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WIN

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Irish Nurses and Midwives Organisation

World of Irish Nursing & Midwifery

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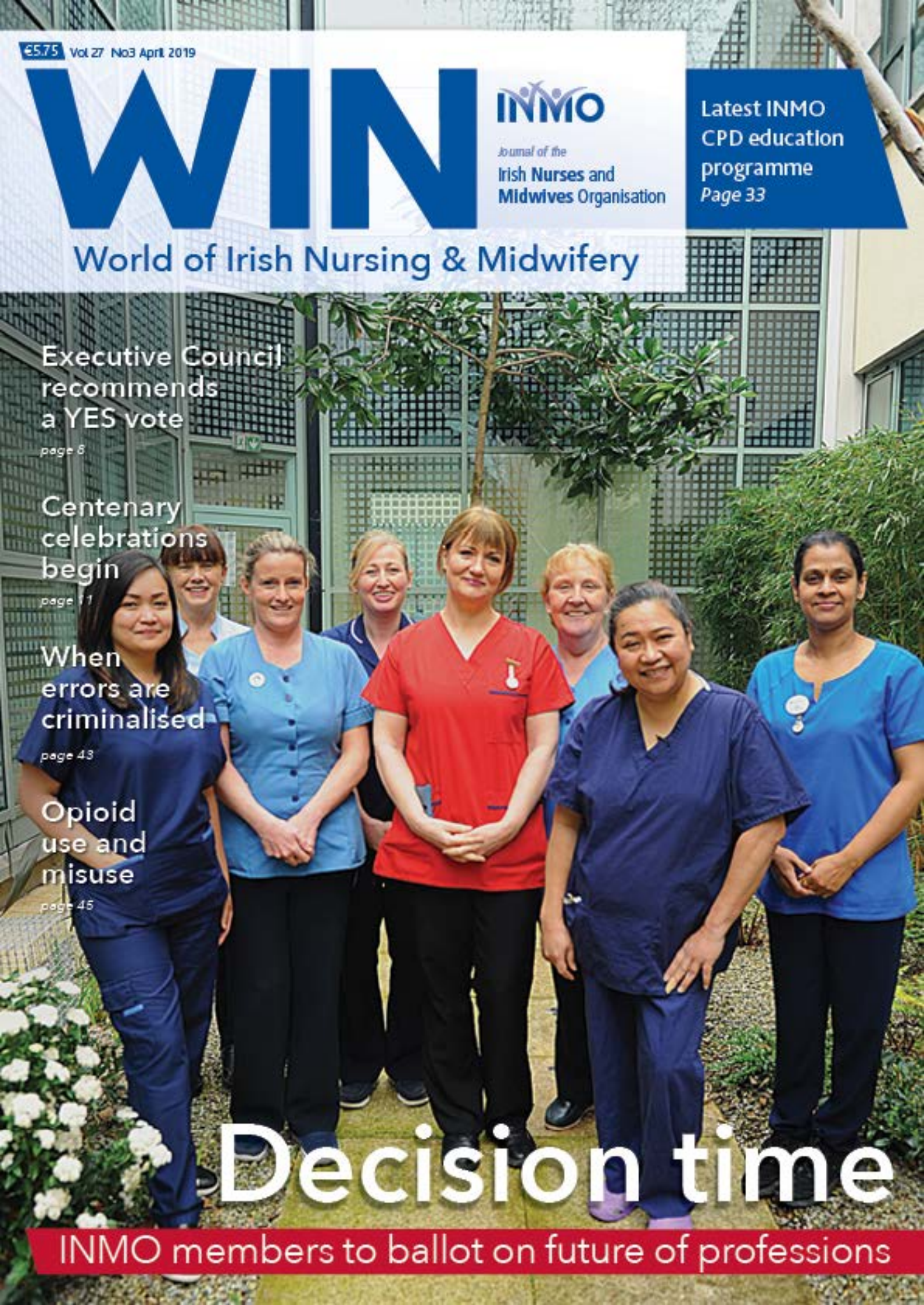

Decision time

INMO members to ballot on future of professions

Cover image *pictured on this month's WIN cover are (l-r): Jan Hailey Reyes, Grace Ryan, Jane Lyons, Teresa Kelly, Christine Hogan, Margaret Armstrong, AJ Turla and Asha Pinsharan*

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Decision time

AT THE time of going to press, INMO members are on the cusp of making a very serious decision for the future of our professions as nurses and midwives.

Following your determined and unified strike, we have secured proposals in two main phases, aiming to deal with recruitment and retention problems across nursing and midwifery. The first phase will significantly improve pay for staff nurses and midwives, using a new salary scale – which is shorter, meaning you get to the maximum point faster.

It will also see a large expansion in the number receiving allowances (including midwives and PHNs), along with the previously agreed increase in allowances. And in intellectual disability services, there will be an increase in promotional posts.

While all will benefit significantly from the new pay scale, the proposals give the most benefit to those who are lower on the salary scale, as these are the lowest-paid workers at greatest risk of leaving the country, health service or profession.

But this is only the first phase. Phase two will see an expert group examine how nursing and midwifery has been affected by changes in recent years, and the changes to come – such as the implementation of Sláintecare and shifts in chronic disease management.

Crucially, it is required to examine the salaries of management grades, from CNM1s to directors, given the implications of the salary increases for staff nurses and midwives. The INMO has now confirmed that this expert group will be formed of an INMO nominee, an international nursing/midwifery expert, and an agreed independent chair. If you vote to approve these proposals, the group will be established and report back in time for the next national pay talks – meaning a conclusion in the first quarter of 2020.

We have also confirmed how the Safe Staffing Framework will be funded over the next three years. The Framework sets out how many nurses are needed to provide safe care, based on patient numbers and dependency. The government has committed to annual funding specifically for this framework – something which was missing in the last two HSE service plans.

As a union, we successfully made the argument that these measures are within the Public Service Stability Agreement, meaning that the threatened strike penalties have not occurred and members will still receive percentage pay rises this year and next.

The outstanding issue since we suspended the strike has been over the new contract to accompany the enhanced salary scale. The employers' initial draft contract was completely unacceptable to us as nurses and midwives. Their draft contract sought to split shifts and impose daily location changes. We rejected these proposals, talks became deadlocked and we went back the Labour Court on March 25. We set out the arguments against the employer proposal and I am glad to confirm that the Court agreed with us.

The Executive Council met immediately after the Court's decision and decided to recommend you vote to support these proposals, on which – at time of writing – balloting will begin soon.

The new salary scale, staffing level commitments, and expert review all make significant steps forward for our professions. But members should be in no doubt: these proposals are the beginning of change, not the end. Our campaign for recruitment and retention improvements will continue.

We have only achieved these proposals because we stood united as professionals in nursing and midwifery. We have used all the state's procedures and processes to argue for this change and improvement. We took industrial action when government failed to listen, and we used the very same procedures to ensure we now have an agreement that they cannot shrink away from implementing.

This is the beginning of more work to ensure the next generation of nurses and midwives work in a better-paid, better- staffed and a safer health service. We need you to come on that march with us. Let's begin!

Phil Ní Sheaghdha
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

Centenary celebrations commence

THE INMO was founded 100 years ago in 1919. We kick started our organisation's centenary with a wonderful opening event in Dublin's Mansion House, hosted by the Lord Mayor of Dublin, Nial Ring. Some 90 INMO members attended, along with the granddaughters of our founding general secretary, Marie Mortished. Our thanks to both of them, Judy Lunny and Susan Slott. The INMO's first president, Louie Bennett, was represented by her biographer Rosemary Cullen Owens.

The date of the centenary event was no accident. It was held precisely 100 years after the first public meeting of the INMO – or the Irish Nurses' Union as it was first known. It too was held in the Mansion House. Indeed, this was one of the founding events of what many believe to be the world's first nursing union. The aim of those remarkable women who founded the Organisation was simple: to drive for change, fair pay and improved conditions.

This was all the more radical at the time, given that nursing and midwifery then were exclusively female professions in a male-dominated world. Indeed, much of the resistance to trade union organising at the time came from nurses themselves.

For the coming centenary year, we have selected the themes of:

- *Reflecting on the past*
- *Navigating the present*
- *Modelling for the future.*

The Mansion House centenary event heard a series of addresses from the Lord Mayor, our general secretary, Judy Lunny and myself. It also previewed two pieces which will be launched at the upcoming annual delegate conference: the centenary badge, which I had the privilege to design, and the book of the INMO's first 100 years. The book, by INMO member Mark Loughrey, recounts and catalogues the seminal moments of our union's history. *A Century of Service – A History of the Irish Nurses and Midwives Organisation, 1919-2019* will be published by Irish Academic Press.

• See page 11 for more coverage of Mansion House event

ICTU Women's Seminar

THE INMO participated in the Irish Congress of Trade Union's Women's Seminar on International Women's Day. This year's theme *'Women within the Trade Union Movement'* formed the basis of the opening address by ICTU general secretary Patricia King.

We heard that female membership within the global trade union movement is at its highest point. Of the billions of union members, half are women. Despite this, they are still disproportionately employed in informal sectors and those in formal work are not valued equally with their male counterparts.

While every household is different, many face inequality in the home, bearing the responsibility for the lion's share of care and domestic duties. Women in the workplace are often thought of as invisible and, as Patricia King went on to say, many have roles involving "mammying the men", whose work is often more highly paid.

Patricia King also emphasised the importance of acknowledging that the union movement needs women to lead too. She referenced her own struggles in a male-dominated union world and the difficulties that predominately female unions face. In this, she particularly referred to the INMO's recent strike action and ongoing dispute.

The seminar also saw sessions on women in politics, the centenary of the International Labour Organisation, the future of work, and leadership today. In that last session, I spoke, arguing that for good leadership – culture, role modelling and accountability to members are key, and I concluded by leaving the delegates with the following thought: "a leader knows the way, goes the way and shows the way".

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

Quote of the month

"There are those who look at things the way they are, and ask why?... I dream of things that never were and ask why not?"
Robert F Kennedy

Report from the Executive Council

YOUR Executive Council has been meeting more frequently since the strike, with the usual monthly meetings plus two extraordinary meetings on March 11 and 12, with others on March 29 and April 3.

Finalising government proposals following our strike has been the main focus. Following a Labour Court recommendation, the Executive suspended the strike to allow time for further clarification and for members to vote on proposals. The proposals included expanded allowances, an expert review into our professions, and a new pay scale with a new contract.

The government proposed a new contract that was completely unacceptable. The negotiating team rejected it immediately but made some progress in further talks. However, negotiations reached a deadlock and on March 11 your Executive Council agreed to go back to the Labour Court to allow it examine the disputed clauses. The Executive also took the decision to postpone balloting so that members will be able to vote on the whole deal.

Following the second Labour Court recommendation on April 3, the Executive decided to recommend that members vote in favour of the complete package. Stay tuned, get informed and cast your vote!

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

Executive recommends YES vote

"There is no longer anything to fear in new contract" – General Secretary

AT AN emergency meeting on April 3, held immediately following receipt of the Labour Court recommendation, the nurses and midwives who form the INMO's Executive Council recommended that members vote to accept proposals aimed at resolving the recent strike.

The Labour Court recommended in the INMO's favour on the disputed parts of the proposed new contract for staff nurses and midwives. Its recommendation:

- Recognises that nursing should be "put in a position to lead on (healthcare) reforms"
- Removes proposals for four-, six- and eight-hour shifts – no change to current arrangements
- Removes proposals for changes in workplace locations mid-shift – no change to current arrangements
- Rules out proposals for 'split shifts', where shifts would be divided across the day
- Guarantees that new nurses and midwives can reach the higher 'enhanced practice' salary scale after one year and 16 weeks.

The INMO is now to ballot members, beginning on April 8.

The deal members will be voting on includes:

- A new 'enhanced practice' salary scale, which sees staff nurses and midwives earn up to €2,439 more each year in their career, and get to the maximum point faster
- €5 million in funding for safe staffing levels in 2019, with extra funding in 2020 and 2021
- An independent expert group to look at pay for nurses and midwives in managerial grades
- Allowances expanded to nurses in surgical and medical areas and to those in maternity services in hospitals or the community. Surgical and medical areas are where most graduate nurses commence their careers. They will now attract an allowance of at least €2,230 in addition to the increased salary scale. This would mean a salary of €38,036 after one year and 16 weeks, compared to the €32,171 under current arrangements. This is €5,865 (18%) more
- A 20% increase in those location and qualification allowances, by €372 to €2,230 and by €559 to €3,350 respectively
- Speedier pay increases for new nurses and midwives, who will skip the second increment
- Promotion to senior staff nurse/midwife after 17 years, not the current 20
- Extra promotion opportunities for staff nurses working in intellectual disability, and for 2% of the nursing/midwifery workforce to be made advanced nurse/midwife practitioners
- New or increased allowances for all public health nurses
- Support for education and training.

Decision time:
INMO members set to vote on future of the professions of nursing and midwifery. Pictured above are INMO members from Naas General Hospital (l-r): Jan Hailey Reyes, Jane Lyons, Teresa Kelly, Christine Hogan, AJ Turla, Margaret Armstrong and Asha Pinsharan

INMO general secretary Phil Ní Sheaghdha said: "This Labour Court recommendation is a total vindication for what the INMO has said about the government's draft contract. The government's proposals were completely unreasonable and we are glad to see the Court has recognised this.

"There is no longer anything to fear in this new contract. The nurses and midwives of our Executive Council have now decided to fully recommend this deal to members. It does not resolve all our issues, but we believe it is a significant step forward for nurses, midwives and patients across Ireland.

"This deal gives our health service a real chance to recruit and retain nurses and midwives and compete with international recruiters.

"The deal includes safe staffing levels, increases in take-home pay, and more promotional opportunities."

INMO president Martina Harkin-Kelly said: "This is a hard-won deal. The elected Executive Council and I will be recommending that members vote to accept it.

"This is a good deal for all nurses and midwives and we are confident that the independent expert group will, in phase two, deliver for our members in managerial roles.

"I am particularly glad to note the new contract's provision that nurses and midwives will be in a leading position for the coming healthcare reforms."

Ten reasons for members to vote YES to proposals

1 Safe staffing framework – funding guaranteed

The government will commit to €5 million extra funding in 2019, and more funding in the service plans for 2020 and 2021 to roll out the Framework for Safe Staffing. The framework, for the first time in Ireland sets scientific staff to patient ratios based on the number and dependency of patients. It also sets a ratio of 80:20 (or 85:15 in urgent care areas) for nurses to healthcare assistants. When tested in three Irish hospitals, it saw:

- Better patient outcomes
- Reduced patient length of stay and mortality
- Increase in staff morale
- A 95% reduction in reliance on agencies
- Increase in overall staffing levels.

2 Independent expert group to examine professions and pay

Experts – including an INMO nominee – will examine how our professions have changed and how that should be reflected in pay, especially in light of the new improved salary scale for enhanced staff nurses and midwives. There will be a specific focus on pay for CNMs/CMMs (1, 2 and 3), CNS/CMS, ANP/AMPs, PHNs, and directors/assistant directors of nursing or midwifery. This will conclude before the next national public pay agreement negotiations commence in the first quarter of 2020. No other public sector group has secured this.

3 A new enhanced salary scale

Staff nurses and midwives will be able to achieve a new, higher salary scale – up to €2,439 higher in every year in their career. You can join the new pay scale at your next increment date (from March 1, 2019 on). According to the HSE census, there are over 25,000 staff nurses and midwives. This would mean, for example, a pay increase of around €1,500 or more for senior staff nurses/midwives, or those on the long service increment.

4 A shorter and faster scale

The new 'enhanced practice' scale is shorter, meaning you can get to the maximum point or long service increment faster, leading to higher earnings over the course of a career.

You will also qualify for the senior staff nurse/midwife grade after 17 years, not 20. This will benefit around 1,500 members this year and around 500 the year after.

5 New nurses and midwives get speedier salary boost

New nurses and midwives will be able to skip the second point on the salary scale, accelerating their salary faster, to aid with recruitment of new staff. This means a new graduate would:

- Spend 16 weeks on the first point
- Skip the second point
- Spend a year on the third point
- Move to the new enhanced practice scale.

After a year and 16 weeks, with a location allowance, you could be on €38,036 – 18% more than the current system's €32,171. Without an allowance, it would be €35,806 (11% higher).

6 Higher allowances

Allowances will go up by 20%. The location allowance will be worth €2,230 (an extra €372) and the qualification allowance will be worth €3,350 (an extra €559).

7 Expansion in those getting allowances

Nurses and midwives (including CNM/CMM1 & 2) in acute surgical and medical areas will get the location allowance (€2,230) for the first time, as will nurses and midwives working in maternity services (including in the community). There will also be extra opportunities to get the qualification allowance (€3,350) in these areas.

8 Allowances for all public health nurses

All PHNs working with maternity services will now get the location allowance (€2,330). If you currently get the qualification allowance instead, that'll go up by €558 (20%) to €3,350.

9 More promotion opportunities

2% of the nursing/midwifery workforce will be advanced practitioners (ANP/AMP) – an increase of roughly 500.

Staff nurses working in ID services alongside social care workers can be regraded as CNM1s.

10 Keep the benefits of the Public Service Stability Agreement

We've negotiated to avoid pay penalties, by making our arguments within the agreement. That means nurses and midwives' salaries – in addition to everything above – will increase by 1.75% this September and by 2% in October 2020. Those paying the pension levy also get additional pension relief.

Top questions

What about the changes to the contract?

The government proposed an enhanced practice contract which was completely unacceptable. The INMO rejected it, negotiated and went back to the Labour Court.

The government's contentious proposals such as moving your workplace location midway through a shift, or cutting shift lengths to four hours with no notice, have been removed.

The full contract will be available online, and the nurses and midwives on your Executive Council are recommending accepting it. The new contract recognises that nursing and midwifery should be "put in a position to lead on (healthcare) reforms".

Signing the contract will be optional, but you will not be able to access the new enhanced salary scale without it.

What happens if we vote no?

If we vote no, we do not get the benefits listed above. Your Executive Council will have to look at other ways to progress our claim. If we lodge a pay claim with the government or go on strike, there is a strong risk that we will incur the penalties, which include:

- Suspension of increments until the end of 2020
- A nine month delay in annual pay increases
- Reduced pension relief due in January 2020 – postponed.

An estimate cost of these penalties could be as high as €4,000 over two years for a staff nurse on the ninth point on the scale.

How much is the deal worth to me?

Check the INMO website and social media for a calculator to show just how much the pay proposals are worth to you.

Tony Fitzpatrick, INMO director of industrial relations, reports on current national IR issues

INMO raises concerns about HSE National Investigations Unit

THE INMO met with the HSE last month to discuss its concern about the terms of reference of investigation teams from the National Investigations Unit.

The INMO has raised several concerns about the processes and methodology used by the unit, which was established by the HSE to coordinate investigations that fall under the Trust in Care, Dignity at Work and Disciplinary Procedures policies.

Chief among the concerns is the unit's attempt to ignore the requirements within certain policies for agreement on terms of reference and investigators. The INMO argues that any agreed investigation team must have the relevant clinical knowledge to effectively conduct an investigation.

The INMO aired this and other concerns in the meeting with the HSE and other unions. The unions proposed a review be conducted with agreed terms of reference, timeframes and the appointment of an individual to conduct the review.

It is proposed that the reviewer would meet with the union side and the Investigations Unit and produce a report on addressing these issues.

The unions sought that in the intervening period, where disputes currently exist, that a nominee from the Office of the National Director of HR and the Investigations Unit would meet with the union side to resolve outstanding matters. If there is agreement on the terms of reference, then the investigation could proceed.

The HSE is to examine the issues raised and meet again with the unions on April 8.

Non-cooperation with ASQ roll out continues

DUE to the failure of the HSE's Child Health Nurture programme to engage with the INMO on the Ages and Stages Questionnaire (ASQ), the INMO is continuing to refuse to cooperate with its roll out.

In a meeting on March 20 between the two parties, it was highlighted to the HSE that no appropriate consultation had taken place with the INMO, as the trade union that represents community nurses.

The INMO highlighted that a referral system is already in place that allows PHNs to refer families to relevant services such as speech and language therapy and physiotherapy. The Organisation said that members would continue to use the normal referral processes pending full HSE engagement on the ASQ.

According to the INMO, the roll out of the ASQ would place an additional workload on PHNs who currently endure a significant lack of clerical support – an issue that needs to be addressed.

In addition, with the number of current PHN vacancies in many areas, the INMO pointed out that the proposed changes would have a negative impact on already overstretched staff.

Therefore the INMO's position remains that it will not cooperate with any roll out of the ASQ, pending engagement and consultation taking place.

The HSE agreed to commence the consultation process as required by the Protection of Employees (Information and Consultation) Act 2006 and the subsequent health service/trade union agreement.

The parties are due to meet again on April 10, after which members will be updated. Members are asked not to cooperate with any training on the ASQ model until further instruction.

New package for SATUs sees 25% funding increase

THE INMO has welcomed a new funding, staffing and policy package for Ireland's nurse-led Sexual Assault Treatment Units (SATUs).

The €500,000 package was announced last month by the Minister for Health, as part of a process following representations by the INMO on behalf of SATU nurses.

Four SATU nurses and the INMO had met the Minister in spring 2018 to raise issues which included understaffing, excessive overtime, and a lack of resources.

At the INMO annual delegate conference in May 2018, Health Minister Simon Harris committed to a new national policy on SATUs. Ireland has six SATUs, with the aim of providing a service to victims of sexual assault within three hours of first contact. A total of 941 patients used the services in 2018 – an 11% increase over the past four years.

INMO general secretary Phil Ní Sheaghdha said: "Sexual assault treatment is specialist work, undertaken with great sensitivity and commitment by our members. Ireland's six units are led and staffed by exceptionally dedicated nurses.

"Sadly, the workload in this area has been increasing in recent years. The 25% increase in funding is welcome, and the INMO is glad to see the government take on board policy changes which will make a real difference both to frontline staff and those who find themselves in need of this service.

"There remain outstanding issues, but this is a strong starting point, and will make a measurable difference in the sector."

INMO: Centenary celebrations begin

Organisation marks 100th anniversary at reception in Mansion House

AT THE end of February, the INMO commenced its centenary celebrations with a reception in Dublin's Mansion House – the site of the Organisation's first public meeting 100 years ago.

The INMO began life as the Irish Nurses Union in 1919, primarily to improve pay and set professional standards. It was said to be the world's first trade union for hospital nurses and was initially a branch of the Irish Women Workers' Union.

In the 1930s, it became the Irish Nurses Organisation (INO), affiliating with the International Council of Nurses. In 1990, it affiliated with the Irish Congress of Trade Unions.

In 2010, it changed its name to the Irish Nurses and Midwives Organisation, to reflect the increasing professional and legal distinctions between nurses and midwives.

The INMO now has over 40,000 members throughout Ireland. It provides national representation for its members and their professions, professional training, and trade union services – both nationally and in individual workplaces.

INMO general secretary Phil Ní Sheaghdha said: "The INMO is proudly entering its 100th year. As professions, we have gone from strength to strength since 1919. Nurses and midwives have consistently been to the fore of modernising our health service, while providing life changing and lifesaving care to patients. We are honouring and marking the many thousands who have given their time and energies to grow our professions, stand up for their colleagues and build our collective strength in the union."

INMO president Martina Harkin-Kelly said: "Midwives and nurses are rightly celebrating our contribution to this country over the past century. This centenary year is, in particular, an opportunity to thank and recognise the contribution of all those who have volunteered to represent their colleagues at work, and support the union through sections, branches and the Executive."

Pictured in the Mansion House for the first of the centenary celebrations were: *Eilish Fitzgerald, second-vice president; Phil Ní Sheaghdha, general secretary; Martina Harkin-Kelly, president; and Catherine Sheridan, first-vice president*

Martina Harkin-Kelly and Dublin's Lord Mayor Nial Ring compare chains of office

Mark Loughrey, research nurse/ INMO historian; Judy Lunny, grandchild of the first general secretary; Phil Ní Sheaghdha, general secretary; Susan Slott, grandchild of the first general secretary; and Martina Harkin-Kelly

Phil Ní Sheaghdha; Rosemary Cullen-Owns, biographer of Louie Bennett, first president of the Irish Nurses' Union; and Martina Harkin-Kelly

Albert Murphy, INMO IRO; Edward Mathews, director of regulation and social policy; and Tony Fitzpatrick, director of industrial relations

Trolley figures jump by 14% in March

Limerick shutting down beds despite being worst-affected hospital

MORE than 9,700 admitted patients were forced to wait on trolleys and chairs for beds in March this year, according to the INMO trolley/ward watch analysis.

The total number of patients waiting on trolleys in March was 9,714, including 117 children. This is an increase of 14% on February, when 8,523 patients without beds were recorded.

The worst-affected hospitals in March were:

- University Hospital Limerick – 1,054
- Cork University Hospital – 870
- University Hospital Galway – 722
- South Tipperary General Hospital – 520
- Sligo University Hospital – 483.

UHL had its second-worst day for overcrowding ever recorded last month, with 76 people on trolleys on March 19. The highest trolley figure of 2019 so far, with 617 patients waiting for beds, was recorded on Tuesday, March 26 – this was the highest daily figure recorded since March last year.

Smaller hospitals had severe problems too. Sligo University Hospital saw 483 patients without beds this month – a 35% increase on last March.

INMO general secretary Phil Ní Sheaghdha said: "Overcrowding remains endemic in Ireland's hospitals. Other countries are investing in their nurses and midwives – we need to do the same to recruit and retain more staff. And as Limerick continues to be the most overcrowded hospital in Ireland, management there are closing beds and shutting down an entire ward *(see also page 15)*.

"If our health service doesn't see staffing and capacity increases, conditions will only worsen for patients and staff alike."

Table 1. INMO trolley and ward watch analysis (March 2006 – 2019)

Hospital	Mar 2006	Mar 2007	Mar 2008	Mar 2009	Mar 2010	Mar 2011	Mar 2012	Mar 2013	Mar 2014	Mar. 2015	Mar 2016	Mar 2017	Mar 2018	Mar 2019
Beaumont Hospital	514	598	615	744	937	610	655	581	342	643	721	294	210	329
Connolly Hospital, Blanchardstown	244	288	176	288	170	375	257	573	364	452	300	239	453	277
Mater Hospital	598	416	422	375	496	311	380	262	264	541	356	419	404	443
Naas General Hospital	478	286	225	384	234	778	240	227	234	389	426	338	504	425
St Colmcille's Hospital	216	32	34	155	219	210	189	150	n/a	n/a	n/a	n/a	n/a	n/a
St James's Hospital	670	95	257	234	136	210	75	216	152	335	162	336	282	261
St Vincent's University Hospital	413	464	429	515	594	560	456	404	178	599	672	131	268	225
Tallaght Hospital	734	339	381	686	509	643	211	389	392	409	506	485	508	367
National Children's Hospital, Tallaght	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	6	7
Our Lady's Children's Hospital, Crumlin	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	70	55
Temple Street Children's University Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	107	47
Eastern total	**3,867**	**2,518**	**2,539**	**3,381**	**3,295**	**3,697**	**2,463**	**2,802**	**1,926**	**3,368**	**3,143**	**2,242**	**2,812**	**2,436**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	42	39	146	79	62	129
Cavan General Hospital	355	238	121	113	312	489	249	125	36	65	117	31	54	133
Cork University Hospital	467	341	373	331	586	843	596	308	304	412	550	716	877	870
Letterkenny General Hospital	228	275	42	11	86	51	43	180	277	281	191	450	366	325
Louth County Hospital	12	12	26	1	2	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo University Hospital	281	163	148	48	216	68	220	203	186	247	235	200	301	256
Mercy University Hospital, Cork	200	145	98	163	135	186	172	292	222	251	194	362	302	203
Midland Regional Hospital, Mullingar	6	11	11	28	230	331	288	403	250	562	468	434	433	188
Midland Regional Hospital, Portlaoise	56	39	78	63	24	90	55	60	166	217	260	358	202	215
Midland Regional Hospital, Tullamore	4	n/a	n/a	5	68	224	158	199	396	204	568	537	528	306
Mid Western Regional Hospital, Ennis	71	128	38	38	27	81	27	58	n/a	14	36	22	28	32
Monaghan General Hospital	3	45	37	35	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nenagh General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	15	7	5	7	22
Our Lady of Lourdes Hospital, Drogheda	405	386	194	398	356	541	660	333	474	533	474	216	205	229
Our Lady's Hospital, Navan	41	100	55	105	66	249	117	175	60	75	46	235	172	53
Portiuncula Hospital	78	23	38	16	74	71	105	162	45	99	86	259	133	198
Roscommon County Hospital	108	36	95	91	55	121	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sligo University Hospital	161	46	77	96	153	156	104	242	238	235	213	301	357	483
South Tipperary General Hospital	111	88	55	53	89	104	150	158	250	233	552	496	589	510
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	n/a	48	49	214	265	284	357	364	603	324
University Hospital Galway	258	189	209	305	443	626	409	401	387	634	539	638	709	722
University Hospital Kerry	159	30	148	12	69	81	34	118	76	125	89	232	297	360
University Hospital Limerick	223	42	188	199	237	269	319	924	499	558	710	699	1,022	1,054
University Hospital Waterford	n/a	n/a	19	69	64	148	110	102	352	289	306	420	407	476
Wexford General Hospital	294	86	112	159	34	348	127	273	42	194	94	163	228	190
Country total	**3,521**	**2,423**	**2,162**	**2,339**	**3,326**	**5,125**	**3,992**	**4,930**	**4,567**	**5,566**	**6,238**	**7,217**	**7,882**	**7,278**
NATIONAL TOTAL	**7,388**	**4,941**	**4,701**	**5,720**	**6,621**	**8,822**	**6,455**	**7,732**	**6,493**	**8,934**	**9,381**	**9,459**	**10,694**	**9,714**
Of which were under 16	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**191**	**117**

Percentage increase/decrease:
2018 compared to 2019: -9%
2017 compared to 2019: 3%
2016 compared to 2019: 4%
2015 compared to 2019: 9%
2014 compared to 2019: 50%
2013 compared to 2019: 26%
2012 compared to 2019: 51%
2011 compared to 2019: 10%
2010 compared to 2019: 47%
2009 compared to 2019: 70%
2008 compared to 2019: 107%
2007 compared to 2019: 97%
2006 compared to 2019: 31%

INMO slams management's closure of ward in Limerick

THE INMO has strongly criticised the decision by management at University Hospital Limerick to close an inpatient ward, with the loss of 17 beds.

Ward 1A opened as additional hospital capacity in September 2017 to function as an acute short stay unit for medical patients.

At a meeting on March 28, the day before the closure of the ward, management asked nurses to "take a leap of faith" in their plans to reduce overcrowding in the hospital. The meeting followed an INMO letter to the hospital CEO on March 6, 2018 to object to the loss of hospital capacity.

University Hospital Limerick is consistently the most overcrowded hospital in Ireland, with the INMO's daily trolley/ward watch showing that 11,400 admitted patients were on trolleys, without beds, in the hospital in 2018. In both January and February this year, UHL topped the trolley count charts with 970 and 973 patients on trolleys in each month respectively.

INMO IRO Mary Fogarty: *"Closing beds will only worsen Limerick's overcrowding crisis"*

INMO IRO for Limerick, Mary Fogarty, said: "This is a bad decision for patients and hospital staff alike. Limerick is already the most overcrowded hospital in the country. It simply does not make sense to close further beds when faced with this appalling problem. Closing beds will only worsen Limerick's overcrowding crisis, with longer waits and more patients on trolleys in corridors.

"Our members are understandably sceptical when asked to take a 'leap of faith', given that previous management plans to cut overcrowding have not worked. Sadly, even our compromise proposals to close the beds on a phased basis were rejected by management.

"We have asked management for further engagement over their next steps, to identify ways to improve systems in UHL before a new 60-bed block comes on stream."

Coroner endorses check of placental cord insertion at anomaly scan

THE coroner for Co Monaghan has brought to the attention of the INMO her endorsement of a recommendation following the conduct of an inquest into the death of a baby.

The recommendations states that "the placental cord insertion must be checked and documented at the anomaly scan (ideally at 20-weeks gestation) in all babies, and especially in those cases where there are known risk factors".

Noting that a number of our midwifery members work in the role of midwife sonographer, the INMO wishes to bring this recommendation to the attention of our members.

– Edward Mathews, INMO director of regulation and social policy

Streamlined process for spouses and partners of Critical Skills Employment Permit holders

THE INMO has welcomed changes to the immigration arrangements for spouses and partners of Critical Skills Employment Permit (CSEP) holders.

In a recent issue of *WIN* the INMO highlighted difficulties encountered by members in renewing their Critical Skills Employment Permits (CSEP). The INMO campaigned on behalf of these members and there has been progress made.

In a separate development the government recently announced a streamlining of the process for dependants, spouses and partners of CSEP holders in accessing the Irish labour market. The changes mean these spouses and partners will no longer need to obtain an employment permit.

According to the Department of Business, Enterprise and Innovation (DBEI), under the old process a dependant, partner or spouse of a CSEP holder, who is not a national of the European Economic Area (EEA), wishing to take up employment in the State was required to seek a permit on the basis of their Stamp 3 immigration permission.

On foot of a job offer the stamp holder could then make an application for a Dependant/Partner/Spouse Employment Permit and, if granted, they then had to reapply to the Irish Naturalisation and Immigration Service (INIS) in the Department of Justice for a change of immigration status prior to taking up employment.

Under the new system, the requirement for spouses and *de facto* partners to obtain an employment permit has now been removed by the DBEI. INIS will grant eligible spouses and *de facto* partners of CSEP holders permission to reside in this State on Stamp 1 conditions, which provides direct access to the labour market without the need to obtain an employment permit.

In addition, a new pre-clearance policy becomes effective from April 1, 2019 for non-EEA *de facto* partners of CSEP holders, which will provide certainty to applicants in this category prior to their arrival in the State and make the immigration process as straightforward as possible, both at their port of entry and on registration of their immigration permission.

This will make it easier for the spouses, dependants and partners of CSEPs, such as nurses and midwives, to obtain employment and will make Ireland more attractive in terms of recruitment and retention. Nurses and midwives from outside the EEA will now have certainty in relation to the employment status of family members.

The INMO welcomes this announcement and hopes that it will assist in the recruitment and retention of nurses and midwives who are vitally needed in the Irish health service. For further information on this see **https://bit.ly/2ISoECm**

– Albert Murphy, INMO IRO

WRC recommends on PHN staffing issues in North Lee

SIGNIFICANT difficulties in terms of staffing levels and resources within the North Lee public health nursing services throughout 2018 were addressed recently under the auspices of the Workplace Relations Commission.

The WRC conciliation conference took place on January 15, 2019, following several months of local liaison between the INMO and management within CHO4 to progress matters.

Following the conference, the WRC recommended:

- An increase of the wholetime equivalent in budgeting for PHNs and community RGNs
- An additional five WTE staff to be in place by the time the WRC reconvenes on this issue in May 2019, when further outstanding matters will also be dealt with.
- In addition, additional clerical resources are required in North Lee to cover for the absence or limited amount of clerical support available to PHNs and RGNs in health centre.

The INMO has nominated an assistant director of public health nursing from North Lee to be involved in the review group which has been set up to implement the recommendations.

Additional resources have been approved and the INMO will continue to liaise with CHO4 on these issues. The review group has agreed to complete its work within eight weeks.

– Liam Conway, INMO IRO

ICN calls on governments to act urgently on global nursing shortage

NURSING leaders at the International Council of Nurses (ICN) International Workforce Forum have called on governments to take urgent action to ensure safe staffing levels, decent working conditions and a better future for patients and the nurses who care for them.

Discussions focused on how to meet the world's health priorities despite alarming predictions of a shortfall of 18 million healthcare professionals worldwide by 2030, 50% of whom will be nurses.

Reports from the participating countries showed common themes affecting nurses around the world, including:

- Staff shortages
- Poor working conditions
- Increased violence in the workplace
- Mandatory overtime
- Problems with recruitment and retention
- Unfair, unequal and inadequate remuneration.

While the INMO is a member of the ICN International Workforce Forum, it did not attend the forum in Beirut due to the Organisation's industrial action on these very issues at the time.

The forum in Beirut was designed to inform ICN's member national nursing associations about the development of ICN's policy and advocacy work.

Howard Catton, CEO of ICN, highlighted how valuable the forum had been for sharing experiences and providing a reality check on the current state of the world's nursing workforce.

"Retention is now a critical issue that needs urgent attention from governments as we risk losing nurses faster than we can train them," Mr Catton said.

It was not just how many nurses are leaving the profession, he said, but that many of those who leave are experts with decades of experience. "These nurses are essential for the delivery of high quality and safe care, but also for teaching, supporting and mentoring the next generations," Mr Catton said.

"There is no single answer to the problem of nursing shortages, no silver bullet, but as our recent policy brief showed, we need to implant a range of actions to foster positive and supportive working environments, including fair pay, safe staffing, professional and career development, and the absence of violence, bullying and harassment."

Dr Myrna Abi Abdallah Doumit, president of the Order of Nurses in Lebanon, highlighted that supportive and safe work environments, appropriate financial packages and respect are key to retention.

The Commission on Graduates of Foreign Nursing Schools (CGFNS) has reported that there are 20.7 million nurses and midwives worldwide, and that nurses and midwives form a significant proportion of the migrant community. The migration of nurses and midwives is vital to combating workforce challenges internationally. The forum urged countries to adhere to the WHO Code of Practice on International Recruitment of Health Personnel.

World news

Nurses and midwives in action around the world

Australia

- Macarthur nurses band together to fight for better staff to patient ratios

Canada

- Public health nurses hit the picket line
- Nurses rally in Windsor to back wage demands

Kenya

- Atwoli opposes move to hire nurses on contract

New Zealand

- Nurses' impassioned plea in favour of pay equity: 'We can't afford to live in the communities we work in'
- Nurses unions launch campaign calling for greater staffing numbers at aged care facilities

Portugal

- Nurses with careers of 20 years earning the same as new colleagues is an 'atrocious injustice', says union

Spain

- Victims of abuse report 20% more often if a nurse attends to them
- Nurses ask for support for law that sets a maximum number of patients per nurse

UK

- Scottish hospitals 'stretched to breaking point' as number of nursing vacancies reaches record high
- UK nurses unite over 'punishing' pay deal in Northern Ireland
- Hundreds of NHS nurses worse off despite pay rise

US

- Nurses walk out after sale of hospitals to Santa Clara County

Nurse saves a life on way to work

Aoife McGivney revives bus driver after cardiac arrest at wheel

ON A cold morning in March Aoife McGivney, a 24-year-old nurse who works at the Mater Hospital in Dublin, ran to catch her bus to work, almost missing it by seconds. Little did the driver know that she would save his life on that very journey.

As the bus approached O'Connell Street it went through a red light. People started screaming and Aoife wondered what was going on. When the bus rolled over a bicycle everyone panicked as they could no longer see the cyclist and assumed he had gone under the bus. A female passenger stood up and went up to the driver. She realised he had passed out and called to the other passengers for help. Aoife snapped into action.

The driver was unconscious, but still had his feet on the accelerator. Aoife tried to get him back to consciousness, but she didn't know if he'd fainted or lost consciousness for a more serious reason. She pulled the glass window of his cab down and shook him. When he didn't wake up, she pulled his feet off the accelerator and the bus rolled to a stop. At this point, people outside the bus used the emergency lever to open the doors. With the help of other passengers, she got him out of the bus and put him in the recovery position on the footpath.

He had no pulse and was not breathing so she started CPR. She performed compressions and mouth-to-mouth and asked a bystander to get an AED machine (automated external defibrillator)from a nearby business. A Garda and a member of the public with first aid training assisted her. She brought him back to consciousness before an ambulance took him to hospital.

As all health professionals will know, the first hour of emergency response is crucial and this man may not have survived had it not been for Aoife's training and quick thinking.

When Aoife visited him in hospital a few days later, she said she cried her eyes out. Having seen him go through such trauma and then seeing him looking so well made her emotional. "We're so lucky at how everything turned out that day, it could have been much worse. I'm so grateful to have been there for him. People were amazing, stepping forward with their own training and it was great for me to be able to take a break from doing CPR and pass it on to someone else," she said.

'Hand's for Life' campaign

Aoife appeared on the *Late Late Show* to discuss the ordeal and also helped to launch Irish Heart Foundation's 'Hand's for Life' campaign last month at Dublin Castle. The campaign teaches people how to recognise cardiac arrest and perform CPR. It also aims to provide free CPR training nationwide.

Aoife McGivney: *"It is so important to have CPR training"*

Aoife said: "It is so important to have first aid and CPR training. People shouldn't be afraid to start CPR in an emergency situation. It is important to build people's confidence so that they feel able to perform it, ultimately saving lives."

You owe it to yourself and to your communities to exercise your voting rights in the European and local government elections on May 24, writes **Dave Hughes**

Be sure to use your votes on May 24

ONE hundred years ago the first Dáil Eireann of the revolutionary Irish Republic sat in the Mansion House. That fledgling parliament declared Irish independence, ratifying the proclamation of the Irish Republic that had been issued during the 1916 Easter Rising and adopting a provisional constitution.

Those elected to the first Dáil had stood in what were UK elections in December 1918, when Sinn Féin won a landslide victory, almost wiping out the more moderate Irish parliamentary party. Almost half a million Irish people voted for them in that election, nearly 50% of all those who voted.

The 1918 election itself was a watershed following the Representation of the People Act of the same year, which had increased the potential Irish electorate from 100,000 to almost two million. The Act extended the right to vote to men aged 21 and over, whether or not they owned property, and to women aged 30 and over who resided in the constituency or occupied land or premises with rateable value above £5 or whose husband's did. It also extended the local government franchise to include women aged 21 and over on the same terms as men.

The voting rights we now take for granted did not always exist and the extension of the vote, at that time, led to the modern Ireland we now live in. We owe it to ourselves and to our past to use our votes on May 24 in both the European elections and our local government elections.

100 years ago was a time of great change in Ireland and across the globe. Many regime changes were in the process of happening and colonialism was coming to an end, with Ireland leading the way.

The leaders of the time saw the importance of self-determination and the people's vote. The women and young men who gained a vote in the 1918 election would have been very consciously aware that they at last had a say in the affairs of their nation which they had previously been denied.

"100 years on from the first Dáil, it is time for a rejuvenation of our democracy"

It was also a time, following the end of the First World War, when fascism was growing rapidly across Europe, and where many workers in Ireland, the UK and the rest of Europe struggled to make ends meet with poor living conditions, homelessness, hunger and unemployment fuelling growing discontent and disillusionment with the powers of the time.

Some of this sounds familiar to us today, 100 years later, and while we are measurably much better off than our ancestors all those years ago, in relative terms we do have poverty, homelessness, hunger and growing discontent. These are the conditions that allow fascism with its simple if thuggish responses provide a simplistic answer to the problems of nations and the world.

The elections for Europe and for local government on May 24 are as important as the election of December 1918, which led to the first Irish revolutionary parliament.

Ireland and Europe have just emerged from the worst financial crash in 100 years and the austerity measures imposed have left deep scars on many working people and their families. For many in Ireland and across Europe wages are worth less today than they were a decade ago, public services have been slashed and people's rights have reduced. Even the State pension age has been increased in Ireland, making it the highest in Europe.

The choice facing voters in Europe will be stark in many instances, with far-right parties offering extreme simplistic solutions, centrist parties attempting to hold their ground, environmentalists confronting us with the challenges to our planet, and growing numbers of left-wing parties and individuals giving an alternative voice for the marginalised of our societies.

In Ireland we get two for the price of one with our local government elections happening on the same day as our European elections. We will, no doubt, have a huge choice to vote for in the local elections, which tend to be an entirely different electoral contest to general elections.

Local authorities in Ireland have been rationalised with the urban district councils going out of existence and the towns previously served by those councils now having additional local authority seats. While Irish local authorities through the 1980s and 1990s were stripped of many of their powers, they still play a very important role in delivering local services and exercising local democracy.

The housing crisis that now touches most of the counties of Ireland is an area which will dominate the local election campaigns, and rightly so. Central government will not build houses, it is the local authorities which can and must do it.

More and more local authority elected members have become advocates for their local communities, particularly diverse communities, advocating for – in many cases successfully – greater provision of recreational and community facilities.

100 years on from the first Dáil it is time for a rejuvenation of our democracy. We are challenged by the decision of the people of the UK to leave the European Union, which is now inevitable and which will have consequences for the Irish people and the Irish economy. Not all of those consequences are negative, but many are.

With such challenges facing the citizens of Ireland and Europe this election may also be a watershed. It may be the start of a recognition that politics cannot be dominated by lobbyists on behalf of multi-million corporations and the agenda of bankers, but must instead become more participative, sensitive to climate change and also to allowing the workforce a greater share of the wealth they create.

Use your vote on May 24 and have your say one way or the other.

Dave Hughes is deputy general secretary of the INMO

Planning underway for this year's All-Ireland Midwifery conference

THE All Ireland Midwifery conference planning committee has met a number of times in the past few months to develop the programme for October's conference.

Topics will include the maternity service on the island of Ireland, how to retain world class midwives, the Whelm study carried out in the UK which looked at 'Work, Health and Emotional Lives of Midwives' and aimed to explore midwives' emotional wellbeing.

Other topics will include critical incidents, resilience, service challenges and service changes, succession planning, leading lights in midwifery and the maternity service.

The poster competition is open and applicants are welcome to submit their entries.

The Midwives Section meetings will take place on Saturday, June 8 in Galway and Saturday, September 7 in Limerick. Full details and agenda will be circulated closer to the time.

Midwives are always encouraged to join the meetings, to network and meet with like-minded members.

If you have any queries about the conference or how to enter the poster competition, please send an email to: jean.carroll@inmo.ie

Section roundup

Community intervention teams

THE section office has been contacted by members working in the community, not as RGNs or PHNs but as part of the community intervention team, interested in forming a national group to facilitate networking and working together on national issues.

For those interested in being a part of this new group, please contact jean.carroll@inmo.ie

We will be organising a meeting of interested parties with a view to establishing a networking group or section once approved by the INMO Executive Council.

Assistant Directors Section

THE next meeting of the Assistant Directors of Nursing/Midwifery/Public Health/ Night Superintendent Section will take place on Thursday, April 25 at 11am at INMO HQ.

Edward Mathews, INMO director of regulation and social policy, will attend the meeting along with Steve Pitman, INMO head of education, who will update the Section on professional development.

Care of the Older Person section

THE National Care of the Older Person Section annual conference will be held on September 10 at the Richmond Education and Event Centre. The date has been rescheduled from early March, as given that industrial action was ongoing at the time, it was not feasible to run the conference.

There will be some slight changes to the programme and it promises to be a most interesting line up of speakers and topics. We hope that you can attend.

Retired Section

THE Retired Nurses and Midwives Section is meeting on April 18 and September 19.

In April there will be a talk on how to support people living with dementia and their families following a dementia diagnosis, and general care supports that are available to clients and family members.

In September the talk will be on mindfulness. Both meetings will take place from 11am at the Richmond Education and Event Centre. Formal meetings finish at 1pm and there will be a light lunch, with tea and coffee to follow.

If you have recently retired from work and have not previously attended a meeting, you are most welcome to attend.

The social diary is available on the INMO website, with events planned for April, May and June.

A FAIRER EUROPE FOR WORKERS

CONFEDERATION SYNDICAT EUROPEAEN TRADE UNION

ETUC PROGRAMME FOR THE 2019 EUROPEAN ELECTIONS

1. The European elections – 23-26 May, 2019 – will be decisive for working people. The new European Parliament can either make the EU a better place, or undermine the European co-operation built up over many years.
2. The European Trade Union Confederation (ETUC) – with some 45 million working people in 90 trade unions in 38 countries – believes that a fairer Europe for workers is possible, based on democracy and social justice, quality jobs and higher wages, a socially fair and just transition to a low-carbon and digital economy. This should be the basis of a new social contract for Europe.
3. Stronger and more widespread collective bargaining – negotiations between trade unions and employers – social dialogue and workers' participation in every EU country is essential to achieve a fairer Europe and more democracy.
4. The ETUC calls on all trade union members and all people to vote in the European elections, and to vote for parties and candidates that will support our trade union demands and create a better future for women and men, young people and elderly people in Europe.

CRISIS LEFT DEEP SCARS

5. The crisis has left deep scars on workers. Many people's wages are worth less today than a decade ago. Public services have been slashed and people's rights reduced. Slow economic recovery and falling unemployment have yet to benefit many workers.
6. Working people are understandably disillusioned. Growing inequality, a lack of secure and well-paid jobs, unregulated globalisation, the lack of a just and coordinated EU approach to migration, and climate change have all created uncertainty and fear. The European Union is facing a backlash against austerity and deregulation which made the crisis worse for workers, pensioners and young people. This has fuelled the growth of nationalist, anti-European and far-right forces.

A FAIRER EUROPE FOR WORKERS

7. Change is possible. Europe can be a force for social progress. Nationalism offers no solution to the problems facing us today – not to the monopoly power and tax avoidance of multi-national companies, low wages and poverty, climate change, pollution or fighting terrorism. Together the EU and member states have the power to ensure we all get a fair share of the wealth we help to create.
8. The ETUC has been pushing EU leaders hard to change policies and already we see some improvements. After strong trade union pressure the EU created a new investment plan, adopted a 'European Pillar of Social Rights', put forward new legislative initiatives for better working conditions and made some progress on more sustainable economic policies. These are important changes, but not sufficient. The EU must go much further – to a new 'social contract' that offers all citizens a fairer and more equal society with real opportunities for all.

DEMOCRACY

9. Democracy is at risk from extremists – within the EU, on our borders and beyond. The ETUC calls for EU action to defend democracy and democratic principles, trade union rights and women's rights, uphold the rule of law, apply zero-tolerance for hate speech, improve democratic participation, and preserve the right of people, trade unions and civil society to campaign for the public interest.
10. Democracy must go beyond voting and include real involvement in political decisions as well as democratic participation in society and at the workplace. National governments must stop blaming the EU for bad decisions governments have imposed outside the proper EU democratic decision-making process.
11. Sound social dialogue and effective collective bargaining, especially at branch level, are essential tools of economic and social democracy. The right of workers to

be informed, consulted and to participate in changes at work must be strengthened, including through European Works Councils.

12. The EU must put a Social Progress Protocol in the EU Treaty, to give social rights precedence over economic freedoms.

QUALITY JOBS & HIGHER WAGES

13. Europe needs new economic policies to boost growth that benefits everyone, not just a few. Progressive and sustainable economic reforms must be implemented, making the EU economic policy 'semester' fair and more social, relaunching public and private investment, creating tools to protect working people from economic crisis and shocks. Reforms of the EU budget, monetary union and economic policy-making must ensure that social justice goes hand-in-hand with economic competitiveness.

14. Fairer and progressive tax systems are needed to redistribute wealth, fund public services and social protection, and tackle social problems caused by globalisation, decarbonisation and digitalisation. Efficient tax systems must prevent tax evasion and avoidance and tax companies adequately and equally.

15. All working people in Europe deserve a pay rise, to address wage gaps and to boost sustainable growth and competitiveness. We need better wealth distribution and upward wage convergence for social justice and to tackle growing inequality. It is unacceptable that profits and productivity are not redistributed to workers who have generated them, especially in low-wage countries affected by massive brain-drain which creates disillusionment about the European Union. Work of the same value should be paid the same across Europe, across sectors and for women and men.

16. The solution – to raise wages and achieve better standards of living and work for all – is collective bargaining: negotiations between employers and trade unions for fair wages and working conditions, particularly at branch level in each and every sector and country. This requires EU and national law to reinforce the capacity and strength of social partners, to enable collective agreements to be negotiated and put into practice, and to enlarge their coverage among workers.

JUST TRANSITIONS

17. The parallel transitions towards a low-carbon and digital economy have to be managed so that no one is left behind. We need a new EU industrial policy to create new jobs and opportunities, and to ensure that EU competition and company law do not override workers' social and trade union rights. More democracy at work would also help to achieve change that is socially fair.

18. This means anticipating change and helping workers affected by job disruption and transformation from decarbonisation, digitalisation, automation and globalisation. Workers must have a say on the way jobs are changing and get strong support when jobs are threatened, through public and private investment, social dialogue and collective bargaining and adequate training policies.

19. This means ensuring that all non-standard and precarious workers, in platforms and gig economy as well as in more traditional sectors, including self-employed workers, can have decent pay, equal access to adequate social protection and the same rights as the other workers, including to join a trade union and bargain collectively.

SOCIAL JUSTICE

20. The EU must rebuild its social model, by fully implementing the 'European Pillar of Social Rights' at European and national level. This must include the right to quality education and life-long learning, health and safety at work, fair working conditions, fair wages, secure employment, gender equality, work-life balance and to public services of good quality. Access to adequate social protection systems, fair pensions, housing and social services must be ensured for all, on equal basis in terms of contributions and benefits. All this must happen through the involvement of workers and their trade unions at all levels.

21. Migration must be managed so that human rights are protected, all people have equal treatment at work and in society, and exploitation ends. We need to work together across Europe for the integration and inclusion of migrants, for the benefit of all. Fair mobility must be ensured to all EU and third-country workers, and fight against social dumping must be a priority.

22. EU trade and globalisation policies need to be fairer and give more prominence to social rights, not just serve the interests of multi-national companies. The EU must help implement the UN Sustainable Development Goals – including no poverty, decent work, reduced inequalities and gender equality – in Europe as well as in the rest of the world, and these must shape all EU policies – 'domestic' and international.

23. The EU should work to strengthen global commitment to international co-operation, including to uphold democracy in the UN and ILO, and to make other international bodies more democratic and promote social justice.

Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Query from member

I have recently returned to the Irish public health service after having worked in the NHS since 2008. I have 10 years' service and will be working as a staff nurse. What salary can I expect to receive?

Reply

In 2014, an EU judgement ruled in favour of an INMO claim that nurses who had previous nursing experience in the public health service within the EU before December 31, 2010 should have access to the pre-2011 salary scale in line with their Irish counterparts who were working in the Irish public health service before December 31, 2010.

If you commenced in the NHS in 2008 then the pre-2011 salary scales will apply to you. You will gain full incremental credit in the same manner as if you had been working in the HSE since 2008 and will be placed on the maximum point of the scale.

Query from member

I qualified as a public health nurse in 2013 and have my midwifery qualification. I was advised by my employer that, due to the review of allowances in 2012, this payment was abolished and therefore 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. Can you advise if the midwifery qualification allowance was restored?

Reply

Yes, this is correct the midwifery qualification allowance was restored with effect from July 1, 2017. The midwifery qualification allowance has been restored to all PHNs holding a midwifery qualification. Also, PHNs with a category 2 specialist qualification relevant to their work should receive an allowance. We have raised this with the HSE as all Community Care Areas are not doing so.

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 or
Email: catherine.hopkins@inmo.ie/
karen.mccann@inmo.ie
Mon to Thur 8.30am-5pm/Fri 8.30am-4.30pm

INMO

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

Introducing Executive Council members

Clare Hoban

Staff nurse at Temple Street Children's Hospital, Dublin

CLARE had a short stay in hospital aged 12 when she went in for minor surgery. She was very impressed with the nurses who cared for her and really admired their kindness. That stayed with her and she later decided she wanted to be a nurse.

Clare didn't go directly into nursing after school but came to it as a mature student some years later.

Several years ago Clare had a small issue she needed clarification on in her workplace, so she went to her hospital rep who then got in touch with the INMO industrial relations officer. She found the process really useful and it reinforced her interest in the union.

The rep asked her to be her assistant and Clare eventually took over the role, undertaking rep training and advanced rep training with the INMO. She has been active with the union for about six years.

When asked about the importance of being in a union Clare said: "It's the peace of mind, the support and expertise. There is always someone there to advise you. I try to encourage people to join the union without forcing it down their necks because joining the union was the wisest decision I ever made.

"People often don't realise how much the union has to offer in terms of professional development, as well as support and advice on IR issues."

It is important for Clare to represent paediatric nursing and make sure she does right by her colleagues, but she also works steadfastly for the best outcomes for all nurses and midwives on national issues.

Donna Hyland

Staff nurse at Sacred Heart Hospital, Castlebar

WHEN Donna went into nursing in her early 20s, she felt like she had found her place in the world. In 2011, Donna had her first taste of INMO activism when she became active in the campaign against government plans to phase out payments during fourth-year mandatory placement. This period of activism, when many of her colleagues had to emigrate, got her thinking about how government policy impacts on nurses and midwives, stating: "The issues arising in our current campaign are an accumulation of previous government policy decisions. I think nurses' pay is too low for the work we do as a graduate profession."

When two reps retired in Donna's workplace, she felt it was important to maintain the work they had built, that it was important to be visible and active in the workplace. This gives union members a feeling of empowerment and the mechanisms to resolve issues through agreed processes.

When asked about the importance of being in a union Donna said: "There are so many reasons to join a union. Being in a union teaches us to think from a collective standpoint. Within a union we can negotiate for our pay and conditions. This is our centenary year; our founders did what was considered unthinkable at the time. They founded a union with the sole purpose of representing our professions. The INMO is as relevant today as it was 100 years ago. Trade unions have an impact on societal change. We champion workers' rights and put them front and centre of any social debate and this is a strong reason to join a union."

Donna wants to see a resolution of recruitment and retention issues. She is eight years qualified and seeks improvements for those like her, for graduates and for those who are a long time in the service and feel undervalued.

Karen McGowan

ANP at Beaumont Hospital, Dublin

KAREN worked hard to get her nursing registration and felt the magnitude of it. She continued her membership from student to staff nurse as she knew the importance and values of being a trade union member. She was brought up in a very fair family and carries this attitude through to the workplace.

Karen says: "If you value your registration then you should insure it by having INMO membership. The union will be there in good and bad times for members. There have been a lot of changes in emergency department medicine over the past 10 years and it is important for me to be active and represent my colleagues.

"You don't have to do anything wrong for someone to make a complaint against you and in that instance, you need the right representation, skills and knowledge. Being in a union means no part of the process is missed."

Karen feels that as an Executive Council member it is important not to be too parochial, but to be a voice on the ground to provide information and support to colleagues in the workplace. Safe staffing is a big issue for Karen, not just in ED but throughout hospitals.

Karen says: "It is so important to be visible and active and to be seen on the ground in your workplace as a link between members and the union. This is so important currently with the Labour Court recommendations and the ongoing industrial dispute. Providing clear and correct information, insight and knowledge and having a finger on the pulse puts people's minds at rest and keeps them in the loop."

Guide to NMBI FTP sanctions

Edward Mathews discusses how sanctions are decided following the conclusion of a fitness to practise hearing

THIS final article in a series dealing with fitness to practise (FTP) matters will address the key factors used by the NMBI in deciding on the appropriate sanction following an FTP inquiry.

The approach to sanctions is intimately related to the functions of the Board which are, in short:

- To protect the public
- Maintain public confidence in the professions and regulatory processes
- Declare and uphold professional standards.

These functions have an important guiding, co-ordinating and verifying function in deciding on the right sanction in a given case. Therefore, sanctions are all about the public interest, and that interest in the protection of individual members of the public, the protection of the professions and the deterrence of conduct which poses a threat to these interests. The sanctions process is not ostensibly about punishment and while the effect may be punitive the intent is protectionist. This in turn requires an emphasis on proportionality and the overall circumstances in deciding on the right sanction.

The Board, which is the ultimate decision maker – subject to High Court confirmation in some cases – in choosing the right sanction, will have regard to all the evidence in the case, the relevant legal principles associated with sanctions process and the Board's own guidance on sanction published in 2018.

On the relevant legal principles, Justice Ní Raifeartaigh in the High Court delivered an important judgment in Dowling and Carroll v NMBI reflecting on the legal principles relevant to decision making in this context. These include the seriousness of the conduct, the deterrence of others, the protection of the public and leniency to the registrant in terms of mitigating factors. These principles are exemplified in the Board's *Guidance on Sanctions* document.

The sanctions process in a given case

In commencing an analysis of any case, the Board must first consider the nature of the findings against the registrant and how serious they are. They must then examine any sanctions recommended by the FTP Committee and reflect on those with reference to the core functions of the Board and the regulatory processes. They must include in that analysis the necessity to deter others, demonstrate the gravity of the conduct and uphold the reputation and standing of the professions.

The process of considering the evidence, the circumstances, the functions of the Board, the seriousness of the conduct, the interests of the registrant and the aggravating and mitigating factors lead the Board to reach a conclusion on the right sanction. Some reflection on the range of factors that will be relevant in determining the right sanction in a given case assists in understanding how the process works, and steps which can be taken to minimise a sanction.

Proportionality

The Board must weigh up the competing interests of the public and those of the registrant is reaching a conclusion which is balanced and achieves the necessary vindication of public interests, while at the same time affording necessary weight to the interests of the registrant and appropriate credit to them where possible.

Outcome

The paramount consideration is the risk created to the public. The ultimate outcome for a patient or service user may be a relevant consideration in this regard, but it is not the most important consideration. The most important consideration is the risk historically created and the current status of that risk.

Mitigating and aggravating factors

These factors play a vital role in the determination of the right sanction; however, they are, and will always be, in second place to the ultimate protective functions undertaken by the Board.

Mitigating factors are factors relevant to the person or process which, while not rendering one blameless, have something to say about either the level of blame which should be attached to the individual, or at least the level of sanction that is now appropriate notwithstanding their blameworthiness. These factors deserve special attention as the behaviour and position of a registrant around the time of the matters giving rise to a complaint, or in the intervening time, can have a major impact on the ultimate sanction.

Mitigating factors can include; early admissions, engagement with the FTP process, insight, the occurrence of a once-off incident, work-related stress and conditions of work, remedial action by the registrant and the length of time since the matters giving rise to the incident. However, in addition to these points the personal circumstances of a registrant can form a central plank of mitigation in a case given that one's personal life can have a major impact on work performance.

Aggravating factors, in contradistinction to mitigation, are quintessentially personal factors that tend to increase the level of blameworthiness or the appropriate level of sanction. These include; previous FTP findings, a lack of insight, abuse of a position of trust in relation to a vulnerable person, denial or cover up, attempts to blame others and a failure to take remedial action.

What is notable about these factors, notwithstanding that they often stand in contrast to the same matters, which if approached differently can amount to mitigation, is the capacity of individuals in many circumstances to make decisions and to take steps to avoid aggravating the situation.

It is true that some factors are outside of our personal control. However those that are within our control are powerful tools to

respond effectively and professionally to wrongdoing.

Insight

The central issue here is insight, insight that is associated with admissions and remediation. Where appropriate levels of insight, in its fullest understanding, are displayed by a registrant, this is a powerful indicator that risk has been reduced. This in turn provides a cogent argument for a reduced sanction. There are issues outside of our control and which are highly relevant, however, insight is an area which is within our control and which we should lever to the maximum extent possible.

Demonstrating insight is a powerful indicator of change and risk minimisation. Appropriate evidence of insight starts from immediately after the events in question and continues up to an FTP Inquiry. Thus, there is considerable scope in employment and through personal efforts to maximise the evidence of insight before an inquiry.

Insight starts with recognition of wrongdoing, however, simply admitting one was wrong is not enough in itself. That said, an early admission is an important first indicator of a professional and responsible approach to the matter. Therefore, when things happen it is important to think carefully before admitting wrongdoing, but equally important to think carefully before denying wrongdoing where you are in the wrong. It is important to take advice from the INMO at an early stage. If an admission is warranted then this should be facilitated as early as possible.

In making an admission, and in seeking to demonstrate insight, it is important to demonstrate that:

- You have admitted wrongdoing at the earliest possible opportunity;
- You understand what occurred, and what was wrong with what occurred in the terms of your admission, and through subsequent processes and reflection;
- You have addressed the problem in question and minimised the likelihood of recurrence, including through for example; reflection, education and cooperation with remedial steps taken personally or through your employment
- Admission of wrongdoing at the FTP inquiry
- Offering an apology to the service/service user as appropriate.

The process from the moment of wrongdoing and the ultimate outcome of an FTP inquiry is a long road, however, taking steps such as those outlined above can have a very beneficial effect on the ultimate outcome.

The Board will consider all the circumstances, the seriousness of the wrongdoing, mitigating and aggravating factors, your overall observance of the Code, and the protective functions of the Board in reaching a decision on the right sanction. However, the key message from this piece is that you are not a passive passenger on this journey and the steps you take immediately following issues of concern and in the time leading up to an inquiry can have a significant beneficial effect on the outcome. While the process is long, and inherently stressful, we will guide you from the first moment until the process concludes and it is so important to seek our advice from the outset.

Edward Mathews is INMO director of regulation and social policy

Mitigation in action:

George is working on a busy ward. He cannot find the nurse to co-sign the administration of a medication and signs another nurse's name. Following these matters being brought to his attention he immediately admitted what he had done, and he explained that the nurse's name he signed was not involved. He co-operated fully with the employer disciplinary process including a period of supervised practice. He prepared a reflective piece for his director of nursing that reflected on his role, his professional duties as per the Code and NMBI guidance, and his employer's policies. This piece explained what was wrong with his conduct and why. He has also sourced external education on professional principles and medication management. He fully admits his conduct when the FTP inquiry commences. George will have taken all possible steps to show his insight and he will have tangible evidence of that insight, including objective steps that are likely to reduce the risk of recurrence. He will have positioned himself well ahead of an inquiry.

Framework shows way forward

The Framework for Safe Nurse Staffing and Skill Mix provides evidence-based recommendations to ensure that medical and surgical wards are safely staffed and that patients receive high-quality nursing care, writes **Jonathan Drennan**

A CENTRAL concern among nurses working in clinical settings is safe staffing, that is ensuring that there are the right number of nurses to provide quality care. In addition, when considering safe staffing we have to take skill-mix into consideration; that is the proportion of nursing care provided by registered nurses compared to other grades, such as healthcare assistants (HCAs).

In light of the evidence that lower levels of nurse staffing are associated with adverse outcomes – such as increased drug administration errors, increased episodes of missed care and increased patient mortality,[1,2,3,4] and that higher rates of staffing are associated with lower rates of failure to rescue, reduced falls, decreased length of stay and readmission rates[3,5,6,7,8] – the Department of Health, under the auspices of the Chief Nurse's Office, formed a Taskforce for Safe Staffing.

Framework

The Taskforce consists of representatives from the staff representative unions (including the INMO), the HSE and the Department of Health and is underpinned by a programme of research led by the School of Nursing and Midwifery, University College Cork with partners from the University of Southampton, the University of Technology in Sydney and the National University of Ireland, Galway.

The work of the Taskforce resulted in the publication of a 'Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals in Ireland' (henceforth referred to as the 'Framework').

This Framework outlines a number of recommendations to ensure that the staffing of medical and surgical wards are safe and effective. The recommendations outlined in the Framework were based on the best evidence related to determining the nursing resource in medical and surgical settings and drew on evidence from a programme of research led by the team at UCC[9,10] and consultation with key stakeholders in the healthcare system, both nationally and internationally.

The consultation resulted in a number of recommendations, including that the clinical nurse manager (CNM) grade II role is fully 100% supervisory (that is, they carry no patient caseload), "that a systematic … evidence-based approach to determine nurse staffing and skill mix requirements is applied" and that 80% of staffing in medical and surgical wards is provided by registered nurses (RNs).[11]

The Framework recommended that 'nursing hours per patient day' be the systematic approach to determine nurse staffing requirements.

Approaches to safe nurse staffing

In identifying nursing hours per patient day as the systematic method to determine nurse staffing requirements in medical and surgical settings, a number of other approaches were also considered by the Taskforce, including: professional judgement; nurses per occupied bed; timed-activity; acuity-dependency; regression models; and nurse to patient ratios.[12,13,14] The two principal approaches used internationally are nurse to patient ratios and nursing hours per patient day, and these are considered further.

Both nurse to patient ratios and nursing hours per patient day have been associated with improved patient outcomes. In a systematic review of the literature, Kane et al reported that an increase in nurse to patient ratios was associated with a reduction in patient mortality, failure to rescue and a reduced length of stay; in addition, every additional patient per RN per shift was associated with an increase in the relative risk of hospital-acquired pneumonia, pulmonary failure and medical complications.[2]

Kane et al also reported that an increase in nursing hours per patient day was, as with nurse to patient ratios, associated with decreased mortality and a reduction in failure to rescue and other adverse events.[2] One additional RN hour per patient day was associated with a reduction in the relative risk of hospital-acquired pneumonia, pulmonary failure, failure to rescue and DVT.

Nurse to patient ratios set the maximum number of patients that are allocated to a nurse during her/his shift.[15] There are a

number of states where this approach is used; for example, California in the US[1] and in a number of states in Australia.[16]

The literature has highlighted a number of advantages and disadvantages of using this approach. Advantages include enhancing patient care and safety outcomes and improving the working environment for staff.[15] Disadvantages that have been highlighted include ratios not accounting for patients' level of acuity and dependency or the qualifications or skill-mix of the nurses providing care; in addition, the logistical difficulties of maintaining ratios across medical and surgical settings due to variability in patient case-mix and inflexibility in providing nursing care at particular times have also been highlighted as problematic.[17,18]

The nursing hours per patient day method to determine nurse staffing is based on an approach that measures the extent to which a patient requires care. This approach adjusts staffing based on patient need and is defined as "the total number of productive hours worked by nursing staff with direct care responsibilities per patient day".[19]

This system has been introduced in Western Australia, Tasmania and Northern Territory in Australia.[13] The advantages of this approach include greater flexibility in matching staffing requirements with patient need and takes into consideration factors such as patient turnover, physical structure of the ward, case mix and patient acuity and dependency; this allows staffing resources to be allocated where needed.[14]

The disadvantages of this approach include inconsistency in approaches used to measure patient acuity and dependency on which nursing hours per patient day are based.[18] In Australia, the nursing hours per patient day staffing method introduced in Western Australia included nursing hours per patient day allocated to seven ward types based on patient complexity, presence of a high dependency unit, levels of nursing intervention required, level of specialisation, level of patient turnover and proportion of emergency admissions;[14] this is similar to the approach used in Ireland in three pilot sites.[11]

In Australia, the introduction of nursing hours per patient day resulted in improved nurse staffing, reduced agency usage, reduction in vacancies and increased nurse retention,[14] as well as reductions in nursing sensitive outcomes such as mortality, CNS complications, pressure ulcers, pneumonia and average length of stay.[13]

The recent introduction of nursing hours per patient day as the method to determine safe nurse staffing at three pilot sites in Ireland resulted in an increase in staffing where a negative variance between nursing hours per patient day available and required was identified, a reduction in reports of missed care, an increase in staff perceptions of the staffing resource, a reduction in adverse patient outcomes, a reduction in agency nurse usage and a reduction in the need for one-to-one specialling of patients.[9] Further research is ongoing in these three sites.[9]

When introducing nursing hours per patient day, it is recommended that a nurse dependency management system is used that bases nursing requirements on data that is collected at ward level. Tools include the safer nursing care tool[21] and TrendCare, which was used during the pilot introduction of the Framework. TrendCare is a commercial workforce planning management system (**www.trendcare.com.au**) that provides data on patient acuity and dependency measures, skill-mix and patient allocation and has been identified as a valid approach in predicting the nursing resource for patient care.[20]

The Framework also identified the need for a collaborative approach to determining nurse staffing and skill-mix requirements at ward level that take a number of considerations into account including the ward environment, bed occupancy rates, physical layout, presence of a high dependency unit and, most importantly, patient need. There is also the need in this collaborative approach to involve nursing staff, senior hospital management, human resources and finance. In addition, a robust data system approach, as was used in the pilot, is needed to develop an evidence-based approach to determining staffing requirements at ward level that feeds into decision making at both hospital and hospital group level.

All these approaches must be underpinned by professional judgement of the nursing staff, which is central to the decision making process in ensuring wards are safely staffed.

Next phase

The research is continuing to measure the outcomes in medical and surgical settings in three pilot sites following the introduction of the recommendations in the Framework. In 2018 the Department of Health developed a document entitled *A Pilot to Implement the Framework for Safe Nurse Staffing and Skill Mix in the Emergency Care Area*. This is phase two of the work of the Taskforce on Safe Staffing under the auspices of the Chief Nurse's Office and has outlined a number of recommendations to ensure the safe staffing of emergency floor settings.

These recommendations are now being tested through a programme of research led by the School of Nursing and Midwifery at UCC, which is measuring the association between nurse staffing and skill-mix in EDs and outcomes such as patient ED care time, patients leaving without being seen, the patient experience, care left undone events, staff satisfaction, burnout, organisational environment, staff experiences of violence and aggression, and quality of care. This research is currently ongoing in four pilot sites nationally (three EDs and one local injury unit).

Conclusion

For the first time in Ireland a Framework, underpinned by programme of research, has been published that provides a series of evidence-based recommendations to ensure that medical and surgical wards are safely staffed, thus ensuring that patients receive high quality nursing care. In particular, the recommendation that the number of nurses are determined by a systematic approach, in Ireland's case the nursing hours per patient day approach, provides, for the first time, a method that determines staffing requirements based on patient need rather than solely on professional judgement or legacy issues.

This is underpinned, as outlined in the Framework, by a comprehensive governance process and collaborative approach to safe nurse staffing and skill-mix. The collaborative approach to developing these recommendations has now been extended to the acute floor setting, including emergency departments, with results from this process due to be published later this year.

Jonathan Drennan is the chair of Nursing and Health Services Research at University College Cork and is principal investigator on the programme of research on safe nurse staffing and skill-mix

References on request by email to nursing@medmedia.ie (Quote: Drennan WIN 2019 27(3): 28-29)

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Research team: University College Cork: Prof Jonathan Drennan (PI); Dr Noeleen Brady; Dr Aileen Murphy; Dr Darren Dahly; Dr Ashling Murphy, Prof Josephine Hegarty; Prof Eileen Savage. University of Southampton: Prof Peter Griffiths; Prof Jane Ball. University of Technology Sydney: Prof Christine Duffield. National University of Ireland, Galway: Prof Anne Scott

Understanding your payslip

INMO student and new graduate officer **Neal Donohue** explains how to understand the deductions on your payslip

IN RECENT weeks I have received many queries from internship students and 2018 graduates in relation to pay, increments and payslips. In *WIN* December 2018/January 2019 I discussed the importance of being aware of the nursing and midwifery pay scales and premium payments. In this article, I will discuss pay slips.

The Payment of Wages Act 1991 Section 4 provides that all employees have a right to a pay slip. The pay slip is a statement of your gross wage and details the deductions made by your employer. Pay slips in the public sector and private sector have a similar format and will usually be sent to you electronically.

On your pay slip you will see various acronyms and headings and it is important to know what each means. Your Personal Public Service (PPS) Number is a unique personal identifier used by the Irish government to identify you for taxation purposes. You also need this for accessing social welfare benefits and public services.

Each payslip will also use your staff number or employee number as a personal identifier. Depending on where you work you may be paid monthly or fortnightly. The pay period will be specified on each pay slip. Your Pay Related Social Insurance (PRSI) class (eg. A1) will also be identified and this specifies what PRSI contributions you will pay. Your annual tax credits will also be specified. Tax credits are based on your personal circumstances and are allocated every year.

Tax is calculated as a percentage of your income. Your tax credits are deducted from this to give the amount of tax that you must pay. Any unused credits can carry over to the next year.

On the left side of your pay slip you will see the payments column. In this column you will see your basic pay, which does not include premium payments. If you are entitled to premium payments such as time plus one-sixth, Sunday pay, bank holiday pay, Saturday pay, or night duty pay they will be itemised and added to calculate your total pay/gross pay.

On the right side of the pay slip you will see the deductions column. Deductions from pay are also referred to in the Payment of Wages Act 1991. As an employee, under law you are required to pay tax designated as 'Pay As You Earn' (PAYE) and social insurance (PRSI).

Your tax is calculated on your gross earnings, and as previously mentioned you are allocated tax credits. To examine your own tax and tax credits go to **www.revenue.ie**

PRSI contributions are calculated at 4% of total earnings and they contribute to the national Social Insurance Fund. A wide range of benefits are available to people who have paid social insurance so long as they meet certain qualifying criteria. The social insurance payments available include: jobseeker's benefit; Illness benefit; maternity benefit; paternity benefit; adoptive benefit; health and safety benefit; invalidity pension; widow's; widower's or surviving civil partner's (contributory) pension; guardian's payment (contributory); state pension (contributory); treatment benefit; occupational injuries benefit and carer's benefit.

Universal Social Charge (USC)

The Universal Social Charge was introduced in January 2011 and is another form of tax. Please see the accompanying table for the standard rates and thresholds of USC in 2019. Please note, these rates and bands may change year on year depending on the budget.

Universal Social Charge	
Rate of USC	2019
0.5%	On First €12,012
2%	On next €7,862
4.5%	On next €50,170
8%	On earnings above €70,044

Pension deductions

Nurses and midwives employed in pensionable public service posts on or after January 1, 2013, are members of the Single Public Service Pension Scheme (Single Scheme). The rules of the Single Scheme are set out in the Public Service Pensions (Single Scheme and Other Provisions) Act 2012. You can find further details of this scheme at: **www.hse.ie/eng/staff/benefitsservices/pension-management/single-scheme/**

It is important to note that your employer applies the PAYE tax based on information from Revenue. It is important to contact Revenue to notify it of changes in your personal circumstances such as marital status or having dependants. These details directly affect the allocation of tax bands and credits so ensure all your details are correct.

INMO membership

Undergraduate students can avail of free INMO membership, however, once you graduate there is a fee of €5.75 per week. Many people decide to pay INMO membership through deduction at source, meaning it comes directly from your wages. This deduction is also itemised on the right-hand side of your pay slip.

Neal Donohue is the INMO's student and new graduate officer. If you have a question about the above article, or need support or information, you can contact him at email: neal.donohue@inmo.ie or Tel: 01 6640628

Quality & Safety

A column by Maureen Flynn

Using clinical decision support to manage maternity sepsis

THIS month we finish our series on sepsis by focusing on maternal sepsis. Maternal sepsis is a life-threatening condition defined as organ dysfunction resulting from infection during pregnancy, childbirth, post-abortion or postpartum period.[1] Sepsis is one of the leading causes of direct maternal death in the UK. Irish data based on the codes specified for sepsis and infections, demonstrates clearly an increase in reported diagnosis of both sepsis and infection.

In 2017 there were 62,053 live births with 9,253 women admitted with infection of which 483 were diagnosed with sepsis.[2] While not excluding the possibility that the reporting itself has improved in contrast to an increase in confirmed cases, the insidious nature of sepsis in pregnancy will benefit from clearer guidance on recognition and appropriate escalation.

In response to the rise of sepsis, the Irish National Sepsis Programme developed a clinical decision support tool (CDST), Maternity Sepsis Form, to facilitate early recognition, diagnosis and treatment of maternal sepsis. This tool was designed to be sensitive to include women at risk of sepsis and specific to avoid excessive antimicrobial therapy.

Benefits of using the sepsis form

The National Maternity Sepsis Recognition and Treatment Form was developed to increase timely recognition of deterioration due to infection and a rapid response including time-dependent pathways, diagnostic criteria, the sepsis 6+1 treatment bundle and referral criteria for specialist input. A continuous improvement plan includes sensitivity and specificity analysis.

The midwife/nurse's role

The CDST was developed affording responsibility to both midwifery/nursing and obstetric personnel for maternal sepsis management. The predisposition and recognition page contains details of pregnancy[3] and non-pregnancy related risk factors associated with maternal infection and signs and symptoms of infection that would alert a midwife/nurse to a possible clinical deterioration[4] due to infection of a woman's status[5] (see *Figure*). Many of these concerns (see *Table*) could be considered a normal occurrence in pregnancy due to various physiological changes associated with pregnancy. It was however important to interpret these signs and symptoms in the correct clinical context to minimise the propensity to normalise the abnormal or miss the abnormal in pregnancy due to lack of standardisation.

Also detailed are the presenting symptoms that carry the risk of sepsis. It provides the midwife/nurse with the autonomy to identify possible sepsis and notify the doctor, requesting immediate medical review.

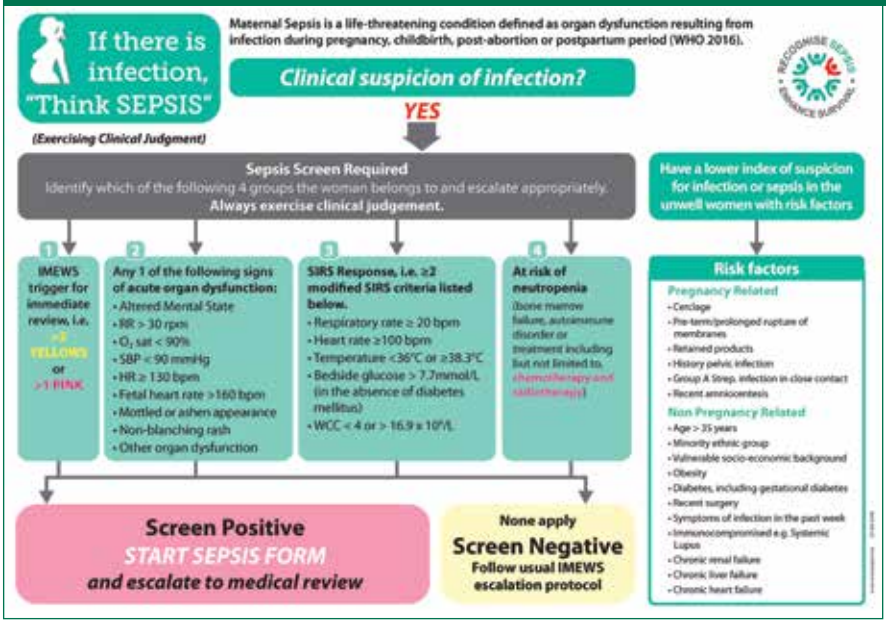
The back page details the diagnostic criteria, gives the doctor the option to opt out of the sepsis pathway, identify 'time zero', the sepsis 6+1 bundle and the sepsis and septic shock criteria. The algorithm prompts the midwife/nurse when to start the sepsis form (see *Figure*).

Table: Indications of possible infection in a woman

- History of fevers or rigors
- Cough/sputum/breathlessness
- Flu like symptoms
- Unexplained abdominal pain/distention
- Pelvic pain
- Vomiting and/or diarrhoea
- Line associated infection/redness/swelling/pain
- Possible intrauterine infection
- Myalgia/back pain/general malaise/headache
- New onset of confusion
- Recent surgery/cellulitis/wound infection
- Immunocompromised/chronic illness
- Possible breast infection

Maternal sepsis can often present with vague non-specific symptoms

Figure: Maternal sepsis screening algorithm



Get involved

At your next unit/team meeting talk about and encourage the use of the clinical decision support tools. For more information on sepsis go to: **www.hse.ie/sepsis**

Maureen Flynn is the director of nursing ONMSD, QI Connections Lead, HSE National Quality Improvement Team

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References on request from nursing@medmedia.ie (Quote Q&S: WIN 27(4):42)

Should a mistake make you a criminal?

Criminalisation in most negligence cases does little to help staff or patients, instead we need to ensure the systems we employ support good practice, write **Siobhan McCarthy** and **Mary O'Dwyer**

A US nurse has been charged with reckless homicide after inadvertently injecting a patient with a deadly dose of a paralysing drug, vercuronium (Norcuron). Radonda Leanne Vaught, from Tennessee, could not find the sedative midazolam (Versed) when she searched the electronic prescribing cabinet so she triggered an override feature and typed the first two letters in the drug's name – 'VE' – and selected the first medicine suggested by the machine.

The patient, who had suffered cardiac arrest and was left partially brain dead, died a day later after she was taken off life support. The patient's family forgave the nurse for the error and do not intend to sue the hospital. The case has raised alarm among nursing and other health professionals. Since the US Institute of Medicine's 1999 report *To Err Is Human: Building a Safer Health System*, it is generally understood that the vast majority of medical errors are due to "systems factors" and not to "bad persons". Rather that healthcare professionals are often at the sharp end of errors, such as administering the wrong drug, due to multiple factors, not least human fallibility.

To offset our tendency to look for workarounds when under pressure at work, software packages should not have functions, or overrides, that allow their misuse. This fatal error was clearly due to multiple factors, often termed latent conditions, beyond the alleged negligent behaviour of the nurse involved.

At the recent National Patient Safety Conference, Prof René Amalberti, senior advisor for patient safety at Haute Autorite de Sante, explained that the level of adverse events in healthcare is likely to increase over the next decades because more people will live for longer with complex needs while healthcare delivery is becoming increasingly complex. Will the projected increase in adverse events, lead to more frequent cases that criminalise well-intentioned healthcare professionals and could this be the case in Ireland?

Table: Percentage of medication incidents reported per specialty 2010- 2014 inclusive

Nationally	Medicine	Surgery	Disability Services	Older Persons
14.7%	21%	10%	14%	9.5%

Medication incidents in Ireland

Medication administration is a routine nursing task that has a high potential for error. This commonplace procedure accounted for 14.7% of the top 10 clinical incidents reported in Ireland from 2010-2014.[1] The main types of medication-related incidents reported were: incorrect dosage, missed medications and incorrect or not reconciled medication on admission, transfer or discharge.

Healthcare errors have not been criminalised in Ireland. Cultures of blame lead to cover-ups, a lack of reporting and unsafe practice. The new HSE Incident Management Framework[2] provides a range of incident review methodologies, graded to the severity of the incident including the 'after action review' process.

Outcome for patients and staff

Some medication incidents cause serious patient harm. Patient harm can affect the emotional wellbeing and functional ability of staff, directly or indirectly involved. Following an error, staff may become second victims due to the emotional toll the incident takes on them[3]. The emotional distress experienced by staff appears to be associated with the severity of the error(s), degree of perceived responsibility, and the outcome for the patient.

Learning from incidents

While criminal behaviour may occur in healthcare from time to time, it is rare. Errors however are common. Rather than inappropriate criminalisation, the best approach is seeking to understand and learn. As a work environment, healthcare is full of complex activities, interacting and impacting on each other, where interruptions and multitasking behaviours create the conditions ripe for error. Systems thinking helps us to understand how to improve the system. Incidents rarely happen because of one single act. Usually, a combination of factors must align for an incident to occur.

If we examine a medication incident purely from the perspective of the bedside and telling the nurse who gave the wrong drug to be more careful in the future, we will fail to notice the other factors that contributed to the error.

Human perception is influenced by what we expect to find, which predisposes people to a confirmation bias[4]. This is exacerbated by stress, tiredness and time pressure. In the Tennessee nurse's case, if the automatic cabinet functioned correctly, the nurse would not have used the override function. If override function blocked predictive text, the nurse would have had to enter the drug's full name thereby preventing dispensing of the wrong drug.

Conclusion

Healthcare is a complex system. Elements far away from the bedside can contribute to incidents. A systems approach is not about evading personal accountability. It's about identifying the contributory factors to enable change to reduce the risk for the harm recurring. Criminalisation in the vast majority of cases is not supportive of patients or health professionals.

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The US opioid epidemic: lessons to be learned

Opioids must be prescribed judiciously and appropriately in order to avoid their misuse and abuse, writes **Elaine Clear**

"The terrorist threat families in America see is not in the streets of Aleppo, it's Fentanyl coming down your street"

– Senator Ed Markey, Massachusetts[1]

OPIOIDS play a vital role in managing moderate to severe acute pain, especially with perioperative care. Problems arise when they are used beyond the acute pain phase and are taken inappropriately.[2] A patient who is still requiring opioids months after discharge from hospital needs to be further evaluated.[3]

When patients have been taking opioids, either legally or illegally, effective acute pain management can be a challenge. Opioid tolerance is a condition that is characterised by a reduced responsiveness to an opioid, manifested by the need to increase doses to achieve the desired analgesic effect.[4] Opioid-tolerant patients are dependent on opioids and will suffer withdrawal symptoms if the opioid is stopped suddenly. When treating acute pain, opioid-tolerant patients usually require much higher doses than opioid-naïve patients; their pain often lasts longer, and their scores are often higher.

Patients addicted to opioids differ from those on long-term opioid therapy by their aberrant compulsive drug-taking behaviour and loss of personal control.[5] Sometimes a patient may exhibit behaviours similar to addiction by demanding more pain relief or appear to become 'addicted' to opioids. In many cases this is due to undertreatment of acute pain or pain-avoidance behaviour and does not mean the patient is addicted to opioids.[5] If unsure, consult the chronic pain team or the psychiatric service.

Globally, prescribed opioid painkillers are among the most commonly misused and abused medicines. Misuse (non-prescribed use), abuse (intentional, non-therapeutic use), diversion (passing/selling to others) or overprescribing are problems that need to be prevented. Opioids are most addictive when used differently from the way they are prescribed, such as crushing a pill so that it can be injected or snorted. A formal assessment may be advisable for patients at risk of abusing opioids prior to discharge. The opioid risk tool (ORT) is a quick and easy tool to use in a busy acute pain setting.[3]

Opioids in chronic pain management

Chronic pain is one of the most prevalent and debilitating medical conditions, but also one of the most complex and controversial to manage. Patients with chronic pain can become physically and psychologically dependent on opioids.[6] Dependence on opioids is associated with many adverse long-term side-effects including loss of libido, fatigue, low mood, poor concentration, opioid tolerance and opioid induced hyperalgesia at high doses.[7] Estimates indicate that the personal and socio-economic impact of chronic pain conditions is as great as and likely greater than conditions such as cardiac diseases or cancer management.[8]

Chronic pain in Europe

A large scale study conducted in 2006 showed that about 20% of the adult population in Europe suffer chronic pain, ranging from 12% in Spain to 30% in Norway.[9] In Ireland, a study on chronic pain called PRIME (prevalence, impact and cost of chronic pain), showed that the prevalence was 36% and that depressive symptoms occur five times more often in people with chronic pain.[10]

Opioid crisis in the US

In 2010, the mortality rate from prescriptions of opioid analgesics was greater than the number of deaths from both suicide and motor vehicle crashes in the US, or from deaths resulting from overdoses of cocaine and heroin combined.[11] It was estimated that 60% of those deaths occurred in patients receiving legitimate prescriptions whereas the other 40% received opioids from multiple prescriptions obtained through doctor shopping, and drug diversions.[12]

In 2016, more than 63,000 people died from drug overdoses – 66% of those were due to opioids[11] and in 2017, the number rose to 70,237 deaths from drug overdoses in the US.[13]

Origins of the opioid epidemic

In 1996, the American Pain Society launched a campaign to introduce pain as the fifth vital sign to make assessment of pain as important a measure of patient wellbeing as the other vital signs. The campaign was in response to growing sentiment that patients in pain were undertreated.[14]

In 2001 the healthcare standards setting and accrediting organisation, The Joint Commission on the Accreditation of Healthcare Organisations (JCAHO),

published a report insisting that pain needed to be regularly assessed and that physicians must accept and respect patients self-reporting of pain. As a result, physicians were placed under pressure to provide adequate pain management, and hospitals and clinics were now at risk of losing federal healthcare funds if JCAHO standards were not met.

This had the unintended consequence of encouraging opioid use in response to patients' self-reports of pain score.[15] The misuse of opioids became a major health epidemic in the US along with all the associated social, medical and financial repercussions.

The rise in deaths from opioid overdoses occurred in three waves, the first reflecting the increase in opioid prescriptions for pain in the 1990s. The overprescribing of opioids led to high rates of misuse and abuse which resulted in widespread addiction. While this was happening, a national scandal occurred. The pharmaceutical company Perdue Pharma began to falsely advertise its new opioid OxyContin as non-addictive. Global sales escalated from $48m in 1996 to $2.4bn in 2012 and between 1991 and 2009 the number of prescriptions for opioid use in the US increased by 300%.[16]

In 2007, Perdue Pharma was forced to pay $634.5m compensation for fraudulently marketing OxyContin as less addictive, less subject to abuse and less likely to cause withdrawal symptoms than other pain medications.[17]

The second wave of deaths from opioids began in 2010 with rapid increases in deaths from heroin overdoses. The third wave began in 2013 with significant increases in deaths from overdoses involving fentanyl, an opioid which is 100 times stronger than morphine. On the streets, it was mixed with heroin and/or cocaine to increase its euphoric effects, often without the user's knowledge, resulting in unintentional fatal overdoses.[18]

Fentanyl abuse also posed a significant danger to public health workers, ambulance crews and police that unwittingly came in contact with it by absorbing through the skin or accidental inhalation of airborne powder, causing respiratory distress and dizziness.[19]

In October 2017, the US Department of Health and Human Services responded to the critical situation by declaring the opioid crisis a public health emergency, but President Trump failed to request funds to address the issue.[20]

In Europe, the first study of prescription drug abuse in the EU was published in August 2016.[21] It found that 7-13% of Europeans had abused prescription opioid pain relievers, compared with 20% of Americans.[22] Dr Scott P Novak suggested that the level of opioid abuse in Europe in 2016 was comparable to that in the US in the early 2000s, prior to the epidemic.

In 2012, the UK was the largest consumer of opioids in Europe with more than 10 million people prescribed an opioid. France was second with four million, less than half the number in the UK.[23] By 2015, almost one million people were dependent on codeine. The author suggested it was probable that like in the US, where one in 16 opioid-naïve surgical patients subsequently became dependent on prescribed opioids, it was probable that the opioids were commenced postoperatively but were not discontinued.[14]

Opioid guidelines

In 2016, the US Centres for Disease Control and Prevention issued new guidelines for prescribing opioids for chronic pain.[24] The guideline recommended that the physician establish treatment goals with the patient and only use opioids if the benefits outweighed the risks.

Opioids for pain management in Europe

In Europe misuse and abuse of prescribed opioids does occur but the scale of the problem is currently far from that in the US. In 2009 a subgroup of the European Pain Federation, the Societal Impact of Pain (SIP) was set up to develop policies governing access to pain treatment, raising awareness of the impact of pain on our health and economic systems, exchanging information and sharing best practices across all member states of the European Union.

In 2011, SIP developed a *Roadmap: Seven practical steps to move forward in pain policy*, which outlined seven steps for policymakers and health institutions to effectively address the societal impact of pain at national and EU level.[25]

In conclusion, while opioids do play a vital role in managing moderate to severe acute pain, we must re-evaluate our dependence on opioids in the long-term. Opiate use must be prescribed judiciously and appropriately.

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Call for national taskforce to tackle respiratory disease

Respiratory disease is one of the most critical health challenges facing the Irish population and health services today, writes **Tara Horan**

A MAJOR new report shows respiratory disease to be one of the most critical health challenges facing the Irish population and health services, with an almost 15% increase in respiratory deaths in a decade

The Irish Thoracic Society is calling for the establishment of a national respiratory taskforce to address the increasing burden of respiratory disease in Ireland, where the death rate from respiratory causes is 38.2% higher than the EU-28 average.

This call came at the recent launch of a major new report, *Respiratory Health of the Nation 2018*,[1] which provides an overview of the impact of respiratory disease in the country as well as information on 11 common respiratory conditions and their impact on two key population groups – children and older people.

The report highlights that deaths from respiratory disease in Ireland rose by almost 15% in the decade to 2016. Respiratory disease now accounts for more hospitalisations than cardiovascular and non-lung cancer cases combined, with the vast majority of respiratory hospitalisations for emergency, unscheduled care. Respiratory diseases accounted for almost 20% of emergency inpatient hospitalisations in 2016. For cardiovascular disease the figure was 11% and for non-respiratory cancers it was 3%.

The Irish Thoracic Society's report draws information from a range of sources and provides the most accurate and comprehensive picture to date of Ireland's respiratory health.

A critical health challenge

Dr Máire O'Connor, co-author of the report and specialist in public health medicine, HSE East, highlights the need for a cross-sectoral approach in addressing environmental and other threats to respiratory health. "This report shines a light on the immense burden of respiratory disease in Ireland, showing it to be one of our most critical health challenges, reflected in the almost 15% increase in respiratory deaths between 2007 and 2016. Respiratory diseases make up three of the top six causes of death in Ireland, with the big three being lung cancer, chronic obstructive pulmonary disease and pneumonia. Death is only the tip of the iceberg of the burden of disease on individuals, families and the health services. While smoking is a key risk factor for many respiratory diseases, we are also seeing the influence of other social and environmental factors on respiratory health."

Respiratory diseases cause almost one in five deaths in Ireland (18.8%). In the period between 2007 and 2016 covered by the report, the number of deaths from respiratory disease increased by 14.6%, with 5,720 deaths in 2016. This compares with a 7.5% drop in cardiovascular deaths in the same period. However, Dr O'Connor said some of this burden can be lifted . "If we take the approach that every breath counts, it will follow that there will be a cross-sectoral approach to address environmental and other threats to respiratory health. It will follow that within the health sector, individuals who are short of breath or have chronic cough will present early to GPs, that GPs will have access to timely lung function tests, and that patients will get the evidence-based interventions, supports and services they require, both at community and hospital level. It will follow at a public or population level, that geographical and socio-economic variations in respiratory health will be addressed, new respiratory programmes implemented, existing programmes evaluated and emerging threats such as antibiotic resistance and vaccination complacency uptake addressed, underpinning all of which will be timely comprehensive data."

Increasing strain on health services

While acknowledging improvements in respiratory care in recent years, Prof Ross Morgan, president of the Irish Thoracic Society, pointed to significant challenges, including a dearth of respiratory specialists.

"What is clear from this report is the increasing strain of lung disease on our health services due to our growing and ageing population. There are too few respiratory specialists, in particular consultants, the numbers of which lag well behind other EU countries, but also nurses, physiotherapists, physiologists and other allied healthcare professionals. In addition, access to elements of good quality care such as pulmonary rehabilitation is severely limited. We also need to meet the challenge of providing integrated care for conditions such as COPD with a properly resourced primary care community.

"Together with improved focus on prevention, awareness and earlier detection of these conditions, our patients need better access to adequately resourced, co-ordinated and specialist services based on best evidence-based practice. That's why the Irish Thoracic Society believes a national taskforce is needed to put respiratory disease on an equal footing with heart disease and cancer where, thanks to dedicated strategies in recent years, patients have experienced improved outcomes. This taskforce is a key starting point if we are serious about stemming the toll of respiratory disease on people's health, quality of life, livelihood and longevity," Prof Morgan said.

Socioeconomic variations

Many respiratory diseases are more common in lower socioeconomic groups. There is a correlation between some of the most common lung diseases and social

Table 1: Principal causes of death in Ireland: Numbers and age-standardised death rates per 100,000 population, 2008-2017[2]

		2008	2012	2016	20171	% change 2008-17	% change 2016-17
Diseases of the circulatory system							
All circulatory system diseases	Number	9,956	9,480	9,237	8,927	-10.3	-3.4
	Rate	426.8	360.5	313.6	292.3	-31.5	-6.8
Ischaemic heart disease	Number	5,185	4,758	4,449	4,238	-18.3	-4.7
	Rate	218.9	178.2	148.0	135.9	-37.9	-8.2
Stroke	Number	2,142	1,935	1,830	1,710	-20.2	-6.6
	Rate	93.5	75.2	63.2	56.7	-39.4	-10.3
Cancer							
All malignant neoplasms	Number	8,199	8,571	9,171	9,175	11.9	0.0
	Rate	306.2	290.1	279.7	271.7	-11.3	-2.9
Cancer of the trachea, bronchus and lung	Number	1,681	1,801	1,911	1,926	14.6	0.8
	Rate	62.2	60.6	57.6	56.7	-8.8	-1.6
Cancer of the female breast	Number	736	689755	752	2.2	-0.4	
	Rate	46.8	40.2	40.7	39.3	-15.9	-3.4
Diseases of the respiratory system**							
All respiratory system diseases	Number	3,522	3,497	3,935	4,079	15.8	3.7
	Rate	156.4	137.6	135.8	136.7	-12.6	0.7
Chronic lower respiratory disease	Number	1,365	1,587	1,712	1,610	17.9	-6.0
	Rate	57.3	59.8	57.3	52.3	-8.7	-8.6
Pneumonia	Number	1,356	1,086	1,086	1,109	-18.2	2.1
	Rate	63.9	45.8	39.9	39.1	-38.7	-1.8

**The figures for 2017 are provisional. **Excludes cancer of the trachea, bronchus and lung (see under 'cancer')*

deprivation. For COPD and lung cancer, this can be explained in part by higher rates of smoking, as well as greater exposure to air pollution and adverse factors in childhood. There are geographical and socioeconomic variations in mortality from respiratory disease in Ireland.

Specific respiratory diseases

Respiratory diseases include a wide range of acute and chronic diseases that substantially contribute to the medical and economic burden on Ireland's health system. The report goes into detail about the 11 most common respiratory diseases, including:

Lung cancer: Lung cancer causes the greatest number of cancer deaths in Ireland, accounting for 20.6% of total cancer deaths in 2016. There was an increase of 11.8% in the number of lung cancers between 2007 and 2016.

COPD: Ireland has the highest hospitalisation rate for COPD among selected OECD countries. Over 87% of COPD hospitalisations are as emergencies. It is the second most common cause of death from respiratory disease, and responsible for more deaths than any non-respiratory cancer.

Pneumonia and acute lower respiratory infection: Pneumonia is Ireland's third most common cause of death from respiratory disease, and the fifth most common cause of death overall. In 2016 they accounted for 31.7% of respiratory inpatient hospitalisations and 40.4% of respiratory inpatient bed days.

Asthma: Ireland has one of the highest rates of asthma in the world. Current estimates suggest that the prevalence of doctor-diagnosed asthma is 21.5% in children and 7-9.4% in adults.

Cystic fibrosis: Ireland has one of the highest global incidences of cystic fibrosis. Seven mutations of the CFTR gene account for over 80% of cystic fibrosis cases in Ireland. The F508del mutation which causes severe or classic cystic fibrosis is a more common cause of cystic fibrosis in Ireland than in many other countries.

Interstitial lung disease and sarcoidosis: Sarcoidosis and idiopathic pulmonary fibrosis are among the more common of the 300-plus interstitial lung diseases. There are approximately 300 deaths each year from these conditions in Ireland.

Other diseases: Obstructive sleep apnoea is increasingly recognised as a public health problem internationally. It is thought it is probably under-recognised in Ireland, as is also the case with pulmonary vascular disease, such as pulmonary hypertension. Respiratory diseases due to external agents, often related to occupations and also due to inhalation of solids and liquids, also account for emergency presentations.

Respiratory infectious diseases continue to cause considerable morbidity in Ireland, many of which, including influenza, are notifiable so incidence data is available. Vaccination is the best protection against influenza but the report notes there is considerable room for improvement in its uptake in Ireland. On tuberculosis, while the number of cases of tuberculosis has fallen over the past decade, this decline has levelled off in the past two years.

Future direction

Respiratory disease is one of the major health challenges of the 21st century for Ireland. *Respiratory Health of the Nation 2018* has outlined the size and the burden of respiratory disease using available national data – the actual size and burden is likely to be much greater.

National strategies for cancer and cardiovascular disease have led to significant improvements in outcomes, including a 7.5% decrease in the number of people dying from cardiovascular disease between 2007 and 2016. In sharp contrast to this, the number of people dying from respiratory disease over the same period increased by 14.6%. The Irish Thoracic Society stresses that it is time that respiratory disease was put on an equitable footing.

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Nutrition in bowel disease

Assessing the nutritional status of the patient with IBD at regular intervals is key to optimising their care, writes **Elaine Neary**

NUTRITION should be high on the agenda for those who care for patients with inflammatory bowel disease (IBD) as well as those who have the condition. The Irish Society of Colitis and Crohn's (ISCC) surveyed its members in 2015[1] and results showed that 34% were using some form of alternative non-medical treatment. Of the 34%, 71% were using dietary management and 57% felt diet could be a trigger of their symptoms. Some 61% believed that IBD specialists disregarded the importance of diet which is a worrying statistic given that many IBD patients still do not have access to a dietitian.

In 2009 the UK IBD standards group stated that "all IBD patients should have access to a dietitian with a specialist interest in IBD". This had not been met when reviewed in 2013.[2] In the 2006 they audited 75% of UK hospitals where the median number of dietitian sessions dedicated to gastroenterology was two per week. Only 52% of patients admitted with Crohn's disease were weighed and only 37% were seen by a dietitian.

The standards recommend minimum staffing of 0.5 WTE dietitians per 250,000 population. This works out at a caseload of 1,000 per 0.5 WTEs for the 240,000 patients with IBD in the UK, which seems grossly inadequate given the nutritional consequences of this disease.

There is only one clinical specialist dietitian post and a handful of senior dietitians specialising in gastroenterology in Ireland so numbers here are also insufficient to deal with the rising incidence of IBD.

Role of diet

Diet has two major roles in IBD – adjuvant and primary therapy. Basic nutrition support is used as an adjuvant or supportive therapy to prolong effects of drug therapy and prevent and treat malnutrition in both Crohn's and ulcerative colitis. Exclusive enteral nutrition (EEN) can be used as primary therapy instead of medication to achieve remission in certain patients with an acute exacerbation of Crohn's disease.[3] Nutritional intervention is tailored to each individual and depends on disease type, location, phase, surgical history, comorbidities, therapeutic goals, patient preference and team consensus. There are many variables.

Limitations

The limitations of diet should be outlined to patients to address any misconceptions. Diet can contribute to or ease symptoms but it does not cause a flare. It can induce remission in carefully selected cases but it must not replace medications if they are prescribed. Diet cannot cure IBD but there is evidence to show diet may prevent IBD developing in the first instance.[4,5,6,7] Our better understanding of the microbiome is also adding to the link between diet and IBD pathogenesis

Using models or diagrams of the gastrointestinal tract can help patients understand how IBD impacts nutrition and vice versa. Not all dietary therapies used by patients are evidence based. Due to gaps in research, knowledge and dietetic services, some patients are seeking their own 'cure'. Interest in diets such as the specific carbohydrate diet, gut and psychology syndrome and paleo is growing alongside gluten-free and low FODMAP diets, which may in time prove useful for functional symptoms or IBS overlap.

Malnutrition

It is well documented that there is an increased risk of developing malnutrition in IBD. Studies show that up to 85% of hospitalised patients suffer from protein energy malnutrition.[8] A wide variation in rates of malnutrition is reported in the literature due to differences in assessment criteria, disease type, severity, and phenotype. Crohn's appears to have a greater nutritional insult than ulcerative colitis with higher rates attributed to it when we look at each condition separately – Crohn's disease 80%,[9] ulcerative colitis 18-62%.[10] Up to 75% of our patients experience weight loss[11] and 50% present in negative nitrogen balance.[12] Healthcare professionals caring for patients with IBD should be aware of these risks and know when to refer their patients to a CORU registered dietitian.

It is very easy for these patients to slip into a malnourished state. In the active phase, IBD is an anorexigenic disease due to increased pro-inflammatory cytokines IL-18 and TNF alpha[13] which, along with altered gastrointestinal hunger hormones GLP and leptin,[14] make it counterintuitive to eat.

Food aversions and fear of eating, otherwise known as sitophobia, can occur which is understandable given that diet and the gastrointestinal tract are inextricably linked. Self-imposed dietary restrictions in an effort to control GI symptoms can compound malnutrition further.[15]

Fatigue is extreme and extra gastrointestinal manifestations such as arthritis[16] can hinder food preparation. Odynophagia due to oral aphthous ulcers can also reduce oral intake.[17] It can be helpful to measure and monitor food-related quality of life at each consultation.[18] Increased nutrient, fluid and electrolyte losses due to malabsorptive symptoms, like diarrhoea, high output stomas or fistulae, lead to wide ranging deficiencies and deficits.

Lean body mass and muscle function are significantly reduced in all stages of disease, a known predictor for the development of osteoporosis.[19] Body fat distribution differs too – a depletion of visible fat and increase in intra-abdominal fat over time may play a role in the inflammatory process. Screening tools and BMI do not detect these changes. Useful anthropometric methods include skinfold thickness, mid-upper arm circumference, dynamometry and newer generation bioelectric impedance analysis technology.

The use of DEXA reports and CT should be explored for this purpose too given that many IBD patients undergo these investigations routinely.[20] Positive or negative changes in body composition may be due to IBD medications. Although there are many reports of weight gain, fluid retention and false appetite from taking steroids, more recent studies have not found a

dose-response relationship of oral glucocorticoid therapy on energy intake, appetite, body weight or body composition.[21] Infliximab causes weight gain by inducing remission, a welcomed side effect in an undernourished person.[22] It is important that patients receive counselling on these side effects prior to starting, particularly in those who are already overweight or obese and are keen to reduce or maintain weight.

Consequences of undernutrition in IBD are similar to other chronic diseases. Patients should be optimised at all times but particular emphasis should be put on their status pre surgery to ensure best outcomes. PEM leads to increased septic complications following gastrointestinal resections,[23] and post-operative anastomotic leakage has been cited in those who lose greater than 5kgs weight prior to surgery.[24]

If malnutrition is identified at pre-surgical assessment, the dietitian must recommend that surgery is delayed for seven to 14 days for intensive nutrition support to prevent such consequences. If however surgery cannot be delayed, as is the reality for cases of toxic megacolon, total obstruction, ischaemia, or other emergencies, nutrition support should be given immediately post-op.[25]

Malnutrition occurs in quiescent disease or remission too with approximately 40% of patients overweight.[26] This trend is a concern and patients should no longer be encouraged to have a buffer of excess weight between flares. Studies show those with high BMIs are more prone to developing active Crohn's disease[27] and requiring surgery sooner[28] than those in the ideal range.

Healthy eating and micronutrients

It is important to recommend healthy eating for weight management and be explicit when prescribing exercise. A twice-weekly programme of resistance training is required to correct changes in body composition.[29] IBD patients require ongoing and regular monitoring of their nutritional status after they are discharged from hospital. This currently takes place in specialist hospital outpatient clinics if a dietitian service exists. Alternative models of care in primary care should be explored.

Assessment of micronutrients should be measured routinely due to the impact deficiencies can have on outcomes. Supplementation is required due to some drug food interactions such as sulfasalazine.[3]

Low vitamin D is associated with increased risk of surgery and hospitalisation in IBD[31] The literature also mentions that deficiency alters efficacy of medication.[32] Vitamin D was the most common micronutrient deficiency noted in an Irish cohort followed closely by haematinics such as iron, folate and B12.[33] Optimising zinc levels may improve gut integrity in Crohn's disease.[34]

One caveat in the interpretation of micronutrients is the degree of inflammation at time of sampling, so not only should a clinician check if inflammatory markers such as C-reactive protein (CRP) are raised but note how much they are raised.[35] An accurate Vitamin D level for example may not be attained until CRP is less than 10, which for many with acute IBD will not be during an inpatient stay. Similar CRP thresholds are suggested for other micronutrients. Seek and treat all deficiencies using local guidelines. Calcium should also be supplemented if intake is low. Beware of the possibility of transient lactose intolerance[36] in those with small bowel Crohn's and recommend dairy alternatives to meet calcium needs until resolved.

Iron deficiency anaemia increases morbidity and mortality but treating it improves quality of life independent of disease activity. The anaemia seen in IBD patients is usually a combination of Iron deficiency anaemia and anaemia of chronic disease. Anaemia of chronic disease is caused by blood loss, disease severity or phenotype and focus should be on resolving the underlying cause such as giving RCC or treating the disease not giving iron. Iron supplementation should only be given in cases of anaemia. There is no evidence for treating iron deficiency without anaemia in IBD but a decision may be made to supplement depending on a case by case basis

Excess iron is not absorbed in inflammatory states. CRP is a surrogate marker for hepcidin – a peptide that regulates iron absorption. If high give IV as enteral absorption blocked hence difficulties tolerating oral iron.[37] Iron deficiency anaemia recurs quickly following IV replacement so restart when ferritin <100 or HB <12. Check levels in three-monthly intervals in active disease.[38] There is a useful reference table for iron requirements based on weight and haemaglobin level cited in ESPEN guidelines 2017.[39]

Levels of albumin are important to assess response to medical treatment and the inflammatory process rather than nutritional status. It is unknown if patients lose response to biologics due to reduced nutritional status or vice versa but we know that biologics are carried on albumin. For example, enteral nutrition providing more than 600kcals of nutritional requirements daily leads to a sustained response to IFX.[40]

In the acute phase and if malnourished a high-calorie high-protein diet is recommended for most with careful consideration of hydration and micronutrients. Fibre may be restricted temporarily or long term in the case of stricturing disease.[41]

In remission and in well nourished states there are no blanket restrictions and patients are advised to follow healthy eating and lifestyle advice to maintain nutritional status between flares.[42]

If nutrition is chosen as the primary treatment for Crohn's, exclusive enteral nutrition in the form of a polymeric formula is administered orally or via nasogastric tube for a minimum of 10 days for a duration of four to six weeks with close dietetic supervision.[43] Exclusive enteral nutrition can be used as a bridging treatment until a medication takes effect or during medication-free periods pre and perioperatively.[44]

Parenteral nutrition should not be used as primary treatment of inflammatory luminal Crohn's disease. Bowel rest has not been proven to be more efficacious than nutrition per se. The most common indication is the presence of short bowel syndrome. Parenteral nutrition is indicated for those who are malnourished, have inadequate or unsafe oral intake, or a non-functioning, inaccessible or perforated gut. Specific indications include obstruction, high intestinal or fistulae output.[45]

Future considerations

One size does not fit all. Nutritional intervention and dietary advice depends on type of IBD, phenotype, location, severity, previous surgeries, symptoms, nutritional status and comorbidities. Obesity is the new face of IBD; we are seeing fewer underweight presentations making is harder to spot malnutrition, but it is there and most certainly worsening the disease course of patients.

Implementing nutrition focused physical findings as part of the nutrition care process will only help to identify patients most in need of support. Assessment of nutritional status at regular intervals regardless of disease phase or care setting is key to optimising the patient throughout the course of their disease. Emerging research in areas such as fibre, pre and probiotics, curcumin and emulsifiers mean advancements in the nutritional management of IBD are on the horizon. Service infrastructure needs to be improved however so that all those with IBD can access a CORU registered dietitian.

Elaine Neary is a CORU registered dietitian and clinical specialist in gastroenterology

References available on request. email nursing@medmedia.ie (Quote Neary WIN 2019: 27 (3): 51-52)

What benefits are patients with diabetes entitled to?

Anna Clarke from Diabetes Ireland provides an overview of the various entitlements for people with diabetes

DIABETES is a lifelong condition and as such is a serious health problem. Over the past 50 years Diabetes Ireland has been instrumental in securing a range of free benefits for people living with diabetes. It is useful for healthcare professionals who work with those with diabetes to be aware of these benefits.

Entitlements for diabetes management

People with diabetes are entitled to free public system healthcare which is in main public hospitals and with a medical card/GP visit card access to the primary care 'Diabetes Cycle of Care'. Entitlement is limited to diabetes care, and other services deemed to affect diabetes, by a doctor or diabetes nurse specialist.

Podiatry services are not covered unless the referral is made though the diabetes team to the relevant community or acute HSE podiatrists as per the 'Diabetes Foot Model of Care'. Having a medical card may permit access to chiropodist care but this is independent of diabetes. People over 65 years of age have free access to community podiatry services where they are available. Diabetes Ireland provides a reduced cost service to members, see: **www.diabetes.ie**/services

Some people may get free dental care under the Dental Treatment Services Scheme for periodontal/gum disease; dentists are familiar with who qualifies and can make the application. Diabetes Ireland can offer reduced dental care insurance for members, see: **www.diabetes.ie/diabetes-and-dental-care**

All people over the age of 12 years are entitled to a free eye retinal test through RetinaScreen (**www.retinascreen.ie**). Any diabetes-related abnormality requiring further attention is covered through the national retinal care pathway. Note this is not a vision test and diabetes does not give additional cover for glasses or eye tests above the national social welfare coverage. A person may be registered blind but still have some vision. A 'blind' person may be entitled to other payments based on their sight loss, eg. blind person's allowance, blind welfare allowance, blind person's tax free allowance, free travel and may also claim and be means tested for carer's allowance, disability allowance, guide dog allowance, companion travel, electricity allowance, television allowance, incapacity benefit, low vision aids and telephone allowance.

Everyone with diabetes who can demonstrate residency in Ireland is entitled to the long-term illness (LTI) scheme which gives free access for diabetes and cardiac medications, pens/syringes, lancets and blood glucose monitoring strips. Payments made prior to approval of the LTI will not be reimbursed. Gestational diabetes is no longer a condition eligible for the LTI scheme because under the legal requirement for an LTI, it is not viewed as a lifelong condition.

Tax relief on medical expenses

A person can claim tax relief on general medical expenses, doctors' fees and certain items/medications prescribed by doctors. Those with diabetes can also claim back glucometer costs, if personally purchased. They can also claim for chiropody/podiatry services or similar treatments.

Tax relief is not available for routine ophthalmic and dental care. However, there are certain dental treatments that do qualify for tax relief, for example crowns, veneers and root canal treatment. It may be feasible to get relief on the purchase of an exercise bike if prescribed for a person with type 2 diabetes by their doctor.

A person may be able to claim tax relief on foods used to treat hypoglycaemia or purchased as part of a dietary plan. A person with diabetes may also be able to claim additional tax relief as tax credits. See **www.revenue.ie** for more information.

Other entitlements

See: **www.diabetes.ie/living-with-diabetes/living-type-1/entitlements-social-welfare-information/** for more information on social welfare payments that might be sought, eg. carer's allowance, carer's benefit, domiciliary care allowance, invalidity pension, supplementary welfare allowance, disability allowance and entitlements around education/employment.

When diabetes must be declared

A person with diabetes is legally required, if asked, to inform any potential employer of any long-term condition during the recruitment process. Under the Employment Equality Act, the company cannot use a medical condition to discriminate in terms of successfully getting the job. Diabetes Ireland advocates for equal rights for all workers with diabetes. A person with diabetes is entitled to time off to attend hospital appointments. However, payment for this time is at the discretion of the employer.

Any person sitting the Leaving Certificate is advised to tick the box on the CAO form for the Disability Assess Route Education (DARE) which, when submitted with a medical form that states the person has type 1 diabetes, permits access to college through reduced points for some courses and access to additional supports, see: **http://accesscollege.ie/dare/**.

A person at risk of hypoglycaemia must inform the Road Safety Authority of having diabetes and must get a medical form completed to establish fitness to drive. Should the person have more than one severe hypoglycaemic event in a 12-month calendar period, their ability to drive warrants re-establishment.

All people diagnosed with a medical condition must declare it to any insurance company when asked regarding medical status or subsequently when their medical status changes during the lifespan of a policy.

Conclusion

This is a brief look at the benefits available to people with a diagnosis of diabetes. There are many other benefits which the person will be entitled to, based on any comorbidity or their socio-economic status. Where a case based on either of the above may be borderline, the financial and personal burden of having diabetes should be stressed to enable a more compassionate outcome.

Anna Clarke is the health promotion and research manager at Diabetes Ireland

New focus for ENT services in Ireland

A new model of care sees increased MDT involvement in the provision of otorhinolaryngology services in Ireland. **Tara Horan** reports

THE National Clinical Programme in Surgery (NCPS) recently launched a new model of care on the provision of otorhinolaryngology head and neck surgery (ORL-HNS) in Ireland, aimed at improving the quality of care for patients.

This focuses on standardising care delivery and improving access to ORL-HNS services throughout the country. It provides recommendations for implementation by the HSE, hospital and community managers, clinicians, and multidisciplinary teams caring for patients.

'Otolaryngology Head and Neck Surgery: a model of care for Ireland' was written by Prof Michael Walsh, clinical advisor at the NCPS, which is an initiative of the HSE and the RCSI.

ORL-HNS is the oldest and third largest surgical specialty in Ireland. It manages disorders of the ear, nose and throat and related structures in the neck (thyroid, salivary glands) and the skull base. The specialty assesses and manages sensory losses such as hearing, balance, taste, smell, and the functional loss of speech and swallowing.

Approximately 2% of the population is referred for ORL-HNS services, with an estimated 18 referrals per 1,000 population. With appropriate training and support, the model of care states that a proportion of this work could safely be provided in primary care as well as by other members of multidisciplinary teams, including advanced nurse practitioners (ANPs), clinical nurse specialists (CNSs) and health and social care professionals.

With 38% of ORL-HNS admissions being unscheduled, there can be major detrimental impacts on routine scheduled care admissions. The most frequent unscheduled admissions are ingestion or inhalation of foreign bodies, life-threatening infections such as abscess formation in the upper airway, airway obstruction and haemorrhage.

However, any specialty model of care must take into account both elective and acute presentations, as well as inpatient, outpatient and ambulatory care. A number of factors contribute to waiting list challenges in ORL-HNS, including the availability of adequate and protected bed and theatre capacity.

The model of care notes that an area of particular concern is rolling theatre closures arising from staffing shortages. While more efficient use of existing beds and theatre capacity in hospitals will increase capacity, it says that other initiatives such as ambulatory care centres are also needed.

Recommendations

The model of care proposes a number of new ways of working that would have a significant impact on care delivery for patients requiring ORL-HNS intervention. Its recommendations include:

- Medical treatment of rhinitis and a proportion of ear microsuction in primary care by GPs who are trained in ORL-HNS procedures
- Direct access from primary care to diagnostic audiology and vestibular services
- Joint specialist speech and language therapists and ORL-HNS voice and swallowing clinics
- Outpatient referrals should be triaged according to the national Outpatient Services Performance Improvement Programme prioritisation model
- Outpatient clinic capacity should follow otorhinolaryngology best practice guidelines
- Implementation of the following one-stop multidisciplinary clinics in each hospital group:
  - Acute vestibular assessment and rehabilitation clinic
  - Specialist combined respiratory and ORL-HNS multidisciplinary clinic
  - Rapid access speech/swallow clinics
  - Paediatric ORL-HNS clinic (obstructive sleep apnoea)
  - Direct referral audiology/otology clinic
  - Direct access neck lump clinic
- Outpatient procedures should be costed to incentivise cost savings through ambulatory care
- Implementation of day-of-surgery admissions
- An increase day case and ambulatory surgical procedures, including tonsillectomy, in children and adults
- Separate delivery of complex ORL-HNS scheduled surgery from routine ORL-HNS scheduled surgery
- Designate and resource four specialty 'hub' centres delivering complex head and neck surgical oncology, supported by four 'spoke' sites nationwide, as recommended by the National Cancer Control Programme.

Next step in defining best practice

This is the third model of care published by the NCPS – the previous two defining the standards of care that should apply to acute surgery (2013) and elective surgery (2011) in Irish hospitals. The development of specialty models of care is the next step in defining best practice, according to Prof Deborah McNamara, co-lead NCPS. "It allows a deeper understanding of the range of activity delivered by specialist services and of areas where there are unmet needs. It is also an opportunity for each specialty in surgery to define how the multidisciplinary surgical workforce can best deliver the care required by Irish patients, taking into consideration the new ways of working that are now the standard of care," she said.

Otolaryngology Head and Neck Surgery: a model of care for Ireland is available for download at the RCSI website, **www.rcsi.ie**

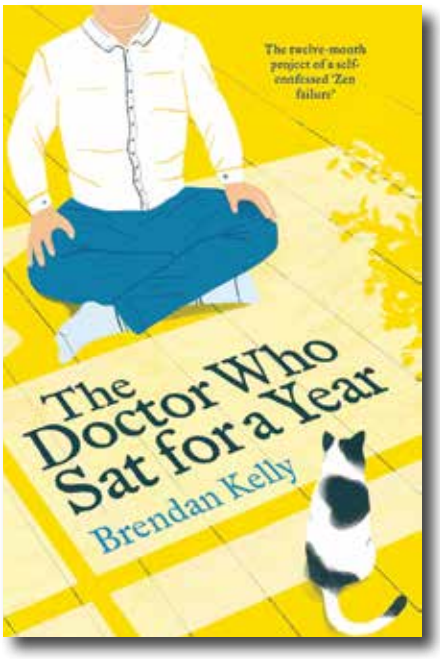
Living life in the moment

IS YOUR mind filled with a hundred swirling thoughts? When you try to clear it, does it quickly fill up again with a hundred more? Detaching from your thoughts can be liberating, but it's not straightforward.

A new book gently explores the practicalities and benefits of setting aside 15 minutes a day for meditation. Sit upright in a chair in a quiet place, focus on your breathing and let your mind clear – easier said than done.

In *The Doctor Who Sat for a Year*, Brendan Kelly, professor of psychiatry at TCD and lover of the three 'C's – cats, cake and cinema, describes his attempts over a year to embrace meditation as part of his daily routine.

Someone once said: "You should sit in meditation for 20 minutes a day, unless you are too busy – then you should sit for half an hour".



Many nurses will identify with Brendan's professional life in a job on the frontline dealing with human suffering, with long hours on-call handling emergencies. He is one of those unlucky people who doesn't sleep well, so it's exhausting to imagine how he also copes with family life, his prolific writing on history and mental health, and his eclectic interest in art and culture.

Brendan has had a longstanding interest in Buddhism and holds a masters degree in Buddhist studies (within his extensive portfolio of masters degrees and PhDs). The book runs at a gentle pace, full of wit and charm. Reading through it is in itself a bit of a time-out.

In a world where constantly being busy is seen as a virtue, the book explores the benefits of embracing meditation, set against a wry look at our human imperfections. And nothing is more imperfect and frustrating as a trip on a low-cost airline. Coming into the holiday season, the section 'Fly like Buddha: A practical guide for the spiritual tourist' (p.130) comes highly recommended.

After the year-long diary of how he fared, the 'How to meditate' self-help section is just seven pages at the end. I like the last line, clichéd though it is: "This moment is all we have. It is all we will ever have. Life is a series of nows. We need to live them".

– Geraldine Meagan

The doctor who sat for a year by Brendan Kelly is published by Gill Books. ISBN 978-0-7171-8457-6

CROSSWORD Competition

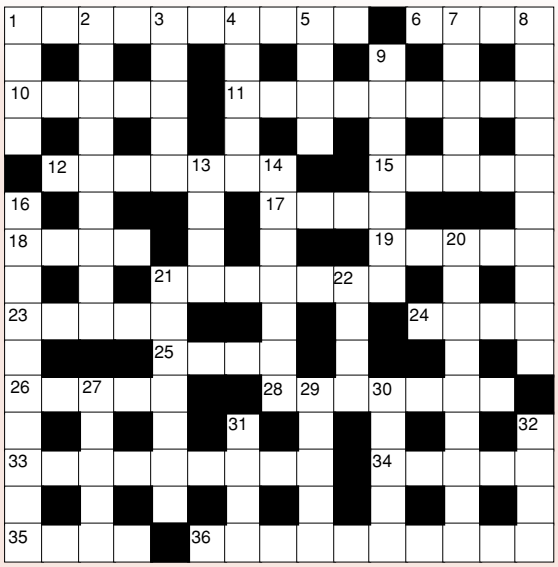
WIN a €50 gift voucher

Across

1 Exile causes one somehow to bin anthems (10)
6 Unwanted email (4)
10 Relating to the Pope (5)
11 Cane's aria about an obstetric section (9)
12 Sweet-tasting bread from France (7)
15 Pours down (5)
17 Arrived (4)
18 Strikes (4)
19 It's a more pleasant French city, right? (5)
21 Looks for food - over a long period of time! (7)
23 More sage (5)
24 Informal photo (4)
25 Middle-Eastern potentate (4)
26 The 'ticker' (5)
28 Demonic (7)
33 The new altar flap will disintegrate (4,5)
34 Daniel Day-Lewis' Poet Laureate father (5)
35 Urban area (4)
36 Open-air pub facility (4,6)

Down

1 Large breakfast-rolls (4)
2 Hire pints out? That's not good for your kidneys! (9)
3 Volley of shots (5)
4 Chaim is confused about an Old testament prophet (5)
5 Requirement (4)
7 Grace, elegance (5)
8 Hand-written document (10)
9 Hurries (7)
13 Hello – or goodbye – in Italian (4)
14 Creamy choux pastry treats (7)
16 "Don't munch the skinny!" Discuss (4,3,3)
20 Persuaded completely (9)
21 Cutting implement found in a strange war fest (7)
22 Orient (4)
27 Permit, let (5)
29 Michaelmas daisy (5)
30 The capital of Ghana can be seen from part of a lilac craft (5)
31 Dublin theatre with five bars? (4)
32 Family, tribe (4)



March crossword solution

Across: 1 Stableboys 6 Leah 10 Costa Brava 11 Rigoletto 12 Ironing board 17 Area 18 Unit 21 Smetana 23 Fleet 24 Obey 25 Omar 26 Locum 28 Spectre 33 Olfactory nerve 35 Test 36 Modernised

Down: 1 Sect 2 Assertive 3 Learn 4 Byron 5 Yoga 7 Extra 8 Hook and eye 9 Ali Baba 13 Imam 14 Gaiters 16 Duffel coat 20 Ambergris 21 Stomach 22 Nude 27 Cuffs 29 Payee 30 Conan 31 Hobo 32 Weed

The winner of the March crossword is: Sheila Ward Tullamore, Co Offaly

You can now email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included.
Closing date: Friday, April 19, 2019
If preferred you can post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin, A96E096

Name:
Address:

MONEY MATTERS

Is your life cover right for you?

Ivan Ahern discusses three key reasons why you should consider reviewing your life insurance

LOVED ones come first when we think about future financial security. You should ask yourself, would your spouse or children be significantly affected if you were not there to provide for them? Consideration should also be given to anyone in your life who would face a financial challenge if you passed away. This could involve having to pay off any loans or debts that you have.

As with any insurance policy, it's important to review your life cover on a regular basis to ensure that you have the right level of protection for your changing needs and also to see if you could save money by switching policy. There are three main reasons for doing this:

- If your circumstances have changed
- If you have never reviewed your cover
- There are better policies available.

Your circumstances have changed

Buying a new home or having a child are two big life events that require a life cover change but there are lots of other circumstances where this also applies. Variations in your personal circumstances or even your lifestyle can mean that the life insurance you and your loved ones require has changed. You should ask yourself:

Has your health status changed?

For example:

- You've given up smoking
- You've been working out and have lost weight
- You've been eating healthily and your blood pressure is down as a result.

Has your financial status changed?

For example:

- Your income has changed
- You've taken out additional loans.

Has your marital status changed?

- If you got married, your spouse needs to be factored into your cover
- If you got divorced, the list of beneficiaries on your policy needs to be updated.

Have you taken out other policies?

If you or your partner have subsequently taken out other policies that include an element of life cover, you should review all policies collectively to ensure that you're not over insured and that you're on the right policy type for your situation; for example single cover, joint cover or dual cover.

You've never reviewed your cover

If you own your own home, it's highly likely that when you took out your mortgage protection, you availed of the policy that your mortgage provider offered you. If so, you should consider the following:

- Most mortgage providers deal with only one insurance company, which may not offer the best rates or terms available on the market
- Since you took out your policy, you've paid several years off your mortgage, so the level of cover you need has naturally decreased over time.

There are better policies available

There are hundreds of life insurance policies available on the Irish market today and it can be mind boggling to find the right one for you.

The fact is that this is a highly competitive area and, as a result, life insurance providers are constantly offering new types of cover at more and more affordable prices.

You should take advantage of what this competitive market has to offer by reviewing your present cover.

INMO members can avail of a free life insurance review with Cornmarket.

For more information visit www.**cornmarket.ie/life-insurance** or contact us at Tel: 01 4200965.

Ivan Ahern is a director at Cornmarket Group Financial Services Ltd

Implementation of bereavement standards completed nationally

A BEREAVEMENT forum held at University College Cork last month marked the completion of the two year implementation programme for the National Standards for Bereavement Care Following Pregnancy Loss and Perinatal Death.

The day-long forum brought together expert representatives from Ireland's 19 maternity hospitals to discuss the work of the National Implementation Group over the past two years.

The National Standards, launched in August 2016, seek to define the care that parents and families should receive following a pregnancy loss or perinatal death in Irish maternity hospitals.

The group began work in March 2017 within the National Women and Infants Health Programme. The group, led by Dr Keelin O'Donoghue and Riona Cotter, is a 14-member team of professionals from different healthcare backgrounds with expertise in perinatal bereavement care.

Pictured at the Bereavement Forum at University College Cork were (l-r): Jillian Cassidy, Prof Alexander Heazell, Riona Cotter and Dr Keelin O'Donoghue

The group has worked in collaboration with management teams and healthcare professionals from all 19 maternity hospitals across the country, as well as parent support groups, bereavement charities and parent representatives to ensure that all families who experience pregnancy loss or perinatal death will receive consistent compassionate care.

The group has been responsible for examining and developing educational programmes around bereavement care as well as ensuring that maternity staff are supported in their practice, and the development of a parental experiences feedback tool.

Irish hospitals operating below recommended midwife to birth ratio

IRISH hospitals require more than 620 extra midwives in order to operate within the recommend standard ratio of midwives to births of 1:29.5, according to professor of midwifery at Trinity College Dublin, Valerie Smith.

Prof Smith was speaking in Galway at the recent medico-legal conference 'The Risky Miracle of Childbirth', an event which heard from experts in the fields of obstetrics, midwifery and medical negligence litigation about recent changes to the legal system relating to mothers and children injured during childbirth.

Also speaking at the conference was Johan Verbruggen, a medical negligence solicitor with Callan Tansey Solicitors, who described his personal experience of injury during his own birth. He said: "Following a mismanaged labour and delivery, for which I required resuscitation, I was diagnosed with Erb's palsy, a near-total paralysis of my right arm, but in truth it could have been much worse. My parents were deliberately misinformed about what had happened to cause this injury.

"They litigated successfully on my behalf against the Western Health Board in December 1996. It was through the litigation process that they discovered what went wrong and how preventable this traumatic birth was."

An appreciation: Philomena Canning

THE death has occurred of inspirational midwife Philomena Canning. Philomena, who advanced the practice of homebirths and women's rights, passed away on Friday, March 22, 2019 after a three-year battle with cancer.

Philomena championed the rights of pregnant women to choose to give birth at home and in other non-medical settings. She had been involved in a long running dispute with the HSE having been incorrectly deprived of her right to work since 2014. Philomena wished to open homebirth centres in Dublin, but her indemnity insurance was withdrawn without notice. Even after her insurance was restored, she could not practice until the HSE carried out a systems analysis. By the time her practice was exonerated in 2016 she had lost everything and was diagnosed with cancer soon after. She took a case for damages against the HSE and subsequently sold her house due to the financial burden.

The case was only resolved weeks before her death. She had hoped for her day in court to highlight her experience and her concerns for safety in maternity

Inspirational midwife Philomena Canning championed the rights of women to choose the setting in which they want to give birth

care. However, when she received a terminal diagnosis of ovarian cancer, she asked for a settlement so she could access funds to pay for the anticancer drug, pembrolizumab. Sadly, she died at St Vincent's Private Hospital on March 22.

Shortly before her death she said: "They have hounded me, made my life hell since 2014. I just ask now to be able to relax. It's a simple thing to ask – to go to my grave in peace."

She will be remembered by all those whose lives she touched and by future generations of nurses and midwives. She was a true pioneer in her field.

On behalf of Ireland's midwives and nurses, the INMO sends its deepest condolences to Philomena's friends and family. She was a model to all midwives and was ahead of her time. May she rest in peace.

Pioneering nurse remembered in 'Women on Walls' portrait collection

MARY Frances Crowley, founding member and first dean of the faculty of nursing and midwifery at the RCSI, was featured in a collection of portraits unveiled at the college last month.

The collection, entitled 'Women on Walls', depicts eight historical female leaders in healthcare.

Having earned her registered nurse certificate in Britain, Mary Frances Crowley returned to Ireland in 1941 to take up a senior position in Sir Patrick Dun's Hospital. Then in 1944 she was appointed assistant matron of the Royal Victoria Eye and Ear Hospital.

Immediately after the war, Dean Crowley travelled to northern France as matron of the Irish Red Cross Hospital at Saint-Lô, where Samuel Beckett was storekeeper, interpreter and driver. For their work at Saint-Lô, Dean Crowley and her staff were awarded the Medaille de la Reconnaissance Française.

Returning to Ireland, Dean Crowley later founded the nursing training school at the Royal Victoria Eye and Ear Hospital and became director of nursing studies. In 1974, her ambition of many years was realised with the establishment of a faculty of nursing at the RCSI, the first of its kind in Ireland or Britain.

Dean Mary Frances Crowley's portrait will hang in the board room of the RCSI building on St Stephen's Green, Dublin

Prof Cathal Kelly, RCSI CEO, said: "We are immensely proud to unveil these portraits of ground-breaking RCSI women today. These pioneers made significant contributions to education and healthcare here at the RCSI, in Ireland and much further afield. We hope that by recognising them through this landmark initiative we might inspire future generations of women and girls to pursue a career in healthcare and science.

"Each of these women had a profound impact and we want history to remember their legacy. It is our duty to help preserve their stories and celebrate their achievements. It is right and proper that today they take their place not just on these storied walls of RCSI but also in the history of healthcare".

Further information about 'Women on Walls at RCSI' and scheduled tour times see: **women.rcsi.com**

April

Tuesday 9
International Nurses Section meeting. INMO HQ. 5.30pm. Contact jean.carroll@inmo.ie for further details

Wednesday 17
RNID Section meeting. Richmond Education and Event Centre. 11am-1pm. Contact jean.carroll@inmo.ie for further details

Thursday 18
Retired Section meeting. 11am-1pm. Richmond Education and Event Centre. Contact jean.carroll@inmo.ie for further details

Saturday 27
PHN Section meeting. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie for further details

Saturday 27
Community RGN Section meeting. 11am-1pm. Contact jean.carroll@inmo.ie for further details

Monday 29
National Children Nurses Section meeting. INMO HQ. Our Lady's Children's Hospital, Crumlin. 11am-1pm. Contact jean.carroll@inmo.ie for further details

May

Wednesday 1
21st National Orthopaedic Nurses conference. Lady Martin Auditorium, Cappagh National Orthopaedic Hospital, Finglas, Dublin. Contact rosemary.masterson@cappagh.ie for further details

Wednesday 8 - Friday 10
INMO annual delegate conference 2019. Knightsbrook Hotel, Trim, Co Meath. *See page 17 for further details*

Thursday 16
Student allocation liaison officers networking group. INMO HQ. From 12pm.Contact jean.carroll@inmo.ie for further details

Saturday 18
School Nurses Section meeting. INMO HQ. From 10.30am.Contact jean.carroll@inmo.ie for further details

Tuesday 21
Telephone Triage Section meeting and education workshop. INMO Limerick. Contact jean.carroll@inmo.ie for further details

Saturday 25
CNM Section meeting and workshop. INMO HQ. 10am. Contact jean.carroll@inmo.ie for further details

June

Wednesday 5
Orthopaedic Nurses Section meeting – via teleconference. 11am. Contact jean.carroll@inmo.ie for further details

Saturday 8
PHN Section meeting. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie for further details

Saturday 8
Community RGN Section meeting. 11am-1pm. Contact jean.carroll@inmo.ie for further details

Saturday 8
Midwives Section meeting. Galway University Hospital. From 2pm. Contact jean.carroll@inmo.ie for further details

Tuesday 11
Care of the Older Person Section meeting. Richmond Education and Event Centre. From 11am. Contact jean.carroll@inmo.ie for further details

Tuesday 11
'A rights-based approach to dementia care' workshop. The Richmond. 10.30am-1pm. Organised by the Care of the Older Person section. Early bird rate: €30 before June 31. Book now: 01 6640641/18

Friday 14
Third Level Student Health Nurses Section meeting. Richmond Education and Event Centre. 11am. Contact jean.carroll@inmo.ie for further details

Wednesday 26
Clinical Placement Coordinators Section meeting. Richmond Education and Event Centre. 10.30am. Contact jean.carroll@inmo.ie for further details

September

Saturday 7
Midwives Section meeting. Limerick University Maternity Hospital. From 2pm. Contact jean.carroll@inmo.ie for further details

Tuesday 10
National Care of the Older Person Section annual conference. Richmond Education and Event Centre. Contact jean.carroll@inmo.ie for further details

Saturday 14
School Nurses Section meeting. Midland Park Hotel, Portlaoise. From 10am. Contact jean.carroll@inmo.ie for further details

Thursday 19
Retired Section meeting. From 11am. Richmond Education and Event Centre. Contact jean.carroll@inmo.ie for further details

INMO Membership Fees 2019

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

Condolences

- The INMO would like to express its deepest condolences to our colleague Marion Behan and her extended family on the death of her sister Rose Leech on March 17, 2019. May she rest in peace.
- On behalf of Ireland's midwives and nurses, we send our deepest condolences to the friends and family of the inspirational midwife, Philomena Canning. RIP.

Tuesday 24
Telephone Triage Section meeting and education workshop. Richmond Education and Event Centre. Contact jean.carroll@inmo.ie for details

October

Saturday 12
PHN Section meeting. INMO HQ. From 11am. Contact jean.carroll@inmo.ie for further details

Saturday 12
Community RGN Section meeting. INMO HQ. From 11am. Contact jean.carroll@inmo.ie for details

Thursday 17
All Ireland Midwifery Conference. Armagh. Contact jean.carroll@inmo.ie for further details

Thursday 17
Student Allocation Liaison Officers meeting. 12pm. Contact jean.carroll@inmo.ie for further details

Upcoming Events

- The INMO's 40th Annual Golf Society day will take place on Friday May 24, 2019 at Thurles Golf Club, Co Tipperary. Tee times can be booked when payment of €50 is made. Contact 087 9886269 or 086 3629704 to make your booking. We are marking 40 years of this event and hope that you will join us for what promises to be a great day.
- Professional certificate in musculoskeletal casting and splinting (adults and children). (Special Purpose Award; NFQ level 8; 30ECTS). Commencement date: September 2019. For more programme details, please email: ioct@cappagh.ie