be taken for granted

THE difficulties posed by the snow, impassable routes to work and overnight stays in work, demonstrated the fortitude of INMO members and other frontline employees over the past number of weeks as they faced the challenges with good will, good humour and selflessness. The additional strain on the health system was in the context of an already seriously overcrowded hospital system, with a predictably sharp attendance increase to an all-time, unwelcome, record of 710 admitted patients without a bed on March 12, 2018.

The INMO was quick and forthright in defending the right of members to be treated fairly if unable to attend work. This resulted in the Health Minister intervening and confirming penalties would not be imposed on those unable to attend work due to conditions outside of their control.

We know that when unexpected events occur frontline staff, including nurses and midwives, display a core commitment to the delivery of services regardless of the circumstances. This demonstrates a level of fortitude that is often taken for granted. The level of inter-agency co-operation and good humour displayed in assisting staff to get to work, assisting staff to get home from work and generally supporting personnel needed to provide care in difficult circumstances, was remarked on time and again by INMO members. However, this experience has shown that the level of planning to get staff to work and provide for their needs at work in conditions such as those just experienced, must be improved considerably.

Every day, demanding situations are presented to health service staff, leading to increasing pressure to discharge patients earlier, to provide care to very sick patients in the community and to improve turnover times – and all this in an era when staffing shortages are widespread in the nursing and midwifery workforce. The collective camaraderie that was evident during the recent storms is not a once off; it is demonstrated daily as nurses and midwives provide support to each other and to other health professionals.

While this camaraderie is necessary in the workplace, it is the responsibility of the employer to provide formal debriefing and support in difficult periods. This support must include clear and unambiguous commitment to develop a plan with trade unions on how staff will be communicated with, catered for and accommodated in extreme weather conditions. The INMO was critical of the approach taken by the HSE in respect of Storm Emma and, alongside other health service unions, we are now in a process of developing protocols for similar events in the future.

We view supporting members at times of adversity as an extremely important part of our role. The INMO recently made a presentation on the implementation of the Maternity Strategy to the Oireachtas committee on Health. One of the committee members asked who supported midwives when they are subjected to panels of enquiry and investigations post adverse events? We were proud to say unequivocally "we do". The representatives of the HSE present concurred that INMO support in the workplace and at proceedings was evident, and that the employees gained most support via the INMO.

The policy decisions and commitment of previous, and current, Executive Councils to ensure the provision of high quality professional services, industrial relations services, and legal and counselling services to INMO members as an integral part of membership is unwavering, unstinting and wholly necessary. The requirement for the employment environment to be supportive and non-punitive in challenging times is essential to allow camaraderie and good will, described earlier, to flourish.

The theme of the 2018 ADC is '*Innovation in Practice – Nurses and Midwives Leading the Way*'. I look forward to meeting delegates next month and hope we will have a lively, informative and successful event.

Phil Ní Sheaghdha
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

State of play

SINCE my last column we had the 'Beast from the East' and Storm Emma bringing Siberian conditions across the country. Despite the elements, our members' unselfish dedication was the stuff of legend with many facing adverse weather conditions to go on duty (*see page 8 & 11*). As your president, I want to humbly convey gratitude on behalf of the Organisation. I am so proud of your resilient actions and proud to be a nurse. Please note that following intervention by the INMO, public sector employees who worked during the red weather warning will receive full pay and time off in lieu. Those who could not make it to work due to the weather situation will be paid as normal. Please ensure that you do not have annual leave deducted in respect of this weather event. We are awaiting clarification on private sector and section 39 employees. In recent weeks the health service has faced some challenging circumstances to say the least; there were over 100 deaths from flu and an increase in those admitted with measles, not to mention the record-breaking March 12 trolley figure of an astounding 714 patients nationally left to languish on trolleys. This figure is the equivalent of the bed capacity of one of the large Dublin teaching hospitals.

Inaugural education seminar at the Richmond

YOU will have read in the March issue of *WIN* that Valentine's day saw the first official educational seminar in the newly refurbished Richmond. I was truly honoured to be the sitting president witnessing and participating in the occasion, that returns the corridors therein, to nurses and midwives once again, after 117 years. The event could not have happened without the stalwart dedication and attention to detail of Elizabeth Adams, director of the Richmond Education and Events Centre, who progressed the vision of former general secretary Liam Doran, to become a reality. The president and Executive Council of 2012/14 who took the bold decision to purchase the distinctive red-brick complex for €2.9 million, during austere times, must be acknowledged. Education has always been one of the core provisions of the INMO for its members and the event commemorated an educational seminar held in the Richmond Hospital some 80 years earlier by the then INO. Professional development education programmes for members will now take place in an innovative, flexible, responsive, caring and welcoming environment, that will accommodate a variety of adult learning styles that encourages learners to present their opinions while respecting the views of others. If you are in Dublin, don't forget this is a members' building – your building – so please call in to visit and make use of its amenities.

Care of the Older Person annual conference

WITH topics including advanced care directives, role expansion, burnout, wound dressings, the role of the advanced nurse practitioner, fitness to practise and pensions, this was indeed a conference that was relevant and timely with issues that nurses working in older person services deal with daily. As always, I was honoured to have been asked to address the conference by the Section officers: Caroline Gourley, chair; Margot Lydon, vice chair and secretary of the Castlebar Branch; Noreen Watts, secretary and former Executive Council member; and Eileen O'Keeffe, education officer and chair of the Cork ADC organising committee. My address cautioned that the increases in societal elderly cohorts will greatly compound the impact on demand. This is not simply about increasing beds, as additional resources – most importantly nurses and midwives – are required to staff these beds and will form the basis in brokering the National Workforce Plan 2018, as a means of addressing the ongoing recruitment and retention crisis.

ICTU Women's Conference

This event fell foul of the adverse weather and is to be rescheduled for July 2018 in the Killyhevlin Hotel Enniskillen. More information will follow.

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

Quote of the month

"When the going gets tough, the tough get going" – Billy Ocean

Report from the Executive Council

THE Executive Council met on March 5 and 6. The stance taken by the HSE to penalise those who could not get to work during the red weather alert by deducting annual leave was condemned by the Executive Council and was strenuously pursued by the general secretary and management team. This resulted in a statement by the Health Minister rescinding the stand taken by the HSE.

With just one Executive meeting in April remaining before ADC on May 2-4, preparations are being finalised. Standing Orders Committee met to review and group the 47 motions up for debate at ADC. This is also a rule change year, with one rule change in from Care of the Older Person Section. The format of ADC this year has undergone some reconfiguration to ensure that the programme is inclusive and sets the tone for the theme *'Innovation and Practice – Nurses and Midwives Leading the way'*.

The Executive commemorated International Women's Day on March 8 with a photograph outside the Richmond, under the theme of 'Bread and Roses', selected as the theme arising from the struggle of female textile workers in the US that gave rise to the day.

The adjudicators reached agreement on this year's CJ Coleman Award winner which will be presented on the Thursday night of ADC.

Centenary plans continue and we now have a fully representative geographical committee. Your input will be sought at ADC. The Editorial Book Committee met to finalise the centenary book before it goes to print. A huge debt of gratitude is owed to Mark Loughrey for his writing skills. The history of our union over the past 100 years has been preserved for the future.

Get in touch

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

March 4: INMO calls for declaration of emergency period in health service

THE INMO called for the first two weeks of March to be declared, and treated, as an emergency period in the Irish public health service.

The Organisation was extremely concerned about the pressures that were brought to bear on the service following the emergency weather conditions.

This concern arose from three main points:

- The extended period of severe weather would create a delay to discharges and a backlog of patients scheduled for admission for elective procedures
- INMO members, and many other front-line staff, worked tirelessly and for extended periods, and would need rest periods. Rosters would need to be re-arranged to accommodate this, which in turn, would reduce available staff for services in the short term
- INMO records show the trolley count for February 2018 was 19% higher than the same time last year, with 10,772 patients waiting on trolleys for an inpatient bed, indicating that hospitals were already overburdened before the adverse weather event began.

On March 4, 2018 INMO general secretary Phil Ní Sheaghdha called for the following two weeks to be given emergency status. "This means extraordinary measures should be put in place to focus on recovering from the adverse weather event, ensuring prioritisation of emergency care. This will require all non-urgent and routine cases to be cancelled during this period.

While welcoming the HSE statement that cancellations would be in place for all routine elective cases on March 5, she said this must be extended. "In this crisis all measures to properly resource and staff the health service must be explored and the assistance of services in the private acute hospitals must also be sought."

Ms Ní Sheaghdha continued: "The dedication to duty of all healthcare staff, our nurse and midwifery members, medical and ambulance staff, and the examples of co-operative working between the civil defence, army and Gardaí in ensuring staff got to work and were able to deliver health care in very difficult circumstances, is a true example of selflessness and pride in the job they do every day.

"This is to be commended and the INMO now requires the employer to ensure practical appropriate plans are in place to cope with the aftermath of this crisis."

The INMO is in discussions with the HSE on the planning in place for this adverse event and is calling for agreed protocols for events of this nature that may occur in the future.

March 9: Record breaking 3,112 on trolleys in a week as INMO repeats call for emergency period

THE INMO recorded over 600 patients on trolleys, in hospitals around the country, every day in the week March 5-9. At that point there had been 14 days so far this year that saw in excess of 600 patients on trolleys, as compared to 2017, when this occurred on only three occasions in the entire year.

The INMO renewed its call for a two week period in March to be declared, and treated, as an emergency period in the Irish public health service, meaning that extraordinary measures should have been put in place to focus on recovering from the extreme weather event.

INMO general secretary Phil Ní Sheaghdha said: "We saw record trolley figures this week, as predicted by the INMO, due to pressures on hospitals following Storm Emma. The INMO requested an emergency two-week period which the HSE was not willing to implement.

"This massive surge in attendance at EDs was predictable and known to the HSE. Any reasonable and responsible employer and service provider would have sought by any means available to minimise these risks to patient and staff safety. It is not possible for the hospitals, or staff, to continue to provide safe care under these conditions. The INMO is calling for emergency status to be immediately declared and emergency response plans put into operation."

INMO heroes during red weather alert

Team from Saoirse unit, Clonakilty Hospital

Members of the medical team in Tallaght Hospital with some of the local heroes that volunteered to ferry them to nearby hotels and homes before and after their shifts

ED nurse, Celine O'Rourke, making her way to Mullingar Hospital

March 12: Crisis beyond comparison

Highest trolley figures ever recorded, as situation worsens in EDs

THE INMO recorded 714 patients on trolleys in acute hospitals on March 12, 2018. University Hospital Limerick had the highest number of admitted patients with a total of 80 on trolleys at 8am that morning.

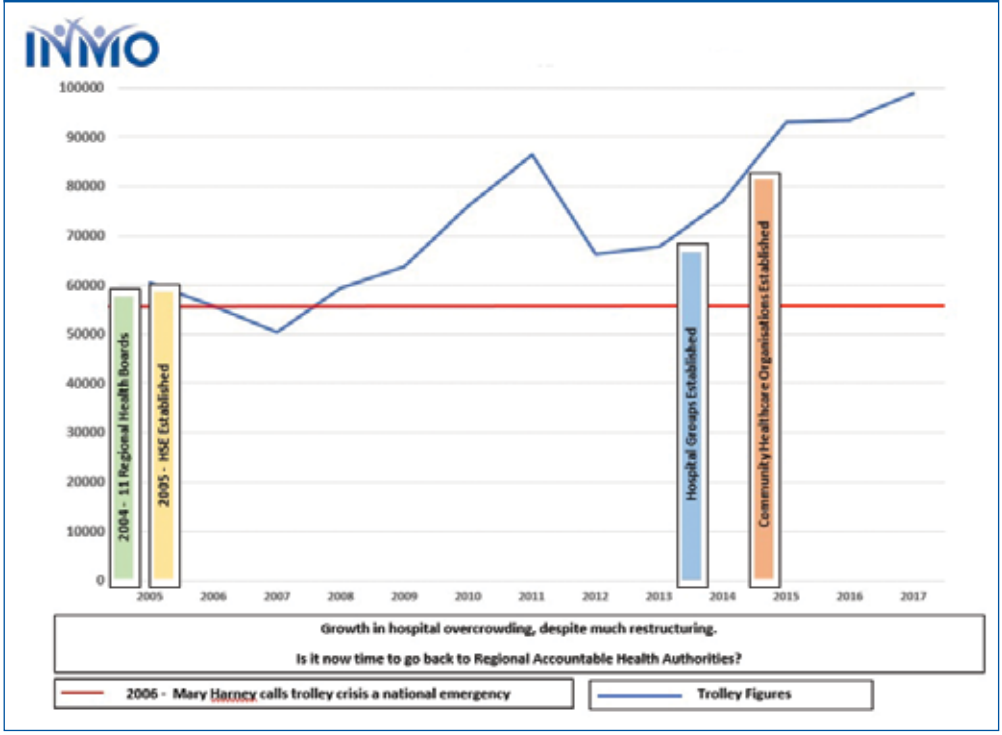
The INMO has repeatedly called for a two week period in March to be declared, and treated as an emergency period in the Irish public health service, meaning that extraordinary measures should have been put in place to focus on recovering from the extreme weather event.

In this crisis all measures to properly resource and staff the health service must be explored and the assistance of services in the private acute hospitals must also be sought. The Organisation also said that ensuring prioritisation of emergency care also required all non-urgent and routine cases to be cancelled during this period.

INMO general secretary Phil Ní Sheaghdha said: "We saw record trolley figures in the first week of March with a total of 3,112 in just one week and yet each daily total from that week was surpassed by the extraordinary figure of 714 admitted patients on trolleys on March 12. This upsurge was predictable and the INMO warned against inaction or insufficient action in the wake of Storm Emma. It is unfortunate for both healthcare staff and patients that these warnings were not heeded and that emergency measures sought were not put in place. The INMO, yet again, called for emergency status to be immediately declared and emergency response plans put into operation."

A meeting of the ED Taskforce took place that afternoon, at which the INMO raised this issue as a priority which could not wait any longer to be addressed *(see page 10)*.

INMO Annual Trolley and Ward Watch figures 2005-2017



March 20: Overcrowding crisis not over – 500 patients on trolleys

THE INMO trolley/ward watch figures for Tuesday, March 20 showed that 500 patients were waiting for an inpatient bed in hospital. This included 342 waiting in emergency departments around the country and 158 inappropriately placed on already full wards. In addition, there were three children waiting for a bed in Temple Street Hospital, Dublin.

This figure is an increase on Friday, March 16 before the bank holiday weekend, when there were 470 on trolleys plus 13 children awaiting a bed.

University Hospital Limerick had the highest number with 66 patients waiting for a bed, followed by St Luke's Hospital, Kilkenny with 42 and University Hospital Galway with 41.

Speaking on March 20, INMO general secretary, Phil Ní Sheaghdha said: "As predicted the trolley figures are on the rise again following the Bank Holiday weekend. Hospitals are still in crisis and we are now calling on the HSE to continue curtailment of services to ensure figures do not escalate again this week and to allow hospitals deal with the current high numbers.

"The INMO has sought confirmation that all hospitals are adhering to the escalation policy and will be advising again on the health and safety obligations of the employer in situations where workplaces are overcrowded and pose risks to staff."

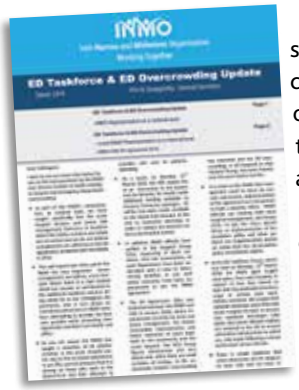
Staffing/skill mix taskforce phase II

Phase two of the ED Taskforce on Staffing and Skill Mix is due to take place on March 22, 2018 and revised draft assumptions will be considered. The issue is that there is no funding in the Service Plan for 2018 to fund roll out. This matter will be discussed via a motion at the INMO annual delegates conference in May.

INMO pushing on at national level to address ED overcrowding crisis

As part of its drive at a national level to address hospital and ED overcrowding, the INMO has sought specifically that the HSE Acute Hospital Division intervenes in hospitals where the trolley numbers are simply out of control, and where local management is not adhering to the ED Agreement of 2016.

This requires site visits, which the INMO has requested. HSE management must intervene where there is a clear breach that has caused, or contributed to, additional volumes of inpatients being cared for in EDs. This places extraordinary pressures on INMO members attempting to provide the best care possible while protecting their registration and their own health and safety.



The INMO sought a cessation of all electives in the acute hospital sector, due to the high level of attendance in EDs and the pressure this places on staff in the departments.

As a result, on Monday, March 12, 2018, the HSE issued an instruction throughout the system for electives to cease and the Minister for Health made additional funding available to increase homecare packages. €5 million was made available to the HSE Social Care Division to accelerate discharge in order to release the pressure on the acute hospital system.

In addition, INMO officials wrote to Hospital Group CEOs, requesting evidence that risk assessments had been undertaken of each department, to determine whether staff safety measures had been implemented as per the 2016 agreement.

Where implemented correctly, the ED Agreement brokered between the INMO and the HSE in January 2016 has made remarkable improvements and better use of extra beds, both in community and acute hospitals. RCSI Group figures clearly demonstrate this and hospital overcrowding has improved and ED overcrowding in all that group's hospitals has been halved in the past year.

The INMO is clear that management needs to focus on precise implementation of the agreement. INMO officials are meeting both local hospital management and Group CEOs to get the focus placed firmly on implementation of the escalation policy and, when patients are inappropriately placed on wards, that the de-escalation policy immediately applies.

At the ED Taskforce Forum on March 12, 2018, the INMO again sought clear plans from each hospital on how they intended to deal with the predicted surge of activity post bank-holiday weekend. The Organisation sought that national directives issue from the Acute Hospital Division to ensure that weekend discharges took place and that senior decision makers were rostered in all EDs.

There is evidence that some admissions are for diagnostic tests only and the INMO has requested that HSE and Group CEOs deal with this immediately by ensuring fast-tracking of diagnostics to avoid unnecessary admissions.

INMO IROs will be advising the reps in each ED of the HSE's response, hospital by hospital, to the issues the Organisation has raised with it. Specific clarifications sought include:

- In light of the persistent, gross overcrowding in your hospital, can you please advise the plan/policy in relation to bed utilisation across the region?
- In addition we seek the policy relating to the utilisation of level 2 hospitals for all day surgery and day diagnostic procedures
- What policy was put in place within the Hospital Group for the utilisation of beds to assist patient flow in the region? When was this most recently reviewed and can you advise of the outcome of said review?
- When was the most recent risk assessment on the effects of these appalling working conditions, on nursing staff, and the outcome of same?

The INMO has notified the director of the Acute Hospital Division, Liam Woods, that in the event that risk assessments determine the environments to be unsafe, the Organisation expects management to fulfil obligations under the Safety, Health and Welfare at Work Act by implementing immediate measures to alleviate the risks posed to staff and that not doing this has consequences under that legislation.

The INMO recognises that this is a very difficult working environment for members and our aim is to maintain focus on this by continuing to highlight the issues in the media and by continuous direct dialogue with employers.

Members are urged to advise IROs if any of the above measures are not being implemented, who will in turn demand intervention by employers.

– Phil Ní Sheaghdha,
INMO general secretary

ED Agreement clearly states:

"During periods of escalation, the provision of good clinical care will continue to be a key priority. In circumstances where staff have not been enabled to deliver this care in a timely manner in line with established clinical protocols, examples of which are set out below, management reiterate that staff will not be held personally accountable for system risks over which they have no control. We have a shared concern that care is provided in a timely manner including items listed below:

- *Manchester triage system*
- *MEWS protocol for sepsis*
- *Head Injury*
- *Administration of medication*
- *Non-delivery of fundamentals of care*
- *Follow up Investigation results*
- *Paediatric protocols to include Children First guidance, PEWS, discharge planning, parental education.*

"To the extent that there is delay in this area, it will be a call for immediate decision by management and collective implementation in order to reduce the risk. To the extent that these issues persist, further escalated action will be required by management. It is anticipated that concerns in this area would be raised by nursing staff in writing or verbally with management.

"And due cognisance will be taken by management of the conditions under which staff are working which will include the level of staffing for the level of activity.

"And, it is agreed that the activation of Step 1 in the Escalation Plan simultaneously recognises that the workplace is evolving into an unsafe environment with a heightened level of risk."

Staff to be credited for Ophelia work

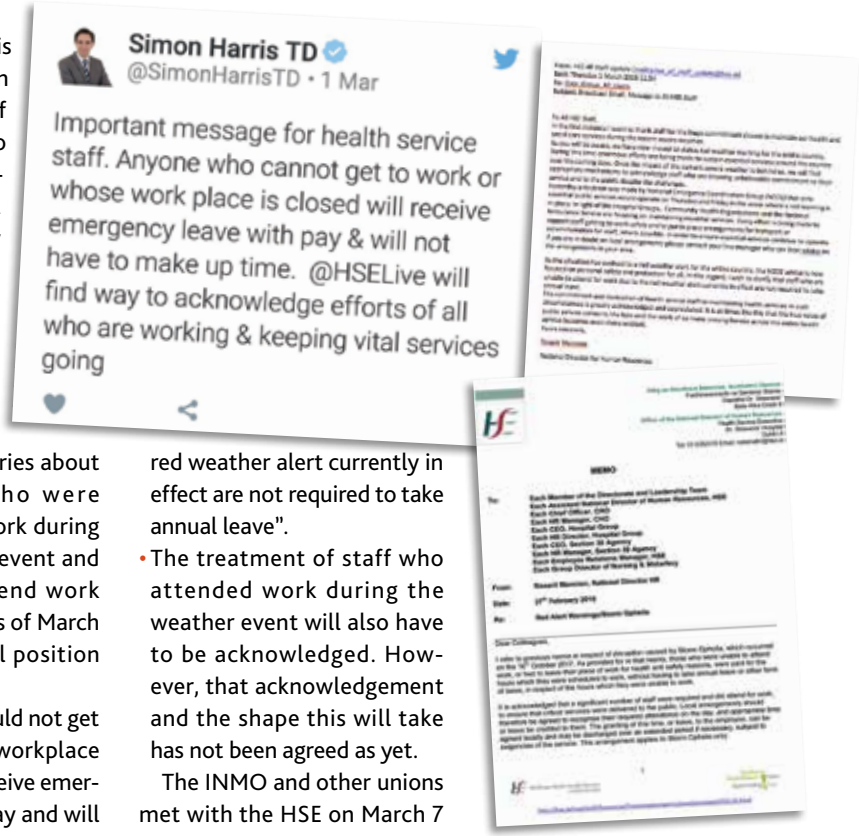
INMO calls for standard procedure for future red alert events

THE heroic efforts and sacrifices made by nurses and midwives during the recent adverse weather events made headlines during early March, just as it was during Storm Ophelia in October 2017. On February 27, 2018, Rosarii Mannion, HSE national director of HR, confirmed in a memo that staff would receive time credited to those who attended work during Storm Ophelia.

The INMO wrote to Rosarii Mannion, outlining that while the INMO welcomed that matters have been addressed regarding Storm Ophelia, there were still issues outstanding with regards to future red weather warning events.

In particular, the INMO did not accept the HSE's position as outlined in the HR memo of February 27, 2018, that staff must take annual leave days if they cannot attend for health and safety reasons.

INMO interim director of industrial relations Tony Fitzpatrick stated that this matter remained in dispute and requested a meeting with Ms Mannion to discuss this matter further. Subsequently, Health Minister Simon Harris and Ms Mannion confirmed that staff "who cannot get to work or whose workplace is closed will receive emergency leave with pay and will not have to make up time".



Following Storm Emma, there has been a considerable number of enquiries about how members who were unable to attend work during the recent weather event and those who did attend work should be treated. As of March 6, 2018, the factual position was as follows:

- Any person who could not get to work or whose workplace was closed is to receive emergency leave with pay and will not have to make up the time
- This was clarified by the Minister for Health, Simon Harris on March 1, 2018 and also confirmed by Rosarii Mannion, national director of HR in a communication to all staff on the same date, which stated: "Staff who are unable to attend for work due to the red weather alert currently in effect are not required to take annual leave".
- The treatment of staff who attended work during the weather event will also have to be acknowledged. However, that acknowledgement and the shape this will take has not been agreed as yet.

The INMO and other unions met with the HSE on March 7 and again on March 14 to discuss this issue and to begin the process of negotiating a standard operational procedure should weather events of this nature occur in the future.

Mr Fitzpatrick has written to the national directors of HR for Section 38 organisations seeking that they adopt the terms applied by the HSE, as it is the INMO's position that the rules that apply in the HSE should be applied in Section 38 organisations.

Members who work in Section 39 organisations and the private sector who are experiencing difficulty should contact the INMO.

INMO heroes during red weather alert

The orthopaedics team made it to work at University Hospital Galway

Rolly Paclibar, member of staff from Connolly Hospital

Galway ICU nurse, Niamh Cunningham, being escorted from Gort to UCHG by Civil Defence driver, Tom

Ciara O'Flynn received assistance from the coastguard in West Cork to get home after three night shifts in a row at Cork University Hospital

Pauline Keenan, CNM2 and Karen Craig, staff nurse, working in ICU, Navan, thanks to the help of Meath River Rescue

Leona Casey from University Hospital Waterford being escorted by local services

Staff from Connolly Hospital helping one another in and out of the snow filled car park

Progress slow on Maternity Strategy

INMO outlines unacceptable slow progress on implementation

AN INMO delegation outlined its concerns about slow progress to the Oireachtas Joint Committee for Health on the implementation of the National Maternity Strategy last month.

In January 2017 the INMO appeared before the Oireachtas Committee and welcomed the launch of Ireland's first National Maternity Strategy *Creating a Better Future Together, 2016-2026.*

The INMO Midwives Section particularly welcomed the recognition, within the Strategy, of the need to give pregnant women appropriate and informed choices about their care during pregnancy, supported by access to the correct level of care and support for their individual needs.

However, one year on, the INMO outlined its concern that progress in implementation is very slow. In a submission to the committee, the Organisation said that no further midwifery led-units have been developed despite the positive feedback surrounding this model of care.

Likewise, the development of community midwifery services remains at planning stage – recommendation 41 of the strategy covering a hospital outreach community midwifery service was due to be fully implemented in Q1 2018; this has not occurred.

Arising from a recommendation in the Report of Maternity Services in Portlaoise General Hospital, directors of midwifery have been appointed to all maternity units/hospitals (19 in total). It is important to note that the post of 'director of midwifery' has a remit that spans both the maternity hospital and the adjoining community services in the context of implementing the Maternity Strategy.

***INMO Oireachtas delegation** (l-r): Mary Gorman, Executive Council member, Phil Ní Sheaghdha, INMO general secretary, and Mary Leahy, first vice-president, at the Dáil where they outlined the INMO's concerns about the slow progress on the implementation of the Maternity Strategy one year on*

The INMO believes that the hospital group structure must provide for the same policy and governance at group level for midwifery services, as is the case for general services. Therefore, the appointment of 'group directors of midwifery' are a necessary national driver for policy and governance changes. The implementation plan published in October 2017, which the INMO was briefed on, set out a plan for the establishment of a maternity network within each Group as a priority and stated specifically that by Q2 2018 a maternity network governance structure would be in place with a network manager, clinical lead, midwifery lead ,and quality and patient safety lead clearly identified.

Discussions have not taken place with the INMO yet in relation to the national governance model. The INMO believes that midwifery services would benefit from a national governance model in the same way in which general hospital governance is enhanced by the national role of 'group directors of nursing'.

The INMO is becoming increasingly concerned at the slow pace of implementation of the strategy and with the low midwife to birth staffing ratios that continue to exist in this country.

The accepted midwife to birth ratio, which arises from evidence based practice, is one midwife to 29.5 births. The Strategy committed to the introduction of this ratio, over a number of years.

As part of the 2017 funded workforce plan, the HSE committed to increasing the staff midwifery numbers from the December 2016 census figure by 96 whole time equivalent (WTE) posts at December 2017. The most recent figures presented to the INMO by the HSE in late January 2018, show that the overall number of staff midwives has fallen by 16 WTE in 2017 (from 1,461 WTEs in December 2016 to 1,445 WTEs in December 2017).

The HSE confirmed that 63 WTE midwives were recruited during this period, however the numbers leaving the service outpace recruitment significantly.

The reality is that the maternity services are severely understaffed and, from the experience of the INMO, there is a funding barrier to realistic workforce/manpower planning starting at undergraduate level and continuing at post graduate level, in all aspects of planning.

Midwifery is a profession that requires continuity of staffing levels and it is a concern that the highly pressurised environments in which midwives work do not lend themselves to retention of staff. The pay for midwives is modestly low for the responsibilities held. The Public Service Pay Commission is currently looking at the barriers to recruitment and retention in nursing and midwifery in Ireland and the INMO made a detailed submission to this body, demonstrating the fact that Ireland is currently the lowest paying country for nurses and midwives of the five main international recruiter competitors.

Ireland is currently unable to retain or recruit sufficient numbers of nurses and midwives to continue to provide safe levels of service to the current model of care delivery. A major improvement in relation to pay and recruitment and retention planning, is required to improve midwifery staffing levels and provide sufficient numbers for the expansion and development of services such as those envisaged by this strategy.

INMO GS addresses IRN conference

"ALL need to feel the benefit of the recovery and trade unions will have failed if we don't achieve that", said INMO general secretary Phil Ní Sheaghdha, speaking at the annual IRN conference in Dublin last month. This conference hears from different perspectives, including unions and managers across the public and private sector and politicians.

"It is our role to ensure that those who took the hit see the benefits, especially those who lost their jobs and whose jobs have been hit by lesser conditions of employment," she said, stressing that the most important thing for unions is that they work together. The most important thing is that we pool our resources in matters of social interest".

On collective bargaining, she said this must mean having equal strength. For employees to have the right to bargain without a right to strike, effectively amounts to "collectively begging", she said. Moreover, she believes that on collective bargaining we fall short of what the European Court of Human Rights deems appropriate.

She said there is a school of thought that trade unions shouldn't have a role in terms of dialogue in national matters. However, she believes that the government's National Economic Dialogue (NED) and the Labour Employer Economic Forum (LEEF) have the potential to be more than an exchange of views. There is no reason why IBEC, ICTU and the government should not have a forum to discuss how matters that are important to the Irish economy play out, she said.

Locally, she said that the orderly management of issues in dispute is a challenge. She acknowledged the importance of independent state dispute resolution bodies, but said that sometimes the "people on the other side of the table", especially in health, "do not have the authority to reach settlement".

On the INMO, Ms Ní Sheaghdha says it is still recovering from the employment moratorium, with staffing levels today at 2,000 below the 2007 level, despite activity levels having jumped.

On retention, the current key issue for the INMO which is being formally reviewed by the Public Service Pay Commission, she said that 250 more nurse managers left since 2016, and although 2,573 staff nurses were taken on, 2,271 had left.

Ms Ní Sheaghdha also addressed pay inequality across health professionals, which she said was leading to emigration and difficulties in recruiting from overseas. The union wants to see 2,600 extra acute beds depending on reform, 190 critical care beds and a substantial increase in beds for care of the older person, all of which require a serious investment in nursing/midwifery recruitment and retention measures.

Finishing her presentation, Ms Ní Sheaghdha compared 2008 nursing and midwifery salaries to today's rates, asking "Is anyone is surprised they are leaving?" A staff nurse on Point 1 of scale in September 2008 earned €31,875 (€16.28/hour) compared to €28,768 (€14.13/hour) in January 2018, and on Point 5 of scale €38,256 (€19.55/hour) in 2008 €34,531 (€16.96/hour) today.

Tony Fitzpatrick, INMO interim director of industrial

National ballot of PHN members

THE INMO conducted a national ballot of public health nurse members on the recently negotiated changes to the PHN transfer panel process, with the results of the ballot due as we went to press.

The changes would make the transfer panel more efficient and effective. All PHNs were balloted as all are eligible to apply for a transfer.

The main changes proposed are that the PHN will identify one geographical area of choice.

Panellists will receive an expression of interest notification solely for the geographical area chosen. If a post becomes vacant in that geographical area, it will be offered to the highest-ranking person on the geographical area panel.

Believing that this proposal is more efficient and should speed up the process of PHNs securing a transfer, the INMO advised members to vote in favour of accepting these changes to the transfer panel.

Under the revised transfer agreement, it is built in that the release of transferees will be governed by Circular 001/2015 and in such circumstances, a transfer applicant should not be unduly frustrated if a suitable approved vacancy arises.

Should the ballot be successful and the changes implemented, an exercise will be conducted to facilitate as many transfers as possible with the positions left vacant being backfilled by student allocation.

ID Expert Group – disability network manager posts

The INMO Intellectual Disability Expert Group continues to meet monthly, with this month's discussions focused on disability network manager posts. I have been in contact with Jackie Nix who is taking on the role of assistant national director of HR on the Community Operations Team.

I outlined the INMO's difficulties with what was happening within ID services, and Ms Nix accepted that the HSE should have engaged with the INMO at an earlier stage.

There was a discussion on the need for recognition of the role of nursing within children's disability services. Ms Nix committed to a direct meeting between the INMO and the HSE on disability services, due to take place at the end of March 2018.

Members of the INMO ID Expert group will be in attendance at the RNID National Conference on March 22, 2018 in Portlaoise. See next month's *WIN* for an update.

National review of weekend working underway

As reported in last month's *WIN*, the HSE is undertaking a national review of weekend working throughout the service. At a meeting in November 2017 regarding the arrangements in place for weekend working, the INMO outlined that the current fee per case system was not fit for purpose and significant numbers of PHNs and CRGNs were not making themselves available for weekend cover.

Members should note that the 1975 and 1981 circulars do not require PHNs to provide weekend cover – they have first preference but may opt out of weekend work if they so wish. This is backed up by Labour Court Recommendations with regard to same. Furthermore, the Dublin arrangement clearly outlines that PHNs will be facilitated to withdraw from weekend working in line with those circulars.

On March 7, 2018 the INMO met with the HSE again on this issue, where I outlined clearly to the employer that our members will refuse to work weekends if more attractive arrangements are not put in place with regard to weekend cover. The INMO has proposed that an agreement similar to the Dublin arrangement be introduced in all regions.

At the meeting management indicated that it is willing to amend the present essential calls/on-call fee per case arrangement for PHNs to a more sustainable and suitable arrangement. However, management said it had difficulties with elements of the Dublin agreement and wishes to examine the issue of clinical governance at the weekends.

It was also agreed that the INMO would examine, in detail, the discussion document presented at this meeting and would forward its proposals to the HSE, with supporting documentation, by March 23, 2018. A further meeting on this issue is scheduled to take place on April 11, 2018 at INMO HQ.

Transfer of tasks for social care – NVIG site visits

THE National Verification Implementation Group (NVIG) met on February 27, 2018 to review the site visit process regarding task sharing in the medical/nursing interface in services for older persons and intellectual disabilities. The process has now concluded. Further data was received from local implementation groups (LIGs) in advance of the final meeting.

The verification process is to decide on the payment of 50% of retrospective payments, awarded by the independent chairperson. Also, before July 2018, the second verification process must be completed to establish if the final 50% of retrospective payment is to be made.

Site visits have been concluded in Sligo, Cork, Mullingar, Kilkenny and Dublin. A number of locations had not paid the time and one sixth due from July 1, 2017. This has now been corrected in CHO 2, 3, 4, 5 and Section 38 organisations.

It is now confirmed that the 50% retrospection will also be approved and that members will therefore receive the time and one-sixth payment for the period February 1, 2017 to July 1, 2017.

relations, reports on current national IR issues

Update on fixed travel and subsistence issues

THE INMO, along with other healthcare unions of the National Joint Council, met with management on March 5, 2018 in relation to fixed travel and issues regarding subsistence.

Fixed travel

Management is seeking to end the practice of fixed travel being paid mainly to employees in the East, CHO 6,7,9, Midlands and South.

At this stage fixed travel has been removed from most staff within the HSE, however, approximately 690 staff are still in receipt of fixed travel. The HSE was contacted by Revenue with regards to this practice and must pay liability of up to €180,000 a year, because of non compliance detected in the 15% auditing process. To comply with Revenue, HSE will require all of those in receipt of fixed travel to complete the same claims documentation as staff on normal mileage. Therefore, the HSE is seeking that staff in these locations would simply do the standard mileage and eliminate the need for fixed travel.

It was agreed at the WRC that Paul Byrne, Corporate Employee Relations Services, would issue a detailed proposal to the union side on this. The unions will then engage with their relevant members affected by the proposal and revert to the chair Aoibheann Ní Shúilleabháin, to reconvene conciliation.

Subsistence

The issue of subsistence is covered by Circular and the National Financial Regulations. However, there are significant anomalies at play within the HSE with regards to the application of this. It appears that these anomalies are down to individual managers interpretation of the circular and NFR. It was agreed that a specific meeting would be convened between the staff panel and HSE representatives (including finance and HSE tax division) to examine these anomalies and to agree a correct and uniform application of the rules.

ODN Section highlights issues of major concern

AT A meeting with the INMO Operating Department Nurses Section in February, members outlined many concerns which the Organisation must investigate and address.

The issues included: staffing levels, excessive on-call, inadequate sleep time, the numbers of staff on call, unacceptable risk due to excessive activity out of hours, staff turnover within operating departments, inadequate controls around theatre activity and the unavailability of intensive care beds resulting in intensive care patients being cared for in the recovery area of theatre for excessive periods.

It is clear that many operating departments are not consistently applying Department of Health circular 33/2003 on on-call arrangements.

To examine the matter in greater depth, I, and INMO IROs, will be in contact with operating departments throughout the country. It is important that members who have any risk concerns highlight these using the internal risk management process in their workplace.

Another major issue is the introduction of operating department attendants (ODA) in certain hospitals. Limerick Institute of Technology (LIT) advertised a level 8 course for ODAs and there are indications that it is doing this in collaboration with the Private Hospitals Association, which runs theatre services in some hospitals, including in Bon Secours hospitals. None of this has been agreed with the INMO, which is in the process of establishing the facts.

Following the meeting with ODN Section officers, we need to assess these concerns in all operating departments, through a survey in the near future – details to follow.

I will be seeking national engagement with HSE management on these issues for our members. I also await terms of reference from the Department of Health with regards to theatre on-call.

Pay restoration underway in S39s

FURTHER to the WRC agreement and the letter from the Secretary General of the Department of Health, Jim Breslin, on Section 39 organisations, various templates and documents have now been issued to S39 organisations as part of the pay restoration exercise agreed.

The documentation was issued to organisations funded by the HSE under Section 39 of the Health Act 2004.

The initial exercise has been carried out in respect of the organisations listed by the WRC in its letter of February 9, 2018. These are the locations where the four ICTU unions have workers in membership.

In the correspondence issued by Stephen Mulvaney, HSE chief financial officer, strict timeframes are given for the organisations to complete the S39 restoration template, which they had to be returned by March 9, 2018.

A signed hard copy of the template, together with copies of audited accounts for the years 2009-2017, were also to be returned to the office of the chief financial officer by March 12, 2018.

Again, S39 organisations were reminded as per the WRC agreement, that if the organisation can restore pay or begin to restore pay within its existing overall resources, without adversely impacting services, they should do so as soon as possible in 2018.

A process has been agreed of validation and assurance between the unions, the HSE and the Department of Health. If the information is not accurate, and correct, it may involve the HSE initiating a site audit of payroll and other supporting data.

It is hoped that the above will assist in members working in S39 organisations having their pay restored in 2018. It is also clearly apparent that the HSE and the Department of Health are anxious to gain a greater understanding of the funding models within S39 organisations and their expenditure.

Pay Commission to survey nurses/ midwives on staffing difficulties

THE Public Service Pay Commission is to carry out a survey of nurses and midwives to determine underlying difficulties concerning recruitment and retention. This is in addition to the detailed information and submissions already made by the INMO and other parties.

Questionnaires have not yet issued for the survey. The design of the survey, and structured interviews, are being carried out by Research Matters Ltd to the Commission's specifications, which require that the survey be undertaken objectively and independently. The Commission has advised that the process is being overseen by independent academic advisers to the Commission (separate to the research) who are experienced in the field of research and surveys to further ensure robustness and objectivity of the process.

The INMO has raised concerns with the Commission in respect of the requirement to have, yet another, study to determine recruitment and retention issues. The Organisation is strongly of the view, that ample evidence exists in the Republic of Ireland, which demonstrates that there is a crisis in recruitment and retention of nursing and midwifery.

"We further hold the view that this crisis is as a direct result of continuous low pay, and disregard for the basic principles of supply and demand, and poor workforce planning during the austerity years," said INMO general secretary Phil Ní Sheaghdha.

In its submission to the Pay Commission, the INMO set out that:

- All measures, apart from pay improvement and pay equalisation, have been tried, tested and have failed to deliver an improvement in recruitment and retention of nurses and midwives
- Retention of staff is a matter that affects nurses and midwives throughout their career. Senior nurses/midwives are leaving the professions and promotions/specialisation roles are now resulting in staff shortages in the front line or just qualified/junior nurses/midwives making up a large part of every ward/community roster
- For just over a decade health service management has continuously shifted the sands in respect of staffing levels. Management has attempted to dilute the skill mix with little regard for the evidence that this leads to poorer patient outcomes and high levels of burnout and resignations among staff
- There is ample evidence from excellent research and studies, both in Ireland and across the globe, that links reduced nursing/midwifery staffing levels to poorer patient outcomes and, in some cases, catastrophic outcomes
- We are now entering a phase of expansion of the Irish public health service which is very welcome to the Organisation and its members. However, unless the base staffing levels of nurses and midwives are correct before we start, we will be struggling with insufficient staffing levels, poor patient outcomes, burnout of staff and continuous dependency on overseas recruitment into the next decade
- Until the pay of the nurse and midwife is improved, this problem will continue.

The Public Service Pay Commission is an independent body and the INMO obviously does not wish to delay its work. The Commission has decided to undertake this research and has advised that it intends to circulate this survey to 200 work locations in the Irish public health service and survey nurses and from all grades from students right through to directors.

This is a voluntary process and it is hoped that this information assists you in answering.

INMO calls for safety at work on IWD

ON International Women's Day 2018 the INMO Executive Council paid tribute to all those who have struggled and been oppressed in working for equality for all women.

Using the theme of bread and roses, the Organisation remembered particularly the women who have worked so hard for equal pay, equal treatment and freedom from oppression and violence in the workplace and beyond.

Violence against women is a pervasive problem within our societies, and this touches all aspects of life, including the workplace.

Assaults on nurses and midwives in the health services are a reality with over 3,500 assaults on health workers in the past six years, and about two-thirds of those against nurses and midwives.

Solidarity on International Women's Day:
The INMO highlighted violence against women in the workplace on International Nurses Day; pictured is a gathering of the Executive Council, directors and officers who paid tribute to all those who have struggled in working for equality for women

The INMO called on health service employers and the State to do more to ensure that services are safe. Services must be adequately staffed, staff adequately trained, health, safety and security measures must be funded and implemented, staff must be supported following assaults and services must adopt a zero-tolerance policy towards the abuse of staff.

Annette Kennedy appointed to WHO Commission

ANNETTE KENNEDY, president of the International Council of Nurses (ICN), has been selected to serve on the World Health Organization (WHO) Independent Global High-Level Commission on Noncommunicable Diseases (NCDs).

The Commission, which was established by WHO director-general Dr Tedros Adhanom Ghebreyesus, aims to identify innovative ways to curb the world's biggest causes of death and extend life expectancy for millions of people.

It will support ongoing political efforts to accelerate action on cardiovascular disease, cancers, diabetes and respiratory disease, as well as reducing the burden of mental health issues and the impact of violence and injuries.

The Commission will advise the WHO on bold and practical recommendations, and new opportunities, for countries to accelerate progress on NCDs, in line with the agenda for Sustainable Development target of a one-third reduction in premature NCD deaths by 2030.

NCDs kill 15 million people between the ages of 30 and 69 each year. Low- and lower-middle income countries are particularly affected by NCDs with almost 50% of premature deaths from NCDs occurring in these countries.

Nurses make an important contribution to tackling NCDs and, as the largest group of healthcare professionals, are the key providers of NCD prevention, treatment and management. Nurses, as the point of first contact, are well positioned to detect, treat and refer patients with NCDs as well as to provide information and counselling to the public on prevention of NCDs.

"It is an incredible honour to be chosen as a member of this High-Level Commission, but also critically important that nurses have a voice at these high-level, policy setting arenas," said Ms Kennedy, who is former director of professional development with the INMO. "Many nurses in both clinical and non-clinical roles are already contributing to these work programmes, and advocating for health policies that integrate NCD prevention into health planning, nursing curriculum and workforce strengthening across the health system continuum.

ICN president Annette Kennedy appointed to WHO Global Commission on NCDs

However, NCDs represent a global health priority to which there is the potential for the profession to contribute further. The work of the Commission will be extremely useful in developing a set of recommendations and measures for action. I am delighted to represent the nursing profession on this Commission." Further information on the Commission is available on: **www.who.int**

INMO general secretary Phil Ní Sheaghdha said: "We would like to congratulate Annette on her appointment which is a great achievement for an Irish nurse. We wish her all the best and look forward to working closely with her in her new role."

World news

Nurses and midwives in action around the world

Canada
- With demand for nurse practitioners rising, UPEI looks to keep up
- Quebec nurses push for new law to limit nurse-to-patient ratios
- Coalition seeks private sector pay equity legislation by 2020

Dominican Republic
- Hospitals show a shortage of nurses according to the ADEG

France
- ER strikes in several Lyon hospitals

Kenya
- KNH crisis deepens as nurses down tools

Mexico
- After 40 days, doctors and nurses end strike in Oaxaca
- The high price paid by a nurse for revealing corruption in the health system

New Zealand
- Strike action the 'next option' if nurses reject latest pay offer from DHBs
- Under attack: Assaults on hospital staff on the rise in Northland

UK
- NHS staff offered 6.5% pay rise over three years if they forfeit day's holiday
- Rise in number of nurses and midwives in Scotland 'undermined' by increase in vacancies
- Nursing associates: will they become a cheap substitute for nurses?

US
- Over 18,000 Kaiser RNs prepared to strike in California

Venezuela
- Nurses rejected salary increase announced by Maduro

Delegates set to debate key issues at ADC in Cork

THE 2018 annual delegate conference of the INMO will take place in the Clayton Silver Springs Hotel, Cork on Wednesday, May 2 to Friday, May 4.

This is the Organisation's 99th annual conference and the theme for this year is *Innovation and practice – nurses and midwives leading the way.* Approximately 350 delegates will attend from around the country. Almost 50 motions are up for debate over the three days covering issues such as:

- The right to 'conscientious objection'
- Review of the function of branches and sections
- Massaging of ED figures
- The introduction of a non-nursing grade into the operating theatre
- Safe staffing levels
- Risk management
- Pay parity
- Standardisation of nursing and midwifery documentation
- Property tax
- Medical cards
- Homelessness.

The ADC will kick off with a press conference on Wednesday, May 2 to outline the main issues up for debate throughout the three days. Registration for delegates will be from 1-2.30pm. The conference opens at 2.30pm, with a debate on organisational motions as the first item on the agenda, which will be held in a private session.

At 5pm there will be a debate on educational motions commencing with an introduction by Elizabeth Adams, director of professional development and The Richmond Education and Event Centre. The session will conclude at 6pm followed by dinner and raffle/quiz in aid of a local charity at 7.30pm.

Thursday, May 3 will see a debate on industrial motions in the morning, introduced by Tony Fitzpatrick, interim director of industrial relations.

Edward Mathews, director of regulation and social policy, will introduce social policy motions for debate on Thursday afternoon. Dinner will be at 8pm at which the Gobnait O'Connell Award, CJ Coleman Research Award, Preceptor of the Year 2018 – nominator and winner awards will be presented. This will be followed by entertainment.

Friday May 4 will commence with debate on remaining motions and a presentation on the Taskforce on Nursing/Midwifery Skill Mix. The Minister for Health Simon Harris will address delegates at 12.30pm, followed by a response from Martina Harkin-Kelly, INMO president.

Election of President, first and second vice presidents to serve for 2018-2020 will be held in the afternoon. The conference will close with the annual gala dinner on Friday evening.

– Ann Keating, INMO media relations officer

Integrated care: *INMO interim director of industrial relations Tony Fitzpatrick is pictured at a meeting of the National Steering Committee for the Policy on the Development of a Community Nursing and Midwifery Response to Integrated Model of Care at the Department of Health with (l-r): Mary Wynne, interim director of Nursing and Midwifery Services, HSE; Siobhan O'Halloran, chief nursing officer at the Department of Health; and Susan Kent, deputy chief nursing officer, Department of Health*

Cobh pay restoration now in WRC process

THE INMO attended the Labour Court on March 7, 2018 on behalf of Cobh Community Hospital members seeking pay restoration in line with the public sector workers as per the Public Service Stability Agreement.

The Labour Court is to issue a recommendation to Cobh Community Hospital, which is a section 39 organisation, that the national WRC process which is currently in progress seeking pay restoration for S39 Organisations with Cobh hospital part of this claim, has now superseded the Labour Court process. However, both parties reserve the right to return to the court if required, pending the outcome of the national WRC process.

– Liam Conway, INMO IRO

Wifi – convenience or health risk?

Dave Hughes warns that we may be risking the health of future generations by promoting widespread use of wireless technology

FOR non-smokers, like me, it seems extraordinary that a product sold from behind a blank cabinet and whose packaging contains graphic and horrific images of lung disease and bad teeth, is still purchased by people who say "give me 20 of those please".

Cigarettes were fashionable, widely advertised and seen by governments as employment generating and great sources of revenue for many years. Likewise, until very recently practically every sporting event was sponsored by the alcohol industry and our big stadia were festooned with promotional images to sell more of it.

At the recent Ireland v Scotland rugby international (a great day for all), it was notable that there was no advertising on pitch side for either cigarettes or alcohol. There were, however, repeated adverts for mobile phone and wifi companies.

In Ireland, in recent years, most of the debate about broadband wifi and wireless telecommunications has centred around regional development, employment and universal access. The provision of rural broadband is quite controversial, with two of the three selected companies now having dropped out and a single provider left to stretch the reach of broadband to our most remote areas. Against such a wave of enthusiasm for the undisputed benefits of wireless technology, voices of caution with regard to the health risks of wireless technology have got little airing and, where aired, have sometimes been met with derision and comparisons to the Luddite movement. But, with our enthusiasm for the convenience of wireless technology, are we sleep walking into yet another massive public health disaster that will not be arrested for another three or four generations?

There are authoritative voices out there who suggest that current regulations internationally do not provide adequate protections from the dangers associated with wireless technology. In particular, there is growing concern about the impact of such wireless technology on children and, aside from the social dangers of the technology on health grounds alone, calls have been made for a threshold of 14 years of age before any child should have access to a mobile phone.

In 2015, 220 scientists from 41 nations signed an appeal to the UN for greater health protection on electro-magnetic field (EMF) exposure. Each of the scientists has published peer-reviewed research on biological or health effects of non-ionising radiation, extremely low frequency fields (ELF) used for electricity or radio frequency radiation (RFR) used for wireless communications.

They raised serious concerns regarding the risks for humankind and nature from ubiquitous and increasing exposure to EMF sources generated by electric and wireless devices from electrical power sources and global wireless communication infrastructure.

Scientists claimed that the existing international exposure guidelines do not protect against long-term exposure of low intensity effects and are insufficient to protect the health of humankind. Their appeal also called on the WHO to exert strong leadership in fostering development of more protective EMF guidelines and to take precautionary measures to reduce EMF exposures.

Even in Ireland, in a little publicised press advice from our chief medical officer of June 2011, the issue of the possible carcinogenic impact on humans (Group 2B) related to mobile phones and radio frequency, electromagnetic fields was highlighted. Quoting from the chief medical officer he stated: "We may not truly understand the health effects of mobile phones for many years. However, research does show that using mobile phones affects brain activity. There is a general consensus that children are more vulnerable to radiation from mobile phones than adults. Therefore, the sensible thing to do is to adopt a precautionary approach rather than wait to have the risks confirmed." Yet now in 2018 it has become a policy to rollout wifi to all of our schools.

We must exercise caution on the widespread use of wifi and listen to those who advocate greater precaution and precautionary devices. We must protect our children and, challenging though it may be, our desire for convenience may be ignoring their future health.

It is, after all, a fact that the combination of big industry, convenience, fashion and revenue collection, which made smoking and drinking popular for generations in the past, led us to our greatest public health challenges and extracted a huge human cost in terms of chronic disease and mortality.

– Dave Hughes, INMO deputy general secretary

CUH premium

Members in 4C at Cork University Hospital united at the turn of the year to ensure they were paid the appropriate number of hours worked for Sunday premiums. Following dialogue with hospital management this issue has been resolved.

– Liam Conway, INMO IRO

Bandon unit opens following review of staffing levels

BANDON Community Hospital has now begun to open up its new state of the art 25 bed care of the older person facility under an interim staffing arrangement, which was achieved under a Joint Review Group of staffing levels, chaired by INMO deputy general secretary Dave Hughes.

The INMO fought hard to ensure safe and adequate staffing levels for the new unit, and the dispute over staffing levels is now reaching the final stages with a review of the interim proposal to take place when Bandon reaches full occupancy levels.

I would like to thank Bandon Community Hospital members for their strength and determination in carrying out a work to rule over the past six months to ensure that they would work in a state-of-the-art environment with the matching staffing levels to accompany this fantastic new build.

– Liam Conway, INMO IRO

Care of Older Person Section meets in Portlaoise for annual conference

MORE than 100 members of the National Care of the Older Person Section attended its recent annual conference in Portlaoise in March.

In the morning session, Tony Fitzpatrick, INMO interim director of industrial relations, discussed the expansion of the role of the nurse in the care of the older person area. Mr Fitzpatrick emphasised the importance of the role and the work that nurses in this area do.

Prof Willie Molloy, professor of medicine and chair of the newly established Centre for Gerontology and Rehabilitation, gave a paper on advanced care directives. Prof Molloy is the author of *Let Me Decide,* an advanced care directive and palliative care programme, and he gave an enlightening speech that provoked a great deal of discussion on this important issue.

In the clinical area, the topic of understanding wound dressings was covered by Mary Martin, an independent educational consultant in wound management. Her talk included learning about how to choose the best dressing, what the wound needs, what the dressing does and choosing a match. She told the conference that the impact of living with a wound and its treatment can be seen in different ways by different people and that only the patient genuinely understands the significance of that experience.

Attending the INMO National Care of the Older Person Section conference in Portlaoise were (l-r): Prof William Molloy, UCC and consultant geriatrician HSE; Caroline Gourley, Section chair; Margo Lydon, Section vice-chair; Steve Pitman, INMO head of education and professional development; Mary Martin, independent educational consultant; Martina Harkin-Kelly, INMO president; Tony Fitzpatrick, INMO interim director of industrial relations; Tracy Keating, RNAP, Anam Cara; Eileen O'Keefe, Section education officer; Jean Carroll, Section development officer, INMO; and Noreen Watts, Section secretary

The role of the advanced nurses practitioner in community older person care was discussed by Tracy Keating, an advanced nurse practitioner in this area. She outlined her role and how it developed, stating that there is an ever-increasing need for more clinical nurse specialists and advanced nurse practitioners in older person care, as every older person has the right to access to the right care and support in the appropriate setting.

Steve Pitman, INMO head of education and professional development, spoke on burn out and work engagement, a topic most relevant to this sector. He discussed the importance of being engaged in your job and spoke about burn out, how to identify emotional labour and compassion fatigue, and looking at possible solutions to increasing work engagement and ultimately increasing job satisfaction. Delegates were very engaged and there were plenty of questions and answers.

The afternoon session included a talk on pensions from both a private and public perspective. Denis Brophy, an independent financial consultant, hosted this session and it sparked a wide-ranging discussion.

Edward Mathews, INMO director of regulation and social policy, gave a talk on delegation and fitness to practise. This session was extremely informative, once again highlighting the benefit of being a member of the INMO, should you ever be referred to the NMBI.

The day was evaluated highly by all who attended.

The conference planning committee wish to thank all those who attended, the companies who offered their support and sponsorship, and the INMO for its ongoing support in delivering these important days, giving the opportunity to delegates to update their skills and knowledge and affording them the time to network with one another. Plans have started on next year's event already.

ODN conference set for Tullamore

THE Operating Department Nurses Section is holding its annual conference later this month on April 20-21 in Tullamore, Co Offaly. Bookings can be made online at **www.inmoprofessional.ie** or at Tel: 01 6640641 / 01 6640616.

The theme this year is 'Leadership and accountability in perioperative practice'.

Friday afternoon's session will include talks on informed consent and documentation in clinical practice, by Helen O'Shea, a barrister at law. Following this, Edward Mathews, INMO director of regulation and social policy, will cover the topic of open disclosure.

Friday's session will conclude with a meeting of the ODN Section, and following this a light supper will be served.

The topics for discussion on Saturday will include: risk; smartphone usage in the operating theatre; count policy; nurse-led extubation; paediatric spinal surgery; nursing considerations for spinal surgery; accountability and person-centredness.

The poster competition awards will complete the line up for the day.

The planning committee looks forward to welcoming attendees to the event.

Retired Section trip

THE Retired Nurses and Midwives Section is looking forward to its spring break which is set to take place in Kenmare, Co Kerry. The trip starts on Sunday, April 15 and covers four nights.

Bookings can still be made by contacting McGinleys Travel at Tel: 074 9135201.

Any informal queries can be directed to Myra Garahan at Tel: 01 8384407.

Q and A Bulletin Board

With INMO interim director of industrial relations Tony Fitzpatrick

Query from member

I have been out on sick leave for over a year and I am due to return to work in the next couple of weeks. I work as a staff nurse in the public health service. I was asking my employer about my annual leave entitlement, which has accrued during my paid and unpaid sick leave.

I was advised by my employer that while I will accrue annual leave during paid sick leave, I will not accrue annual leave during my unpaid sick leave. Is this correct?

Reply

You have an entitlement to accrue annual leave during your paid sick leave as a nurse/midwife in the public health service as it is classified as working time.

However, due to changes to the Organisation of Working Time Act in August 2015, all nurses/midwives are now also entitled to accrue the statutory entitlement to annual leave during the unpaid period of sick leave. If you have any difficulties you can contact the INMO Information Office at Tel: 6640610/19.

Query from member

I qualified as a public health nurse in 2013 and have a midwifery qualification. I was advised by my employer that due to the review of allowances in 2012, this payment was abolished and I am not entitled to payment of the qualification allowance.

I have recently heard that some of the allowances have been restored as part of the nursing and midwifery recruitment agreement in 2017. I would like to know if the midwifery qualification allowance was restored?

Reply

This is correct. The midwifery qualification allowance was restored with effect from July 1, 2017. Therefore, you should be paid the allowance retrospectively to July 2017.

Please note that the changes introduced in 2012 by government following the review of allowances applied to new entrants only.

Therefore public health nurses already in employment should have already been in receipt of, and continue to receive, the allowance.

Know your rights and entitlements

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

Contact Information Officers Catherine Hopkins and Karen McCann at
Tel: 01 664 0610/19
Email: catherine.hopkins@inmo.ie
karen.mccann@inmo.ie
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 pensions
- Flexible working
- Public holidays
- Career breaks
- Injury at work
- Agency workers
- Incremental credit

Mandatory reporting

Edward Mathews looks at legislative developments in the mandatory reporting of the abuse, or suspected abuse, of children or vulnerable adults

THE duty to ensure the safety and dignity of those for whom they care has long been recognised as an essential part of nursing and midwifery practice. Existing policies and procedures in the health services include the mandatory reporting of concerns regarding the abuse of children or vulnerable persons. Moreover, such duties are implicit in the NMBI's Code of Professional Conduct and Ethics. In addition to these professional obligations, there are now mandatory reporting obligations and in some cases criminal offences in this area by virtue of the Children First Act 2015 (2015 Act) and the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012 (2012 Act).

Children First Act 2015

The Children First Act 2015 came into effect in December 2017. This Act applies to nurses and midwives, among others, and it refers solely to children (under the age of 18 and not married).

The 2015 Act requires that where a nurse or midwife knows, believes or has reasonable grounds to suspect – on the basis of information that he or she has received, acquired, or becomes aware of in the course of his or her employment or profession – that a child has been harmed, is being harmed, or is at risk of being harmed, they must, as soon as practicable, report that knowledge, belief or suspicion to the Child and Family Agency (the Agency).

This specifically refers to a duty that arises where the information relating to the concern comes to the nurse or midwife's attention in the course of their role as a professional. It extends beyond knowledge and covers belief and reasonable grounds for suspicion. Further, it refers to harm that has occurred, is occurring or is at risk of occurring.

The duty also arises where a child discloses to a nurse or midwife in the course of their professional practice that the child believes they have been harmed, are being harmed or at risk of being harmed, then they must urgently report that disclosure to the Agency

The duty to report occurs if information meeting the above criteria comes to the attention of the nurse or midwife after the 2015 Act came into force. That duty applies whether the information refers to issues of concern which occurred before or after the 2015 Act came into force.

The report, in most instances, must be made using the 'mandated report form' prepared by the Agency. The only exception is where the nurse or midwife knows, believes or has reasonable grounds to suspect, that a child may be at risk of immediate harm and should be removed to a place of safety. In this case they can report to the Agency via other methods, but must subsequently complete the mandated form.

If the sole source of the information (that would normally require a mandatory report) comes to your attention from another professional who has a duty to report – and who tells you that a report was made – then you do not have to make a second report. However, where you have information from another source who does not have a duty to report then this may require a separate report. In essence, if the only way you know the information is through another professional telling you that a report was made to the Agency, you need not report again.

A report is not required where the basis for the concern is sexual activity of a child aged 15 or older but younger than 17, and the partner in the activity is not more than two years older. Additionally, one must be satisfied that there is no material difference in capacity or maturity between the parties, and the relationship between the parties engaged in the sexual activity is not intimidatory or exploitative of either party.

If the child in question has said that they believe the activity has harmed them, is harming them or is at risk of harming them then a report must be made. The child must have told you that the information in relation to the sexual activity should not be disclosed to the Agency. This is clearly a somewhat complex exception, which requires careful navigation.

The 2015 Act does not provide for any criminal law sanctions for a failure to report, however, breach of the Act would no doubt be a relevant factor in any fitness to practise proceedings and, depending on the circumstances, a failure to adhere to the requirements of the Act could amount to professional misconduct. Additionally, the 2015 Act is stated to operate in addition to, and not replace, any other legislation, and it is to other obligations that we now turn.

Criminal Justice Act 2012

The Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012 is a relatively short piece of legislation which came into force on August 1, 2012, and provides for offences of withholding information relating to the commission of certain arrestable offences. For the purposes of the 2012 Act, an arrestable offence is one for which a person of full capacity and not previously convicted may be punished by imprisonment for a term of five years or by a more severe penalty and includes an attempt to commit any such offence.

A child in this context is a person under the age of 18, and a vulnerable person

means either a person who is suffering from a disorder of the mind, whether as a result of mental illness or dementia, or has an intellectual disability, which is of such a nature or degree as to severely restrict the capacity of the person to guard himself or herself against serious exploitation or abuse, whether physical or sexual, by another person. A vulnerable person may also be one who is suffering from an enduring physical impairment or injury which is of such a nature or degree as to severely restrict the capacity of the person to guard themselves against serious exploitation or abuse, whether physical or sexual, or to report such to the Garda Síochána, or both, as the case may be.

The 2012 Act creates two offences: Section 2 creates an offence of withholding information on certain offences against children; and Section 3 creates an identical offence except that it applies to information concerning offences against vulnerable persons.

Offences

The offences arise where one knows or believes that a relevant offence has been committed, and one has information that one knows or believes would be of material assistance in the apprehension, prosecution, or conviction of a person who committed such an offence, and one fails without reasonable excuse to disclose that information to a member of the Gardaí. In this sense, liability arises not on mere suspicion that an offence has been committed; rather one must at least believe it has been, and one must have material information to assist the Gardaí in the apprehension and prosecution of the offender.

The range of offences about which one may have information, and which carry the obligation to disclose the information to the Gardaí, differ in respect of children and vulnerable adults. In respect of children, there are 19 different offences including: rape, sexual assault, incest by a male or female, false imprisonment, child sexual abuse, assault, endangerment, abduction, child trafficking, child pornography, cruelty, and female genital mutilation, among others. In respect of adults, the relevant offences include rape, sexual assault, incest, trafficking, and assault.

The duty to disclose information in relation to the foregoing sexual offences arises whether they occurred in this jurisdiction or not. In addition, it should be noted that liability under the 2012 Act arises where the information comes to one's attention after the 2012 Act enters into force, ie. post-August 2012, irrespective of when the offence was committed – either before or after that date.

Penalties

If convicted for failing to disclose information the penalty on conviction in the District Court is a maximum fine of €5,000 and/or 12 months imprisonment. Where convicted on indictment, ie. in a higher court, the penalty imposed is variable depending on what the maximum penalty would be for the person who committed the underlying offence, and the penalties range from three to 10 years imprisonment.

Defences

There are a number of defences available to a nurse or midwife in this situation. The first arises where the child is over 14, or they are a vulnerable adult, and they have expressed a view that they do not want the offence disclosed. This defence will only apply where the child is over 14 was capable of forming such a view. Similar provisions apply in relation to vulnerable adults. Where a child is under 14, their own view on reporting will not amount to a defence.

Another defence arises where a parent or guardian makes known their own view, or a view on behalf of a child or vulnerable person, that the matter should not be reported. This applies where they are acting in the best interests of the child or vulnerable person and the alleged perpetrator is not a family member. Where the alleged perpetrator is a member of the family, a defence for failing to disclose can be made when a designated professional has made known a view, on behalf of the child or vulnerable person, that the offence should not be disclosed.

Where a member of a designated profession, including nursing and midwifery, who is treating a child or vulnerable person for the harm arising from the alleged offence has reasonable grounds for forming a view that the matter concerned should not be reported for the purposes of protecting the health and wellbeing of that child or vulnerable person, and they act in the manner expected of their profession, then they will have a defence under the 2012 Act.

Accordingly, one should be aware that the obligations under this Act are not displaced by the reporting obligations that exist within the health services currently. Thus, while in many circumstances, the workplace reporting of information in relation to abuse, which amounts to one of the offences mentioned, may be sufficient, it is still important that where the nurse or midwife has information of the type described above, then they must assure themselves that some professional in the chain of care has reported the matter to the Gardaí, unless one of the exceptional circumstances militating against reporting exists.

General obligation

The 2015 Act has introduced an important general obligation and while not carrying a criminal sanction the Act would no doubt be of relevance in Fitness to Practise proceedings, and of course it has been enacted to give legislative force to a strong moral message that children must be protected, and behaviour or circumstances of concern must not be ignored. Additionally, and potentially referring to some cases which would come within the mandatory reporting provisions of the 2015 Act, the 2012 Act places onerous obligations on all persons to ensure that information relating to the commission of serious offences against children and vulnerable persons does not go undisclosed. This is an important obligation, and one which should be in the mind of nurses and midwives in the context of their day-to-day practice.

Key points emerging from the Act

The following have the potential to impinge on the practice of nurses and midwives:

- If you know or believe any of the listed offences have been committed, and you have information which may assist the Gardaí in the apprehension and prosecution of the alleged perpetrator, then you have a duty to disclose this information
- A person who fails to disclose this information, without reasonable excuse, can face a penalty on conviction ranging from a fine of €5,000 and/or 12 months imprisonment, up to 10 years imprisonment
- The range of offences where this obligation arises is wide and covers all forms of sexual offence or abuse, trafficking, assault, and other exploitative offences
- You may have a defence where your failure to report results from a wish expressed by a child over 14 years or a vulnerable person who has capacity, that the matter not be reported; similarly such views may be expressed on behalf of another by a parent or guardian
- Specifically, nurses and midwives who are caring for persons in relation to the injury or harm arising from the alleged offence, and where they form the view in the best interest of the health and wellbeing of that person that the offence should not be reported, and their actions are in accordance with best practice, will not be liable under the Act

Edward Mathews is INMO director of Regulation and Social Policy

Managing burns: An overview

In the latest update in this series, **Catherine Lewis**, **Stephanie Laidlaw** and **Gerry Morrow** examine the treatment of burns and scalds

A BURN is an injury caused by exposure to thermal (heat), chemical, electrical or radiation energy. Burns usually affect the skin, but may also damage the airways, lungs, muscles, bones or other internal organs. A scald is a burn caused by contact with a hot liquid or steam. Scalds are the most common burn type (accounting for 70% of burns in children). In this article the term 'burn' will be used to include scalds.[1,2]

Non-complex burns (previously described as minor burns) are defined as any partial-thickness thermal burn covering less than 15% of the total body surface area in adults or less than 10% in children, that does not affect a critical area. Non-complex burns also include deep partial-thickness burns covering less than 1% of the body.[2]

Complex burns (previously described as major burns) are defined as any thermal burn affecting a critical area such as the face, hands, feet, perineum or genitalia; also burns crossing joints and circumferential burns. Any thermal burns covering more than 15% of the body surface area in adults or more than 10% in children are defined as complex burns. All chemical and electrical burns are classed as complex burns.[2]

The exact prevalence of burn injuries is not known, as many people will self-treat instead of seeking medical attention. Children under five years and the elderly are most at risk of burn injury – older people may be at increased risk due to reduced mobility, sensory impairment and slowed reaction times.[2]

The prognosis and healing time of a burn injury depend on the extent, depth and location of the burn, and the person's age and associated co-morbidities.

Superficial burns

Superficial epidermal burns typically heal within seven days with conservative management and do not result in scarring. Superficial dermal burns typically heal within 14 days with conservative management and do not result in scarring.

Deep burns

Deep dermal burns may need surgical intervention to heal and may result in some contraction and scarring. Full thickness burns that are complex usually need surgical intervention to heal and result in considerable contraction and scarring.[2] It is possible to die from a serious burn injury.

The skin is a barrier to bacteria and moisture loss; when this is breached, potential complications from burns may present, either soon after injury, or later during the healing process. Early complications include:

- Respiratory distress from smoke inhalation or a circumferential chest burn
- Poisoning from inhalation of noxious gases
- Fluid loss
- Hypothermia
- Wound infection and sepsis
- Toxic shock syndrome
- Cardiac rhythm abnormalities
- Vascular insufficiency
- Acute kidney injury
- Limb loss.

Death may result from severe, extensive burns or electric shock (currents of more than 70,000 volts may cause cardiac arrhythmias and paralysis of respiratory muscles, and are usually fatal).

Later complications from burns include wound infection, chronic nerve pain and itch, scarring (burns that take more than two to three weeks to heal are more likely to result in hypertrophic scarring), contractures, and psychosocial impacts such as depression, anxiety and post-traumatic stress disorder. [3,4]

Assessment of burns

After giving immediate first aid, all burns need to be assessed rapidly and accurately, to reduce the risk of progressive injury and complications. Assess the timing, type and cause of the burn, and the mechanism of injury. Establish the risk of inhalation injury, this could be suggested by:

- Singed eyebrows or nasal hairs
- Sore throat
- Black carbon in sputum
- Hoarse voice
- Stridor
- Wheeze/signs of carbon in the oropharynx.

Symptoms such as pain or itch should be assessed along with any co-morbidities (for example, diabetes mellitus, immunocompromised state or pregnancy) which may affect wound healing and increase the risk of complications.[2,5]

An assessment should be made and documented about the location, size and extent of the burn or burns to determine the severity of the injury. To determine this, the total surface area of the body affected should be estimated. This can be done using the Wallace rule of nines tool for medium to large burns in adults (arm 9%, head 9%, neck 1%, leg 18%, anterior truck 18% and posterior trunk 18%).[6] However, this may over-estimate the area affected. For small or scattered burns, or for assessing the amount of unburned skin in very extensive burns, the person's palmar surface (including fingers extended but closed together) can be used – the palmar surface is representative of about one percent of the person's total body surface area.

The depth of the burn should also be assessed and documented. This can be gauged by examining the skin for colour change, presence of blisters, capillary refill time and pain. If there is any uncertainty on the extent or depth of a burn, arrange immediate referral for specialist assessment, as distinguishing between complex and non-complex burns may not be straightforward clinically.[2,5]

Non-accidental injury

When assessing a burn, the possibility of non-accidental injury should be

considered. Any of the following should raise suspicions of a non-accidental injury:

- Lack of explanation for the injury
- The patient not being independently mobile
- The injury on any soft tissue that would not usually come into contact with a hot object (for example, the backs of the hands, soles of the feet, back and buttocks)
- An injury in the shape of an object (for example, a cigarette or iron)
- An injury that suggests forced submersion.

Non-accidental injury should also be considered if there is a delay in presentation, however this may be due to adequate first aid measures masking the severity of the injury. An unrelated adult presenting a child to healthcare services or a trigger event such as soiling, enuresis or minor misbehaviour by the person could also indicate non-accidental injury. Other indicators may be present and should be considered during the assessment of the injury.[7]

All patients presenting with a burn injury should have their risk of tetanus assessed, those deemed at a high risk of tetanus should be given human tetanus immunoglobulin for immediate protection, irrespective of their tetanus immunisation history. Burns which are at a high risk of tetanus include:

- Those that need surgical intervention which is delayed for more than six hours
- Those that have a significant degree of devitalised tissue or have been associated with a puncture-type injury
- Any burns containing foreign bodies
- Those associated with compound fractures
- Burns in people with sepsis.[8]

Treatment

When giving immediate first aid to a person with a burn, avoid personal injury by checking the area is safe and wearing personal protective equipment if necessary (for example, when treating chemical burns).

Assess the person's airway, breathing and circulation, and for the presence of any co-existing non-burn injuries or trauma that may be life-threatening and require emergency treatment.[1,4]

Initial treatment depends on the cause of the burn. For a thermal burn, the aim is to stop the burning process; this can be done by extinguishing flames using 'drop and roll' or smothering the person with a blanket and removing non-adherent clothing and potentially restricting jewellery (any tar stuck to the skin should not be removed).

Within 20 minutes of the burn occurring it should be irrigated with cool or tepid running water for 20-30 minutes. If water is not available, use wet towels or compresses, ensure the person is kept warm to avoid hypothermia. Immediately after cooling the burn, it should be covered using cling film, layered onto the burn rather than wrapped circumferentially.

Elevate the affected area if possible to reduce the risk of oedema. Pain relief, such as paracetamol or ibuprofen, should be given for mild to moderate pain, codeine may be added for more severe pain.[1,4]

Electrical burns should be treated by safely switching off the power supply and removing the person from the source using a non-conductive material such as a wooden stick. If the person is connected to a high voltage source (1,000 volts of more) they should not be approached. The assistance of emergency services should be sought in this situation. Immediate admission to the nearest emergency department should be arranged.[1,4]

When treating a chemical burn, the causative chemical should be determined, where possible. Any affected clothing should be removed from the person and the chemical should be brushed off, if it is in a dry form. The burn should then be irrigated with water for an hour. Immediate admission should be arranged to the nearest emergency department.[1,4]

After initial first aid measures, referral to the nearest emergency department is required in the following circumstances:

- All complex burns
- All full thickness burns
- Deep dermal burns affecting more than 5% of the body
- Any high-pressure steam injury
- Any burn associated with suspected non-accidental injury
- Burns affecting the face, hands, feet and genitalia
- Circumferential deep dermal burns
- Burns associated with inhalation injury
- Co-morbidities or significant other injuries or trauma
- Burns associated with sepsis
- All children under 10 years of age or adults over 49 years of age.[1,4]

Management

Ongoing management of superficial epidermal burns such as sunburn or scalds involves providing advice regarding measures to provide symptom relief including taking a cool bath or shower, applying topical emollients, applying cold compresses and using simple analgesia. The patient should be advised to maintain adequate hydration to reduce the risk of complications. Advise the person to arrange an urgent review if blisters develop as this may suggest a dermal burn.[1,4]

Superficial dermal burns will require appropriate wound cleaning, debridement, blister management and wound dressing by a person with appropriate expertise and training. Simple analgesia can be used to manage pain, with the addition of codeine, if pain is severe.

The wound should be reassessed after 48 hours to check for signs of infection and for the dressing to be changed. The wound should then be redressed every three to five days until the wound is healed. Following wound healing the person should be provided with advice on skin care, including massaging the area daily with emollient until the burn is no longer dry or itchy (usually three to six months) and using high-factor sunblock over the affected skin for years post healing.[1,4]

If the wound becomes infected, arrange for the burn to be cleaned with 0.9% sodium chloride or lukewarm tap water. A bacteriology swab should be taken from the wound and empirical antibiotic treatment started. A follow-up appointment should be made for the wound to be re-assessed after seven days.[1,4]

Catherine Lewis is clinical author at Clarity Informatics, Stephanie Laidlaw is information specialist at Clarity Informatics and Gerry Morrow is editor and medical director at Clarity Informatics. Clarity Informatics is contracted by the National Institute for Health and Care Excellence (NICE) to provide clinical content for the Clinical Knowledge Summaries service available through the Clarity Informatics Prodigy website at: **https://prodigy-knowledge.clarity.co.uk/**

References – full reference list available from the Prodigy Burns and scalds topic. **https://prodigy-knowledge.clarity.co.uk/**

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CPD Quiz

There may be more than one correct answer to the multiple choice questions listed here. The correct answers *(given below in the inverted text)* are those deemed most appropriate by the authors in the context of this CPD article.

1. What causes a scald?
A) Contact with a hot object
B) Exposure to radiation
C) Contact with a chemical
D) Contact with a hot liquid or steam

2. Which features indicate a complex burn?
A) Any thermal burn affecting a critical area
B) All chemical and electrical burns
C) A deep partial-thickness burn covering less than 1% of the body
D) All thermal burns covering more than 15% of the body in adults

3. Early complications of a burn include:
A) Fluid loss
B) Acute kidney injury
C) Scarring
D) Death

4. When should non-accidental injury be suspected in a patient with a burn?
A) The patient is not independently mobile
B) The burn is in the shape of an object
C) There is no explanation for the injury
D) The patient presented immediately after the injury

After reading this article you may wish to reflect on what you have learned, how this might be applied to your own work and to make a note of this in your portfolio.

Clarity informatics

For further information and resources: **www.clarity.co.uk**

Answers: Question 1 = D 2 = A, B, D 3 = A, B, D 4 = A, B, C

Aiming to build a better union

INMO organiser **Albert Murphy** focuses on various strategies that can strengthen the Organisation

IT IS important that we implement methods that can help us to build a strong workplace organisation. Mapping is a tool that is used by unions to analyse the members in a particular workplace on a structured basis. It is a useful tool for determining membership levels and where the union needs to improve on the recruitment and retention of members. A lot of academic research suggests that the main reason people are not in unions is because they have not been asked.

In order to build a stronger union we intend to map our workplaces over the course of 2018. The best way to do this is by establishing a working group to complete the process of identifying members in all of the workplaces and units where you work. This can be done in consultation with your IRO.

Mapping is also helpful when making contact with members and to seek individuals to become a contact person. This improves communication and helps to address members' concerns within the union.

Engaging with members

The INMO is committed to ensuring that we keep in touch with our members. The contact detail form is the best way of capturing changes to member's addresses or contact details *(see page 40)*.

The INMO fully adheres to data protection law and any information provided to the Organisation is protected under data protection regulations and is thus never disclosed to third parties. Having these details allows the INMO to contact the individual by a variety of methods – by post, email or text message. Copies of these forms are available at your local INMO office.

Recruit a friend campaign

The INMO is continuing to run the recruit a friend campaign. For every new member who an existing INMO member recruits, the Organisation gives a €20 gift card as a token of thanks.

Why not do your new colleagues a favour and ask them to join the largest nursing and midwifery union in Ireland? In this way we can build a stronger union. It is with true unity that the Organisation gains strength.

Upcoming rep courses

The INMO will be holding the first basic rep course in Tralee on April 10 and 11.

We have announced further courses in Limerick and Sligo for later this year. (*see below for full details of all upcoming courses*).

The courses are designed to give participants the skills and confidence to represent members in their own workplace.

Albert Murphy is INMO industrial relations officer/organiser; Email: albert.murphy@inmo.ie

INMO

REP TRAINING

Would you like to become an INMO workplace leader?

Date	Course	Venue
April 10 & 11	Basic	Manor West Hotel, Tralee
June 12 & 13	Basic	INMO Cork
June 19 & 20	Basic	Forsa Offices, Sligo
Sept 11 & 12	Basic	INMO Limerick

For all enquiries email: martina.dunne@inmo.ie

Managing costs on placement

INMO student and new graduate officer, **Neal Donohue**, looks at the cost of living for students on clinical placement and the various allowances available

AT THIS stage in the academic year, student nurses and midwives all over the country have started clinical placements and are experiencing the highs and lows of working in healthcare. Nursing and midwifery can be extremely rewarding professions. I remember my very first placement as a student. I was inspired by the knowledge and skill of the staff who took the time to teach and instruct me. Their knowledge and expertise seemed to be the glue that held the whole system together.

While students learn to navigate the complexities of professional relationships and structures within the health service and learn to understand the concepts of professional accountability and responsibility, they go through a personal growth where their coping mechanisms are challenged in a way that other students are not. They do this while developing a comprehensive knowledge base and clinical skills, along with dealing with the pressures of exams and assignments.

Like all students they also must manage their expenses related to living and education, but there are far higher expenses while attending clinical placements, especially in relation to accommodation and travel.

Costs

In 2017 we saw another year of increases in the cost of rental accommodation. The market shows that there is greater demand in urban areas, which increases the competition for renting. The latest figures in the **Daft.ie** rental report for the final quarter of 2017 show that on average, listed rents increased by 10.4% in 2017. In 2016 there was an increase of 13.5%, in 2015 an increase of 9% and in 2014 an increase of 10.7%.

This is particularly concerning for nurses and midwives, since most hospitals are based in urban areas. Travelling to work or placement can be difficult as public transport does not always cater well for the unsociable hours worked by healthcare professionals. Nurses and midwives are often dependent on finding accommodation close to their place of work.

The cost of transport has also increased substantially in recent years. Since 2007 there has been a significant reduction in national bus and rail services especially in rural areas, while the cost of motor insurance has increased. In 2017 alone, there was an increase in fares on 74% of national transport routes.

The National Student Housing Survey 2017 was carried out by the Union of Students in Ireland on the experiences of third-level students in Ireland. It is worrying that this report highlights the relationship between high accommodation costs and increased student drop-out rates. A total of 89% of the respondents in this study report being at risk of physical and mental health deterioration due to unsuitable accommodation. With such high expenses, student nurses and midwives need to be aware of the allowances available to them.

Allowances

Nursing and midwifery students in first to third year may claim allowances while on clinical placement. These allowances are outlined in HSE HR Circular 9/2004 which states: "A student on the pre-registration nursing degree programme is entitled to an accommodation allowance up to but not exceeding €50.79 weekly for the duration of the placement where it is necessary for the student to obtain accommodation away from his/her normal place of residence".

This allowance is intended as a contribution towards the cost of clinical placement and is not intended to meet the full cost of accommodation. The **Daft.ie** rental report for 2017 shows an average monthly rent of €632 for Dublin city centre. Is the accommodation allowance sufficient to support students in 2018?

According to the Higher Education Authority's Eurostudent Survey VI 2016, the overall average income for full time students was €621, while average monthly expenditure of full-time students on living costs was €718. These figures do not take into account the costs of education, and since nursing and midwifery students have added costs associated with clinical placements we can expect the deficit to be much higher.

Travel

Travel costs for clinical placement may also be refunded as outlined in HSE HR Circular 9/2004. Allowances may be claimed by students when they provide receipts to the student allocations liaison officer in the health service.

Student nurses and midwives are in a more precarious situation than other students because they attend clinical placements, so it is necessary to provide additional financial supports. At a time where there is a recruitment and retention crisis for nurses and midwives we need to re-examine the supports available to students to assist them on their path to registration. All eligible student nurses and midwives should avail of these allowances.

If you have any questions regarding the accommodation and travel allowances, available, please contact me via the details listed below.

Neal Donohue is INMO student and new graduate officer
Email: neal.donohue@inmo.ie; Tel: 01 6640628

Quality & Safety

A column by Maureen Flynn

Introducing the National Office of Clinical Audit

The National Office of Clinical Audit (NOCA) was established in 2012 to create sustainable national clinical audit programmes. It is funded by the HSE Quality Improvement Division and supported by the Royal College of Surgeons in Ireland.

NOCA functions through an executive team which provides managerial and operational support to deliver the objectives of the NOCA Governance Board. Each audit has a multidisciplinary governance group including clinicians, managers and patient representatives.

NOCA supports hospitals to learn from their audits and strongly encourages nurses and midwives to use the findings of the audits within their practice. This column introduces the roles nurses and midwives play within the portfolio of eight national audits in development or implementation phase.

What is clinical audit?

The Commission on Patient Safety and Quality Assurance defined clinical audit as, 'a clinically led, quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and to act to improve care when standards are not met'. Also described by the National Clinical Effectiveness Committee as, 'a cyclical process that aims to improve patient care and outcomes by systematic, structured review and evaluation of clinical care against explicit clinical standards on a national basis'.

Contribution from nurses and midwives

Nurses and midwives make a considerable contribution to National Clinical Audits (NCA), working both at hospital level and nationally to make local improvements, contributing to the governance of NCA.

The NOCA executive team (*pictured below*) includes, Louise Brent, national Major Trauma Audit and Irish Hip Fracture Database (IHFD) audit co-ordinator; Debbie McDaniel, Irish National Orthopaedic Register (INOR) audit co-ordinator; Suzanne Rowley, INOR audit co-ordinator; Mary Baggot, National ICU audit co-ordinator; Fionnuala Treanor, assistant ICU audit co-ordinator; Edel Manning, National Perinatal Epidemiology Centre audit co-ordinator; Deirdre Burke, National Audit of Hospital Mortality co-ordinator; and Marina Cronin, head of quality and development who supports the team through the provision of monthly webinars, audit handbooks and workshops to ensure data quality is of the highest standard and can be utilised easily in the hospitals.

A number of the NOCA team have come from nursing and midwifery, led by a desire to provide evidence for improvement in patient care and outcomes.

Benefits

- Measurement of practice and identification of potential opportunities for improvement at local and national level
- Benchmarking clinical practice against participating hospitals and also internationally (IHFD, MTA, ICU Audit)
- Provision of information for health service planning for policy makers as well as local service managers coming from an evidence-based methodology
- Promotion of transparency and openness as all NOCA audits report findings publicly, up to and including hospital level findings.

Opportunities

You can get involved with NOCA audits through your local audit co-ordinator or hospital quality and safety committees, consider applications for use of audit data from NOCA for research or quality improvement projects.

If you would like more information about the audits or want to get involved, please email: auditinfo@noca.ie, tweet us: @noca_irl or visit: **www.noca.ie**

This column is the first in a series of six about NOCA audits, our next column introduces NOCAs IHFD.

Louise Brent

Debbie McDaniel

Suzanne Rowley

Mary Baggot

Fionnuala Treanor

Edel Manning

Deirdre Burke

Marina Cronin

Maureen Flynn is the director of nursing ONMSD, lead governance and staff engagement for quality HSE Quality Improvement Division

Acknowledgements
A particular thanks to Louise Brent for providing information and assistance in preparing the column and the NOCA team, Collette Tully, executive director; Aisling Connolly, communications and events lead; Kenny Franks, operations manager; Fionnola Kelly, biostatisician; Brid Moran, information manager. We wish to also thank all the clinical leads and audit co-ordinators who work with NOCA

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Weather worsens trolley crisis

March saw an all-time record high for the number of patients left on trolleys but the government ignored calls to declare an emergency period

THE Irish Times (March 12) gave space to the trolley crisis under a headline - **Number of patients on hospital trolleys hits new high of 714.** "There are 714 patients on trolleys or on wards awaiting admission to a hospital bed on Monday – the highest number ever recorded. The Irish Nurses and Midwives Organisation said there were 80 patients deemed to require admission by doctors waiting for a bed at University Hospital Limerick… Nurses said there were 15 children waiting on trolleys for admission to a bed, seven at Temple Street Hospital and eight at Our Lady's Hospital, Crumlin…INMO general secretary, Phil Ní Sheaghdha said the HSE should put in pace an immediate directive to hospitals to cease all elective or non-urgent admissions. She said the INMO had sought such a move on two occasions last week. The nurses trade union is also seeking a declaration that the country's hospitals were now "in complete crisis." Ms Ní Sheaghdha said the conditions under which patients were being cared for were just "unsafe". She said hospitals were just "way too overcrowded, emergency departments and wards." The HSE was just looking for excuses, she continued; it had first attributed the overcrowding surge to the flu season and later then to the recent severe weather."

Trolley crisis worsened by weather

The story was also carried on *Irishhealth.com* (March 13) – **Over 700 patients on trolleys nationwide**. "The INMO has repeatedly called for a two-week period in March to be declared, and treated, as an emergency period in the public health service. This would allow for extraordinary measures to be put in place to focus on recovering from the backlog created by Storm Emma. The Organisation insisted that "In this crisis, all measures to properly resource and staff the health service must be explored and the assistance of services in the private acute hospitals must also be sought'. It said that if emergency care is to be prioritised at this time, all non-urgent and routine cases need to be cancelled during this period. "We saw record trolley figures last week with a total of 3,112 in just one week and on Monday, each daily total from that week has been surpassed by the extraordinary figure of 714. This upsurge was predictable and the INMO warned against inaction in the wake of Storm Emma. It is unfortunate for both healthcare staff and patients that these warnings were not heeded and that emergency measures sought have not been put in place," commented INMO general secretary, Phil Ní Sheaghdha.

RTÉ reported on March 13 "**Extra €5m for HSE as record 714 patients wait for a bed.**" Minister for Health Simon Harris said he has allocated an extra €5m to the HSE to ease hospital overcrowding, as levels reached a new record with 714 patients on trolleys or on wards awaiting admission to a bed according to figures from the Irish Nurses and Midwives Organisation. The money will go towards more home care packages, home help hours and transitional care beds. Mr Harris said that the health service was already congested before Storm Emma and a backlog, built up by the storm, has not been cleared…The general secretary of the Irish Nurses and Midwives Organisation said the circumstances in which people are being cared for now is "absolutely unsafe." Speaking on RTÉ's *News at One*, Phil Ní Sheaghdha said the volume of patients is too high to give proper, correct and humane care. Ms Ní Sheaghdha said the INMO wrote to the HSE last Monday to ask them to declare a national emergency in hospital services for two weeks as a result of Storm Emma, adding that the crisis was entirely predictable. She said the HSE is not planning on a national basis, saying if it was any other industry, there would be a national inquiry into the "predictable surge" in patients. She said the HSE should declare a national emergency."

Staffing issues

General secretary, Phil Ní Sheaghdha's address to the recent IRN Conference was reported on in the *Industrial Relations News* (March 15) under a headline **Union challenge is meeting expectations, social dialogue has role – Ní Sheaghdha**. "For the INMO itself, Phil Ní Sheaghdha says they are still recovering from the employment moratorium, with staffing levels today at 2,000 below the 2007 level, even though activity levels have jumped considerably.

"On retention, which is currently a key issue for the union and is being formally reviewed by the Public Service Pay Commission, she said that 250 more nurse managers left since 2016, and although 2,573 staff nurses were taken on, 2,271 had left. There is also increased level of violence against members, she says, as well as "burnout and early resignation". The consequences are there for patients in terms of "poor skills mix and reduced staff nurse/midwives ratios". Ms Ní Sheaghdha also addressed pay inequality across health professionals, which she said was leading to emigration and difficulties in recruiting from overseas. The agency spend in 2017 was €246m, of which €65m was spent on nursing. The union wants to see 2,600 extra acute beds depending on reform, 190 critical care and 1,300 regarding care of the older person. All of these, she added, require a serious investment in nursing and midwifery recruitment and retention measures."

Ann Keating is the media relations officer for the INMO. email: Ann.Keating@inmo.ie

Improving glycaemic control in type 2 diabetes

Early initiation of pharmacological therapy is associated with improved glycaemic control and reduced long-term complications in type 2 diabetes, writes **Poochellam Muthalagu**

Part two of a two-part article

PEOPLE with type 2 diabetes and hypertension should be treated to a systolic blood pressure goal of ≤ 140mmHg and lower targets may be appropriate for certain individuals.

As a primary prevention strategy in people with type 2 diabetes, in those at increased cardiovascular risk (10-year risk > 10%) aspirin therapy of 75mg/day should be considered. Depending on risk, in most patients with diabetes aged 40 and above, remember to use moderate or high dose statins.[1]

ADA/NICE recommends an HbA1c ≥ 48mmol/mol (6.5%) as the threshold for initiating or up-titrating therapy in general, while ≥ 58mmol/mol (7.5%) remains the trigger for triple therapy.[2]

Pharmacological therapy

Early initiation of pharmacological therapy is associated with improved glycaemic control and reduced long-term complications in type 2 diabetes.

The initial treatment is guided by the level of HbA1c at diagnosis, the presence of osmotic symptoms, evidence of catabolic state, and the presence of chronic diabetes complications that may preclude the use of a particular therapeutic agent.

In addition, a patient's age, body weight, convenience of administration, and impact on work-related issues (such as driving motor vehicles) also play a crucial role in determining the order of medications used. The efficacy and side-effect profile of each drug in the individual patient is also taken into account.

Metformin

Metformin is considered the agent of first-line for treatment of type 2 diabetes in the absence of contraindications. Metformin lowers basal and postprandial plasma glucose levels. Metformin alters the composition of gut microbiota and activates mucosal AMP-activated protein-kinase (AMPK) that maintains the integrity of the intestinal barrier. Metformin in combination with the activation of AMPK decreases hepatic gluconeogenesis. It also decreases intestinal absorption of glucose and improves insulin sensitivity by increasing peripheral glucose utilisation.[3]

Metformin reduces fasting blood glucose by approximately 20% and HbA1c by 1.5%. It can be used in combination with sulphonylureas, glinides, alpha-glucosidase inhibitors, insulin, thiazolidinediones (TZD), glucagon-like peptide-1 receptor agonists (GLP1), dipeptidylpeptidase-4 inhibitors (DPP4), and sodium-glucose co-transporter 2 inhibitors (SGLT2).

Metformin is contraindicated in patients with factors that predispose to lactic acidosis, such as renal impairment, concomitant liver disease or excessive alcohol intake, unstable or acute heart failure and hypoxia.[3]

Insulin secretagogues: sulphonylureas and meglitinides

Sulphonylureas are commonly used as second-line agents in patients with type 2 diabetes, They can act as an alternative first-line treatment if the patient cannot tolerate metformin and if the patient is not overweight. Sulphonylureas can also be added to metformin if glycaemic control is inadequate. Sulphonylureas stimulate pancreatic beta cells to release insulin.

The glucose-lowering effect is said to be high for sulphonylureas. The main side-effects are loss of efficacy due to beta cell failure, weight gain and hypoglycaemia.[4]

Thiazolidinediones

NICE recommends that thiazolidinediones (TZDs) should be considered as second-line therapy, in addition to metformin, if the risk of hypoglycaemia with sulphonylureas would be unacceptable.

TZDs increase insulin sensitivity by acting on muscle and adipose tissue to increase glucose utilisation and decrease glucose production in the liver.

TZDs act as insulin sensitisers; thus, they work in the presence of insulin. They must be taken for 12-16 weeks to achieve maximal effect. TZDs are associated with an increased fracture risk and in some patients may lead to heart failure.[4] There is also a possible increased risk of bladder cancer with use of pioglitazone.[4]

Weight gain is the result of fluid retention and the activation of PPAR-gamma in the central nervous system (which increases feeding) and the up-regulation of genes that facilitate adipocyte lipid storage.

Incretin-based therapy

The incretin agents (GLP1 and GIP), secreted by intestine L cells, increase insulin secretion and inhibit glucagon in response to nutrient inputs. The glucoregulatory effects of incretins are the basis for treatment with inhibitors of DPP4 in patients with type 2 diabetes. Agents that inhibit DPP4, an enzyme that rapidly inactivates GLP1, increase active levels of these hormones and, in doing so, improve islet function and glycaemic control in type 2 diabetes.[4]

Dipeptidyl peptidase-4 inhibitors: DPP-4 inhibitors (eg. sitagliptin, saxagliptin, linagliptin, vildagliptin) are a class

of drugs that prolong the action of incretin hormones. DPP-4 degrades numerous biologically active peptides, including the endogenous incretins GLP-1 and glucose-dependent insulinotropic polypeptide (GIP). DPP-4 inhibitors can be used as a monotherapy or in combination with metformin or a TZD. They are given once daily and are weight neutral.

GLP-1 agonists (ie. exenatide, liraglutide, dulaglutide): GLP1 is secreted in response to food intake and stimulates insulin release, reduce glucagon, and slow gastric emptying. GLP-1 agonists are easy to use, as they are characterised by fixed doses and flexibility in time of administration (except exenatide).

The glucose-dependent mechanism of action, and the resultant lack of hypoglycaemia is a major advantage which increases the safety of these drugs, while maintaining efficacy.[5] Weight loss with liraglutide and exenatide, and lack of weight gain with DPP-4 inhibitors is another factor which encourages use of this class of drugs. GLP-1 receptor agonists aid weight loss, and liraglutide was recently licensed for individuals without diabetes as a weight loss treatment.[6] A common side-effect of GLP-1 receptor agonists is nausea, which is usually temporary and disappears around two weeks after treatment initiation. In addition, GLP-1 receptors also increase satiety and augment weight loss.[7] At present, GLP-1 receptor agonists are only available in an injectable form.

The lack of other major side-effects such as oedema and GI disturbance with DPP-4 inhibitors is another advantage. The incretin-based therapies can be used in mild to moderate renal failure with appropriate dose adjustments, and can be given to elderly patients.

Newer therapies targeting renal glucose handling

Sodium glucose cotransporter-2 inhibitors

SGLT2 inhibitors (eg. dapagliflozin, canagliflozin, empagliflozin), the newest antihyperglycaemic drug class, have a novel mechanism of action. Instead of inhibiting hormones and enzymes involved in the digestive process, this new drug class targets the SGLT2 protein, which is located on the proximal renal tubules.

By inhibiting SGLT2, the renal threshold for glucose is reduced, renal glucose reabsorption is blocked, and glycosuria is increased.

The change in the renal glucose threshold is likely to be behind the low rate of hypoglycaemia seen with SGLT2 inhibitors.

The mechanism of action is insulin-independent, which makes SGLT2 inhibitors complementary to other glucose-lowering treatments. Average HbA1c reduction afforded by SGLT2 inhibitors when used as monotherapy or as an add-on to metformin is 0.32% to 1.17%. As with other type 2 diabetes therapies, greater HbA1c reduction is observed with higher baseline levels. Average weight loss recorded in clinical trials was 1.5-3kg compared with placebo; however, weight loss tends to plateau, and some patients regain lost weight.

Adverse events include polyuria, genitourinary infections, hypotension, bone fractures, and diabetic ketoacidosis. With regard to the latter, the American Association of Clinical Endocrinologists (AACE) and American College of Endocrinology (ACE) convened a conference in October 2015 to review the clinical data. An expert consensus statement was issued noting that the incidence of diabetic ketoacidosis to be 'infrequent', requiring no change in recommendations.[7]

Newer insulins

Longer-acting insulins have been developed to provide a more stable basal insulin profile over a 24-hour period. The action of insulin can be delayed by increasing its molecular size and slowing its absorption. Degludec is formed of hexameric chains that slowly separate, releasing the active monomer that can then be absorbed. In clinical trials, in patients with type 2 diabetes, it was non-inferior to glargine and had lower levels of hypoglycaemic episodes, particularly at night (nocturnal hypoglycaemia).[7]

The long half-life of degludec compared with traditional, long-acting insulins means that patients can be much more flexible about the timing of their basal insulin doses, without compromising their glycaemic control.

This may be particularly useful for people with erratic lifestyles. Glargine U300 is a more concentrated form of insulin glargine available as 300 units/ml in a pre-filled pen. U300 also has a longer half-life compared with glargine. In trials, it was associated with fewer nocturnal hypoglycaemic episodes than glargine, with no change in the overall glycaemic control.[7]

Ensuring adherence to treatment

The prevalence of type 2 diabetes is increasing in Ireland due to the ageing population and increase in obesity. A multidisciplinary approach for the management of diabetes includes involving the patient.

Successful treatment of type 2 diabetes is often complicated by the inevitably progressive nature of the condition and the need to balance target blood glucose levels against an increased risk of treatment-related adverse effects such as hypoglycaemia and weight gain.

All patients with diabetes need full initial assessment and regular review to ensure that they are achieving their target HbA1c. They should be monitored for CV risk factors and microvascular complications.

A lifestyle intervention programme to promote weight loss and increase activity levels should be included as part of diabetes management. Adherence to treatment is often compromised by the fear of hypoglycaemia and weight gain, and therefore patient education is a vital aspect of management. Most patients require combination glucose-lowering agents and many patients will require insulin.

Poochellam Muthalagu is a consultant endocrine physician at Cavan General Hospital

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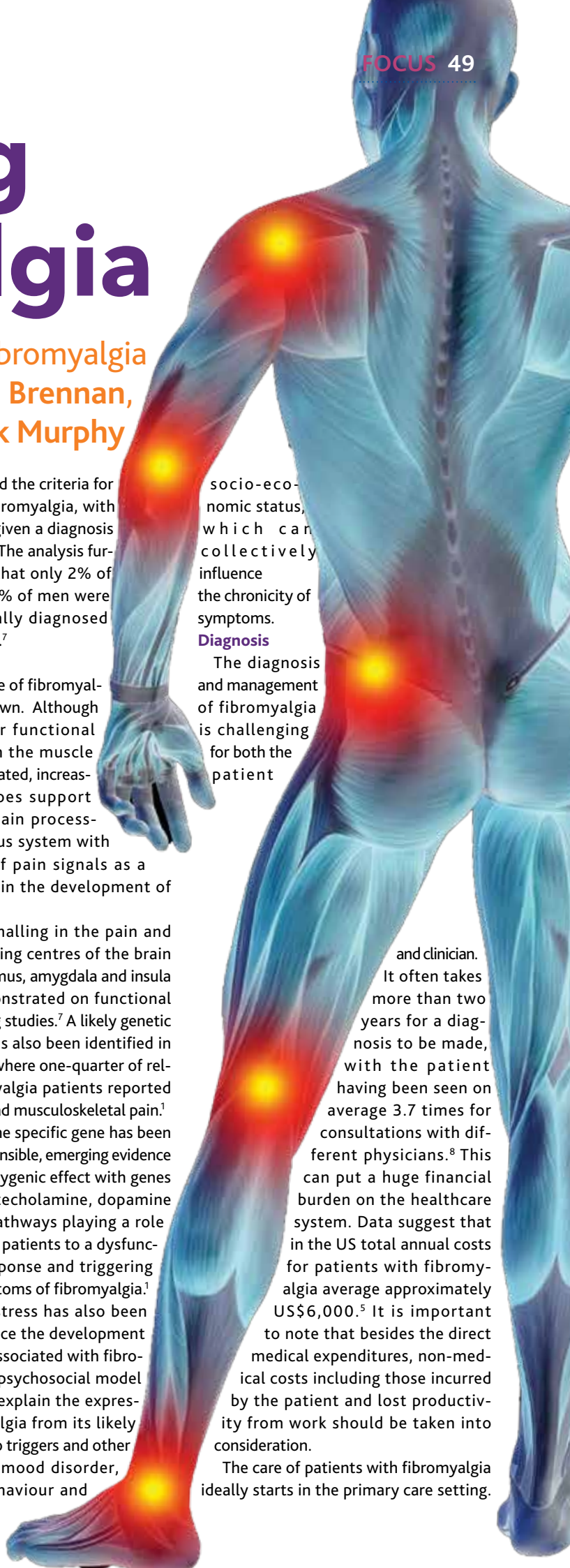
Managing fibromyalgia

Diagnosis and management of fibromyalgia can be challenging, write **Declan Brennan**, **Peter Polydoropoulos** and **Patrick Murphy**



FIBROMYALGIA has become an increasingly more recognised condition, in particular over the past two decades.[1] It is diagnosed in patients who subjectively complain of chronic widespread pain of a 'burning' quality of greater than three months. This pain is bilateral, above and below the waist, with multiple tender points along with a range of symptoms including persistent fatigue, cognitive dysfunction, functional bowel disorder, non-restorative sleep and mood disorder.[2,3]

It is estimated that 10-20% of the population report some kind of chronic musculoskeletal pain that cannot be traced to a causative factor.[4] Statistics for Ireland are limited, but worldwide prevalence of fibromyalgia of 0.4-9.3% has been reported.[5]

The American College of Rheumatology (ACR) and the European League Against Rheumatism (EULAR) have produced updated guidelines in 2010 and 2016 respectively for the diagnosis of fibromyalgia. These are well suited and practical for use in general practice.

The ACR 2010 criteria provide a sensitivity and specificity of almost 85% in separating chronic musculoskeletal pain from fibromyalgia. Patients are assessed by using the widespread pain index that divides the body into 19 regions and scores the number of regions that are reported as painful. The symptom severity score then assesses severity of fatigue, unrefreshing sleep, and cognitive symptoms. Both the widespread pain index (max. 19) and symptom severity scores (max. 12) are combined into a single questionnaire with scores from 0 to a maximum of 31. A modified and more useful version of the ACR 2010 (available at www.rheumatology.org) allows for direct patient administration.[6]

Historically, women were assumed to be more commonly affected by fibromyalgia.[7] However, a study from Minnesota in the US found that 4.9% of men and 7.7% of women fulfilled the criteria for a diagnosis of fibromyalgia, with only 27% being given a diagnosis of the condition. The analysis further concluded that only 2% of women and 0.15% of men were actually medically diagnosed with fibromyalgia.[7]

Causes

The exact cause of fibromyalgia is not yet known. Although no structural or functional abnormalities in the muscle tissue are appreciated, increasing evidence does support dysfunctional pain processing in the nervous system with amplification of pain signals as a key mechanism in the development of fibromyalgia.[7]

Abnormal signalling in the pain and emotion processing centres of the brain such as the thalamus, amygdala and insula have been demonstrated on functional magnetic imaging studies.[7] A likely genetic predisposition has also been identified in familial studies, where one-quarter of relatives of fibromyalgia patients reported chronic widespread musculoskeletal pain.[1]

Although no one specific gene has been shown to be responsible, emerging evidence is strong for a polygenic effect with genes affecting the catecholamine, dopamine and serotonin pathways playing a role and predisposing patients to a dysfunctional stress response and triggering the clinical symptoms of fibromyalgia.[1] Psychosocial distress has also been shown to influence the development of chronic pain associated with fibromyalgia. The biopsychosocial model could therefore explain the expression of fibromyalgia from its likely genetic factors, to triggers and other factors such as mood disorder, maladaptive behaviour and socio-economic status, which can collectively influence the chronicity of symptoms.

Diagnosis

The diagnosis and management of fibromyalgia is challenging for both the patient and clinician. It often takes more than two years for a diagnosis to be made, with the patient having been seen on average 3.7 times for consultations with different physicians.[8] This can put a huge financial burden on the healthcare system. Data suggest that in the US total annual costs for patients with fibromyalgia average approximately US$6,000.[5] It is important to note that besides the direct medical expenditures, non-medical costs including those incurred by the patient and lost productivity from work should be taken into consideration.

The care of patients with fibromyalgia ideally starts in the primary care setting.

Primary healthcare professionals have the best knowledge of our patients from the biopsychosocial perspective as well as providing primary care over a prolonged period of time and it would only seem right that the primary care setting should be the focal point of management. An early and positive diagnosis could reduce costs by avoiding unnecessary testing, imaging, medication use, specialist referrals and primary care visits.

The diagnosis of fibromyalgia is based mostly on the clinical evaluation and with simple blood tests. Although testing for the typical 18 sites for tenderness as specified by the ACR is helpful, it should not be used to confirm the diagnosis as the examination alone is mainly a subjective technique. It is reported that 25% of patients diagnosed with fibromyalgia do not have 11 tender points.[7] However, asking the patient about the associated symptoms including non-restorative sleep, poor concentration and fatigue in the setting of chronic widespread pain strongly suggests a diagnosis of fibromyalgia.

Only simple blood tests like FBC, U&E, TFTs (to rule out hypothyroidism), ESR, CRP, a comprehensive metabolic panel, and fasting glucose test are needed. Vitamin D levels could also be taken because vitamin D deficiency can aggravate pain, although it doesn't cause it.[9] Antibodies such as ANA, RF and anti-CCP may be requested if the examination suggests an autoimmune cause. Specialist consultation should be sought if symptoms suggest an alternative diagnosis.

Management and treatment

There is no cure for fibromyalgia and treatment should aim towards reducing symptoms and a goal of the patient reaching optimal function in daily life. Management of symptoms should take into consideration the fluctuating and heterogenous nature of symptoms in a multimodal, patient-tailored approach.[1] Educating the patient is helpful since diagnosis and an explanation for their symptoms should reassure the patient that they do not have a more severe illness.[1] This would hopefully reduce the need for unnecessary investigations.[7]

Recent EULAR guidelines recommend focusing on pain, fatigue, sleep and daily functioning. These recommendations are evidence-based, can be tailored to the individual patient and include both pharmacological and non-pharmacological therapies.

The EULAR guidelines in *Figure 1* suggest a graduated approach, beginning with non-pharmacological therapies such as exercise with an individualised pharmacological plan thereafter for the treatment of either severe pain or sleep disturbance (or both if they are present). Psychological therapies are included in updated guidelines and include education an cognitive behavioural therapy (CBT).[8, 9]

Figure 1: Management of fibromyalgia (EULAR guidelines 2016)[8]

History and physical examination

↓

Diagnosis of fibromyalgia

↓

Patient education and information sheet

↓ if insufficient effect

Physical therapy with individualised graded physical exercise (can be combined with other recommended non-pharmacological therapies such as hydrotherapy, acupuncture)

↓ if insufficient effect

Reassessment of patient to tailor individualised treatment

If needed to exclude treatable comorbidities:
- Laboratory and/or radiological exams
- Referral to other specialties

Additional individualised treatment

Pain-related depression, anxiety, catastrophising, overly passive or active coping	Severe pain/sleep disturbance	Severe disability/sick leave
↓	↓	↓
Psychological therapies Mainly CBT • For more severe depression/anxiety, consider psychopharmacological treatment	Pharmacotherapy Severe pain • Duloxetine • Pregabalin • Tramadol (or in combination with paracetamol) Severe sleep disturbance • Low-dose amitriptyline • Cyclobenzaprine or • Pregabalin at night	Multimodal rehabilitation programmes

Non-pharmacological:

- Active therapy including aerobic exercise (20 min/day, two to three times a week)
- Passive therapy including balneotherapy (heated spa or pool treatment), massage, manipulation

Psychological:

- Education to explain symptoms and mechanisms of fibromyalgia
- CBT to reduce pain with focus on what links pain, thought (mood) and behaviour (negative coping strategies).

Pharmacological:

- Anti-depressant: amitriptyline 10-50mg
- Anti-convulsant: pregabalin 300-600mg
- Serotonin-norepinephrine re-uptake inhibitor: duloxetine 60-120mg
- Tramadol and paracetamol combination: Tramadol 37.5mg/325mg paracetamol four times per day.

Experience at a clinical level involves starting amitriptyline 7.5mg nocte titrating up to 50mg (if needed) per night optimal for pain and sleep relief. Pregabalin can be started at 25mg, twice daily for pain and anxiety, titrating up as needed. Side-effects can be an initial complaint with pregabalin, especially with increased sensitivity to alcohol.

Sleep hygiene is imperative, as patients with disturbed sleep patterns and lifestyle changes often experience increased fatigue, which might result in non-compliance. Care should be taken with prescribing medications such as opiates and neuroleptics due to their addictive nature.

Declan Brennan is a general practitioner in Mullingar; Peter Polydoropoulos is a psychiatry registrar at St Loman's Hospital, Mullingar and Patrick Murphy is a consultant physician at the Midland Regional Hospital, Tullamore

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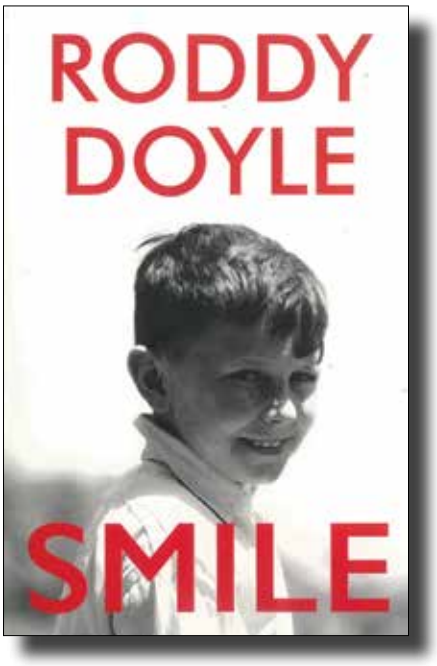
An uncomfortable truth

RODDY Doyle, in a prolific writing career, has always been popular with the reading public, but not always with some critics, who have a tendency to view him a bit allergically, refusing to nudge him over the sometimes pretentious line between popular and literary fiction, notwithstanding his Booker Prize win in 1993. In fact, Roddy Doyle tends to get a more enthusiastic critical response outside of Ireland.

Here's a thought. It would save much angst if authors simply pre-submitted their manuscripts (preferably on pigskin vellum) to selected critics. Then they could be informed in advance as to what does and doesn't 'work' and be educated by countless 'if onlys', eg: "if only you'd written it in Swahili", "if only it wasn't a book, but a Wispa, as I'm a little hungry at the moment and don't feel like writing a review" or "if only this writer was another writer who I like better/once bought me a pint/is my first cousin" etc. However, as one character inhabiting 'Doyleland' might opine: "feck the critics!"

Roddy Doyle is known for dealing successfully with complex and sensitive societal themes. His *The Woman who Walked into Doors* is perhaps the most



impressive work of recent fiction written by a man from a woman's perspective. *Smile* similarly digs into the consequences of violence and abuse in Irish society; in this case the appalling abuse, both physical and sexual, that existed in parts of the Irish school system until relatively recently.

Doyle shines a light on an unfair and uncomfortable truth surrounding such abuse – the irrational guilt of the victim. But *Smile* is about more than that. It is about the treachery of memory and our self-delusional pasts, which often come back to mug us.

The narrator of *Smile*, Victor, is a separated, once half-famous writer and media performer who now lives out a lonely middle age. He meets up with the strange Fitzpatrick, a man not recalled by Victor but who claims to be his acquaintance from their school days.

Exactly who is Fitzpatrick? Did he really go to school with Victor? This is ultimately answered in a surprising and skilful denouement.

In *Smile*, Roddy Doyle's prose style is characteristically direct, concise and witty, and his characters are succinctly well drawn, inhabiting comfortably the 'Doyleland' of laconic working class/lower-middle class Dublin.

While this is ultimately a serious book, it always entertains, and moreover is a satisfying read.

– Niall Hunter

Smile by Roddy Doyle is published by Johnathan Cape London. ISBN: 978-1911214755. RRP STG £13.99

Crossword Competition

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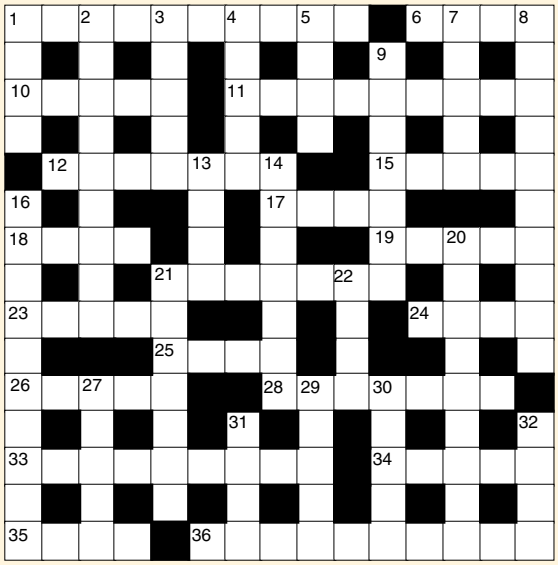

Across
1 Worthy of a silver medal at the Olympics (6-4)
6 Self-satisfied (4)
10 Somehow, Edouard was meant to be a great painter (5)
11 Sport played in a swimming pool (5,4)
12 Give an insect 50% of a rugby position (3,4)
15 Fruit used in winemaking (5)
17 & 32d Legs honk out where the Maze prison used to be (4,4)
18 Circular plaything (4)
19 Avoid capture. (5)
21 Might Lear wed in such sheltered style? (7)
23 Surpass a garden party? (5)
24 Mark on the skin from an old wound (4)
25 Was the Russian ruler a sleepy character in the automobile? (4)
26 American animal that sprays a foul-smelling liquid (5)
28 One can show respect for a piece of regalia (7)
33 It's said to be the sincerest form of flattery (9)
34 Lessen, ease off (5)
35 For long periods of time, one's nose was out of joint (4)
36 The final hole in a full round of golf (10)

Down
1 Totals (4)
2 Barge around with a lab cat? No! (5,4)
3 A mark usually scored in wood (5)
4 Place an archer's weapon before the Spanish part of the body (5)
5 Fill to satisfaction (4)
7 Tumour growing from muscle fibres (5)
8 Fruit for a chaperone (10)
9 Boasted (7)
13 Recess found in a church (4)
14 Blooms (7)
16 English county where one relocated her shop, sir (10)
20 One's not sure if this could make one's aunt nicer (9)
21 A form of tetanus (7)
22 Change gear in a fury (4)
27 Workers' organization (5)
29 Type of seashell (5)
30 Jet (5)
31 Flightless bird associated with New Zealand (4)
32 See 17 across.

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Closing date: Friday, April 20, 2018
Post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin

Solutions to March crossword:

Across:
1 Beta blockers 7 Orb 9 Peak 10 Tremor 11 Ursa Minor 14 Envoy 16 Tuck 18 Gulls 21 Group 22 Horde 23 Harpy 24 Aged 25 Polar bear 26 Debar 29 I Spy 33 Tralee 34 Hips 36 Awl 37 London Bridge

Down:
1 Bye 2 Take 3 Bath 4 Ocean 5 Kyoto 6 Sour 8 Blackberries 9 Prima gravida 12 Snooze 13 Graph 14 Edgar Allan Poe 17 Unruly 19 Layer 20 Shops 27 Erred 30 Pull 32 Thud

The winner of the March crossword is:

Kathleen Delaney
Douglas
Cork

MONEY MATTERS

Reviewing your life insurance

Ivan Ahern highlights reasons to review your life insurance at various stages in life

YOU may feel you don't need life insurance yet or that there's no need to review the cover that you already have, but life's milestones and changes in your circumstances can affect the level of life insurance you need.

Reviewing your life insurance ensures that you have the right cover to meet your current needs and could also save you money. Life insurance protects what matters most, providing financial security for your loved ones and those who would face a financial challenge if you passed away (for example paying debts or loans you may have).

Here are some key reasons why you should take out or review your life insurance at different stages in your life:

In your 20s and 30s

Getting married or having a child

With increased financial dependence on you, your spouse or partner and children need to be factored into your cover. When your children are young, your life insurance needs are often greater, which is why it's important to ensure you get the right cover to suit your needs.

Buying your first home

When you purchase a home, it's common to take out the mortgage protection offered by your mortgage provider. However, they may not offer the best rates or terms for your needs, so it's good to shop around.

In your 40s

Changes in mortgage

As you pay off your mortgage, the level of cover you need will decrease over time. If you have taken on a new mortgage for a new home or house renovation, you will need to review your cover accordingly.

Changes in your health

If you have given up smoking, increased your activity and as a result lost a significant amount of weight, or have been eating healthily and your blood pressure has come down, this can impact on the cost of your life cover.

Family changes

As your family grows, there are more people depending on you financially who need to be included in your cover. You may also require financial protection for your parents, for example if they became ill or required nursing home care in the future.

Other policies

If you have taken out other policies that include an element of life insurance, you should review these collectively to make sure you are not over-insured and that you have the right policy for you.

In your 50s

Financial status

As you move through life, your financial status can change, which may require more or less life cover. This could include changes in income, additional loans or mortgages, or children who are no longer financially dependent on you.

Providing for your children

There could be additional costs required for your children that you can factor into your life insurance, for example third level education fees, wedding costs or house deposits.

Inheritance tax

Your children may require additional financial protection for any inheritance tax bill they receive, which you can provide for through your life insurance.

Future needs

The future needs of your spouse or partner can also be included in your life insurance, for example cover for home care or nursing home care when they reach old age.

Other points to remember

- If your circumstances change or you haven't reviewed your life insurance in a number of years, you should review your cover to ensure you've got the right level of protection
- Not all insurance policies are the same. Life insurance providers are constantly offering new types of cover, at more affordable prices, so it makes sense to review.

You can avail of a free life insurance review with Cornmarket. For more information visit: **cornmarket.ie/life-insurance** or Tel: 01 420 0965.

Ivan Ahern is a director of Cornmarket Group Financial Services Ltd.

Public health risk linked to sea bathing

Sea swimmers at risk of gastrointestinal disorders such as diarrhoea

PEOPLE who swim in the sea or take part in water sports are at risk of experiencing gastrointestinal disorders such as diarrhoea, and also ear aches, according to new research that examined the current evidence in this area. The research looked at sea bathing in high-income countries and the possible associated public health risks.

The results showed that swimming in the sea increased the odds of reporting ear ache by 77% and for gastrointestinal illnesses and diarrhoea by 29%.

"Our paper shows that spending time in the sea does increase the probability of developing illnesses such as ear ailments and problems involving the digestive system such as stomach ache and diarrhoea," said Dr Anne Leonard, University of Exeter Medical School.

"We think that this indicates that pollution is still an issue affecting swimmers in some of the world's richest countries," she added.

This large-scale project reviewed 6,000 studies and refined these down to 19 key studies for inclusion in a meta-analysis. It is the first systematic review of the evidence on whether spending time in the sea is associated with an increased risk of infections.

The study focused on high income countries including the UK, US, Australia, New Zealand, Denmark and Norway.

Interestingly, the study found no difference in terms of picking up an infection between those who put their heads under the water and those who don't.

The researchers at the University of Exeter concluded that despite significant investment to improve water quality in the sea, the water in developed countries is still being polluted from sources like industrial waste, sewage and farmland run-off.

The researchers hope that this review will lead to further efforts to clean up our coastlines. In addition, they say that more research is needed on the micro-organisms responsible for infections.

While sea swimming has many benefits, the research team said that it is important that people are aware of the risks in making a decision to go into the sea. Although people recover from infections, some can prove more serious for vulnerable people such as the elderly or very young people with pre-existing health conditions.

The paper 'Is it safe to go back in the water?' was recently published in the *International Journal of Epidemiology*. It was funded by the European Regional Development Fund.

INMO's Richmond nominated for conservation award

THE INMO's restoration and redevelopment of The former Richmond Hospital building was shortlisted as a finalist in the Irish Construction Excellence (ICE) Awards.

Nominated under the 'Public or Heritage Building/Conservation or Restoration' category, the ICE Awards are the premier recognition and performance excellence for the contracting sector in Ireland. Townlink Construction submitted the application on behalf of the work carried out at The Richmond.

The Richmond project involved the complete refurbishment of the former Richmond Hospital building to form a new teaching, training and event hosting facility for the INMO.

The building is a protected structure, constructed in the 1890s, that previously accommodated a hospital and a courts service.

The contractors had to ensure that all works undertaken within the building were carried out with due care and attention to the historic nature of the building.

The INMO project, which is now the Richmond Education and Event Centre, faced stiff competition with The National Gallery, the GPO Witness History and Medieval Mile Museum, Kilkenny all nominated in the same category. Nonetheless, being a finalist among such company was an achievement in itself.

The winner was due to be announced as *WIN* went to press.

April

Monday 9
Nurse Midwife Education Section 11.30am INMO HQ. Contact jean.carroll@inmo.ie for further details

Saturday 14
PHN Section Meeting. INMO HQ 11am. Contact jean.carroll@inmo.ie for further details

Saturday 14
School Nurses Section Meeting. Follow up on documentation workshop. INMO HQ. 10.30am. For further details contact jean.carroll@inmo.ie

Saturday 14
Radiology Nurses Section Meeting. INMO HQ. 11am. For further details contact jean.carroll@inmo.ie

Monday 16
National Children's Nurses Section Meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie for further details

Tuesday 17
Student Allocation Liaison Officers Meeting. INMO HQ. 12pm. Contact jean.carroll@inmo.ie for further details

Wednesday 18
RNID Section Meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie for further details

Friday 20
ODN Section Meeting. Tullamore Court Hotel. 6pm. Contact jean.carroll@inmo.ie for further details

Friday 20 - Saturday 21
ODN Section annual conference
See page 60 for full details

Thursday 26
Retired Nurses Section Meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie for further details

May

Wednesday 2 - Friday 4
INMO annual delegate conference
The Clayton Hotel, Silver Springs, Cork. *See page 20* for more details

Wednesday 15
Retired Section Social outing. Tour of Mary Aikenhead Heritage Centre. Our Lady's Hospice, Dublin 6. Contact: Ann Igoe - a.igoe123@gmail.com

Thursday 17
CPC Section seminar. Richmond Education and Event Centre. *See page 28* for full details

Wednesday 23
Telephone Triage Section Meeting, followed by a workshop on mental health issues. INMO Limerick office. Places are limited. Tel: 01 6640641 to book. Contact jean.carroll@inmo.ie for further details

Wednesday 23
Orthopaedic Nurses Section Meeting in UHG. 11am. Contact jean.carroll@inmo.ie for further details.

June

Saturday 9
Third Level Student Health Nurses Section Meeting. INMO HQ. Contact jean.carroll@inmo.ie for further details

Thursday 21
ODN Section Meeting. INMO HQ. Contact jean.carroll@inmo.ie for further details

Saturday 23
PHN Section Meeting. INMO HQ. Contact jean.carroll@inmo.ie for further details

Tuesday 26
Research Nurses/Midwives Section Seminar. INMO HQ. To avail of early-bird rate Tel: 01 6640641/18. *See page 34* for details

INMO Membership Fees 2018

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