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WIN

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

World of Irish Nursing & Midwifery

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Protecting the frontline

WHO chief nurse calls for standards to be upheld

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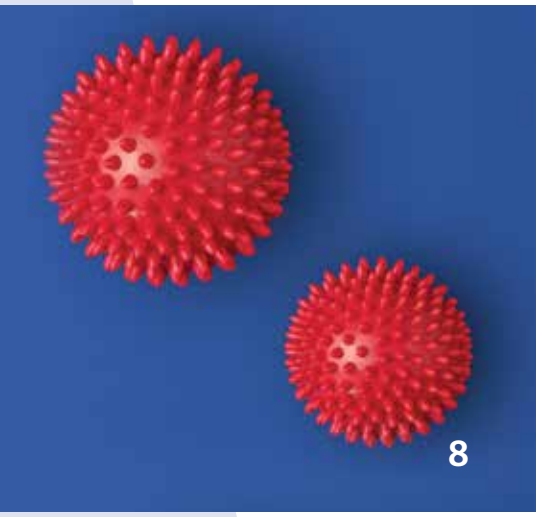
Up to 4 sprays per hour may be used. Do not exceed 2 sprays per dosing episode and do not exceed 64 sprays (4 sprays per hour, over 16 hours) in any 24-hour period. **Step I: Weeks 1-6:** Use 1 or 2 sprays when cigarettes normally would have been smoked or if cravings emerge. If after a single spray cravings are not controlled within a few minutes, a second spray should be used. If 2 sprays are required, future doses may be delivered as 2 consecutive sprays. Most smokers will require 1-2 sprays every 30 minutes to 1 hour. **Step II: Weeks 7-9:** Start reducing the number of sprays per day. By the end of week 9 subjects should be using HALF the average number of sprays per day that was used in Step I. **Step III: Weeks 10-12:** Continue reducing the number of sprays per day so that subjects are not using more than 4 sprays per day during week 12. When subjects have reduced to 2-4 sprays per day, oromucosal spray use should be discontinued. To help stay smoke free after Step III, subjects may continue to use the oromucosal spray in situations when they are strongly tempted to smoke. One spray may be used in situations where there is an urge to smoke, with a second spray if one spray does not help within a few minutes. No more than four sprays per day should be used during this period. Regular use of the oromucosal spray beyond 6 months is generally not recommended. Some ex-smokers may need treatment with the oromucosal spray longer to avoid returning to smoking. Any remaining oromucosal spray should be retained to be used in the event of sudden cravings. Paediatric population: Do not administer this medicine to persons under 18 years of age. There is no experience of treating adolescents under the age of 18 with this medicine. Method of administration: After priming, point the spray nozzle as close to the open mouth as possible. Press firmly the top of the dispenser and release one spray into the mouth, avoiding the lips. Subjects should not inhale while spraying to avoid getting spray into the respiratory tract. For best results, do not swallow for a few seconds after spraying. Subjects should not eat or drink when administering the oromucosal spray. Behavioural therapy advice and support will normally improve the success rate. **Contraindications:** Hypersensitivity to nicotine or to any of the excipients. Children under the age of 18 years. Those who have never smoked. **Special warnings and precautions for use:** This medicine should not be used by non-smokers. The benefits of quitting smoking outweigh any risks associated with correctly administered nicotine replacement therapy (NRT). A risk-benefit assessment should be made by an appropriate healthcare professional for patients with the following conditions: Cardiovascular disease: Dependent smokers with a recent myocardial infarction, unstable or worsening angina including Prinzmetal's angina, severe cardiac arrhythmias, recent cerebrovascular accident and/or who suffer with uncontrolled hypertension should be encouraged to stop smoking with non-pharmacological interventions (such as counselling). If this fails, the oromucosal spray may be considered but as data on safety in this patient group are limited, initiation should only be under close medical supervision. Diabetes Mellitus. Patients with diabetes mellitus should be advised to monitor their blood sugar levels more closely than usual when smoking is stopped and NRT is initiated as reduction in nicotine induced catecholamine release can affect carbohydrate metabolism. Allergic reactions: Susceptibility to angioedema and urticaria. Renal and hepatic impairment: Use with caution in patients with moderate to severe hepatic impairment and/or severe renal impairment as the clearance of nicotine or its metabolites may be decreased with the potential for increased adverse effects. Phaeochromocytoma and uncontrolled hyperthyroidism: Use with caution in patients with uncontrolled hyperthyroidism or phaeochromocytoma as nicotine causes release of catecholamines. Gastrointestinal Disease: Nicotine may exacerbate symptoms in patients suffering from oesophagitis, gastric or peptic ulcers and NRT preparations should be used with caution in these conditions. Paediatric population: Danger in children: Doses of nicotine tolerated by smokers can produce severe toxicity in children that may be fatal. Products containing nicotine should not be left where they may be handled or ingested by children. Transferred dependence: Transferred dependence can occur but is both less harmful and easier to break than smoking dependence. Stopping smoking: Polycyclic aromatic hydrocarbons in tobacco smoke induce the metabolism of drugs metabolised by CYP 1A2 (and possibly by CYP 1A1). When a smoker stops smoking, this may result in slower metabolism and a consequent rise in blood levels of such drugs. This is of potential clinical importance for products with a narrow therapeutic window, e.g. theophylline, tacrine, clozapine and ropinirole. The plasma concentration of other medicinal products metabolised in part by CYP1A2 e.g. imipramine, olanzapine, clomipramine and fluvoxamine may also increase on cessation of smoking, although data to support this are lacking and the possible clinical significance of this effect for these drugs is unknown. Limited data indicate that the metabolism of flecainide and pentazocine may also be induced by smoking. Excipients: The oromucosal spray contains small amounts of ethanol (alcohol), less than 100 mg per dose (1 or 2 sprays). This medicinal product contains less than 1 mmol sodium (23 mg) per spray, i.e. essentially 'sodium- free'. This medicine contains 12 mg propylene glycol in each spray which is equivalent to 157 mg/mL. Due to the presence of butylated hydroxytoluene, Nicorette QuickMist may cause local skin reactions (e.g. contact dermatitis), or irritation to the eyes and mucous membranes. Care should be taken not to spray the eyes whilst administering the oromucosal spray. **Undesirable effects:** Effects of smoking cessation: Regardless of the means used, a variety of symptoms are known to be associated with quitting habitual tobacco use. These include emotional or cognitive effects such as dysphoria or depressed mood; insomnia; irritability, frustration or anger; anxiety; difficulty concentrating, and restlessness or impatience. There may also be physical effects such as decreased heart rate; increased appetite or weight gain, dizziness or presyncopal symptoms, cough, constipation, gingival bleeding or aphthous ulceration, or nasopharyngitis. In addition, and of clinical significance, nicotine cravings may result in profound urges to smoke. This medicine may cause adverse reactions similar to those associated with nicotine given by other means and these are mainly dose-dependent. Allergic reactions such as angioedema, urticaria or anaphylaxis may occur in susceptible individuals. Local adverse effects of administration are similar to those seen with other orally delivered forms. During the first few days of treatment irritation in the mouth and throat may be experienced, and hiccups are particularly common. Tolerance is normal with continued use. Daily collection of data from trial subjects demonstrated that very commonly occurring adverse events were reported with onset in the first 2-3 weeks of use of the oromucosal spray, and declined thereafter. Adverse reactions with oromucosal nicotine formulations identified from clinical trials and during post-marketing experience are presented below. The frequency category has been estimated from clinical trials for the adverse reactions identified during post-marketing experience. Very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1 000 to <1/100); rare (≥1/10 000 to <1/1 000); very rare (<1/10 000); not known (cannot be estimated from the available data). **Immune system disorders:** Common Hypersensitivity Not known Allergic reactions including angioedema and anaphylaxis **Psychiatric disorders:** Uncommon Abnormal dream **Nervous system disorders:** Very common Headache Common Dysgeusia, paraesthesia **Eye disorders:** Not known Blurred vision, lacrimation increased **Cardiac disorders:** Uncommon Palpitations, tachycardia Not known Atrial fibrillation **Vascular disorders:** Uncommon Flushing, hypertension **Respiratory, thoracic and mediastinal disorders:** Very common Hiccups, throat irritation Common – cough; Uncommon Bronchospasm, rhinorrea, dysphonia, dyspnoea, nasal congestion, oropharyngeal pain, sneezing, throat tightness **Gastrointestinal disorders:** Very common Nausea Common Abdominal pain, dry mouth, diarrhoea, dyspepsia, flatulence, salivary hypersecretion, stomatitis, vomiting Uncommon Eructation, gingival bleeding, glossitis, oral mucosal blistering and exfoliation, paraesthesia oral Rare Dysphagia, hypoaesthesia oral, retching Not known Dry throat, gastrointestinal discomfort, lip pain **Skin and subcutaneous tissue disorders:** Uncommon Hyperhidrosis, pruritus, rash, urticaria Not known Erythema **General disorders and administration site conditions:** Common Burning sensation, fatigue Uncommon Asthenia, chest discomfort and pain, malaise. **MAH:** Johnson & Johnson (Ireland) Limited, Airton Road, Tallaght, Dublin 24, Ireland. **PA Number:** PA 330/37/16. **Date of revision of text:** November 2019. Product not subject to medical prescription. Full prescribing information available upon request. IRE/NI/20-4095



On the cover this month (l-r): Tania O'Neill, midwife; Elizabeth Iro, WHO chief nursing officer; and Ciara Brennan, nurse

NEWS & VIEWS

FEATURES

CLINICAL

LIVING

JOBS & TRAINING

WIN – World of Irish Nursing & Midwifery is distributed by controlled circulation to **more than 40,000** members of the INMO. It is published monthly (10 issues a year) and is registered at the GPO as a periodical. Annual Subscription: €155 incl. postage paid. Editorial Statement: *WIN* is produced by professional medical journalists working closely with individual nurses, midwives and officers on behalf of the INMO. Acceptance of an advertisement or article does not imply endorsement by the publishers or the Organisation.

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Breastfeeding: The best start

Health benefits for infants

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

Long-term benefits for children

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

Benefits for mothers

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

Support for mothers is essential

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

Work and breastfeeding

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

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Working Together

The Irish Nurses and Midwives Organisation supports breastfeeding

For more information log onto www.breastfeeding.ie

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A challenge for our professions

THIS is an unprecedented time for the Irish population and most certainly the health service. The rapid spread of Covid-19 is placing substantial pressure on our already burdened systems. We know from experience that such pressure is first and most acutely borne by health workers. There are doubtlessly dark days ahead.

Worldwide, nurses and midwives have not been found wanting and certainly in Ireland it will be no different. The mission for our professions in the coming weeks and months is clear: provide expert care in exceptional circumstances, while maintaining safe standards.

The job of the INMO is to support our members in that mission – and ensure that you do not face negative financial, health, industrial or academic consequences due to this crisis.

Our priorities are that none of our members are put at unnecessary risk, that personal protective equipment as recommended is available and that you are supported in your work to combat the worst effects of this virus.

We are fully mobilised to provide dedicated support to our members: advocating and arguing on your behalf with the HSE, dealing with concerns in individual workplaces, and ensuring that government and regulators support you now to do the job.

At the time of going to print, for example, we have focused nationally on securing a workable childcare solution, clarity and employment for students on placement, and ensuring public health recommendations on self-isolation apply to essential healthcare workers including nurses and midwives.

Internationally, we have liaised with other nursing unions and representative organisations around the world to hear what they have learned from dealing with the crisis, and have worked to bring back nurses and midwives who are keen to return to Ireland to help defeat Covid-19.

Locally, we have intervened on the advice of our members to secure additional personal protective equipment wherever there were shortages, dealt with individual occupational health issues and ended car park charges for staff at many hospitals.

By the time you read this, however, the fast pace of Covid-19 likely means that we are dealing with a new range and scale of issues. As ever, I would encourage you to read our dedicated webpage, which has the latest updates: **inmo.ie/covid19**

The issues will change, but our approach will likely remain the same: constructive work in the immediate term to see off this virus, while ensuring that the crisis is never used to harm our hard-won rights, pay and protections at work.

Government advice on preventing Covid-19's spread has meant that our offices are now mostly closed, but we have redeployed staff to ensure that we maintain supports to members. The office may be closed but the union is open and all officials and support staff are working.

That same government advice also has major impacts on the INMO's other business. All of our training courses have been cancelled and the library service is only available remotely.

We have postponed our annual delegate conference until October, with the knock-on effect of a delay in choosing a new Executive Council and officers. Balloting for the new Executive has just completed – those ballots will be left unopened and secured until our annual conference, meaning that the current Executive's term has been extended.

Like any organisation, we have had to adapt to the challenges posed by Covid-19. We will keep you informed of any further organisational changes we need to make.

But wherever or however we work, the purpose of the union is the same. We are over 40,000 women and men, standing together for dignity, fairness and safety in our work.

Covid-19 may change many of our practices and approaches but it will not change the values of our professions or our union. *Dá fhaid é an lá tiocfaidh an oíche.*

Phil Ní Sheaghdha
General Secretary, INMO

Irish Nurses and Midwives Organisation

Working Together

"You insure your car, you insure your house; Why not insure your profession?"

Nurses and Midwives; Together we are Stronger

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- Representing nurses and midwives individually and collectively in the workplace
- The leading voice for nurses and midwives in Irish health care
- Campaigning for restoration of Nurse and Midwife pay and hours
- Providing expert representation in workplace relations
- Full support in NMBI fitness to practice public hearings with expert professional and legal representation
- Professional development offering career development and professional education
- Professional library service
- Employment information service – law – conditions of employment – your rights and entitlements
- Access to income continuance protection plan (supplementary to the sick leave scheme)
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- Free legal aid for occupational or bodily injury claims
- Legal and counselling helplines

Union membership costs €5.75 per week

Join today by visiting www.inmo.ie/joininmo

Your priorities with the president

Martina Harkin-Kelly, INMO president

Unprecedented times

AT CERTAIN times in history courage becomes paramount. At this time of global pandemic the courage society most needs is that of its carers. I would like to acknowledge the incredible lengths that all of you go to and will continue to go to in your crucial work, while you continue to manage your own concerns for yourselves, your loved ones and your communities. We have kept channels of discussion with the HSE open and the union will keep you all informed of outcomes of ongoing discussions. I urge you to regularly check the INMO website for daily updates on matters relating to your protection and the protection of your patients during this pandemic. I also urge you to use the #couragetocare hashtag where possible on social media to highlight the pivotal role your professions are playing in protecting the most vulnerable in our society.

It's hard to believe that this was supposed to be my final *WIN* article. I honestly don't know where the past four years have gone. However, due to the current crisis I will continue to serve in the role of president until our now rescheduled ADC in October 2020. My time as president has felt like a whirlwind from the outset and indeed as we enter the eye of the storm it continues to be a privilege to serve this dedicated and tenacious workforce.

Although normality may seem like a distant memory, we continued to operate as usual until recently and my usual round up follows as normal.

HSE anti-bullying symposium

THE HSE anti-bullying symposium was recently held in Dublin. The event highlighted the need to develop and foster values of dignity and respect in the workplace. A panel of eminent speakers drew on national and international evidence bases to clearly demonstrate the impacts of bullying on health and wellbeing. With an overall emphasis on civility and human dignity, a particular highlight of the event was the overview of the RCSI's civility project, a behaviour and working environments project presented by Margaret O'Donnell, clinical lead and consultant plastic surgeon at the Blackrock Clinic.

RCSI conference

IN FEBRUARY I attended the opening dinner and award ceremony of the 39th Nursing and Midwifery Research and Education Conference. The theme for the conference was '2020: The WHO Year of the Nurse and Midwife: Celebrating Nurses and Midwives' Contribution to Healthcare Locally and Globally'. Honorary fellowships were awarded to three very worthy recipients: Lord Nigel Crisp, public heath leader and advocate; Elizabeth Iro, chief nursing officer of the WHO; and nurse Vivien Lusted, winner of the 2019 Florence Nightingale medal, who was recognised for her humanitarian work. All three were honoured for their outstanding work and exceptional leadership and their positive impact on health and society.

ICTU women's conference

THE Irish Congress of Trade Unions' women's conference was attended by a strong INMO delegation. Participants debated a range of issues relating to gender inequality in Irish society. This year's conference theme was 'Realising our rights – Women organising for change'. The conference was opened by George Lawlor, Wexford's Lord Mayor, who recounted for the delegates Wexford's rich history of trade union activism. Patricia King, ICTU general secretary, centred her address on two key anniversaries: the 25th anniversary of the Beijing Declaration and Platform for Action, and the 40th anniversary of the UN Convention on the Elimination of All Forms of Discrimination Against Women. Ms King highlighted the fact that despite the existence of such landmark conventions, issues of inequality still persist, and that progress towards equality is slow. During the conference the INMO presented a motion on the increase in the pension age and female workers. The motion was passed.

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

Thought for the month

"A diamond is a chunk of coal that did well under pressure"

Report from the Executive Council

THE Executive Council met on March 2-3. The main consideration on the agenda was the postponement of ADC 2020. Following government announcements of restrictions on public gatherings, it was clear that the event would have to be moved to later in the year. The decision to postpone was taken by the Executive Council under rule 5.1. The Executive praised the organisational work to date of the Sligo Branch.

It was also noted that as elections for president and vice-presidents take place at ADC, these officer elections could not take place until October and that the Executive Council itself would need to be elected one month in advance of that. The Executive agreed that under the rules of the Organisation these changes should be put to branches and sections immediately in the form of a special motion. Branches and sections would vote on whether the ballot papers for the election of a new executive council may be returned by March 25, 2020, as previously planned, and then remain sealed and held by the Organisation's solicitor until Monday, September 7.

Branches and sections would also ballot on the extension of the term of the current executive council up to the concluding day of the 2020 ADC. The date for the return of this ballot was Friday, March 20.

Regular Executive Council meetings were convened by conference call throughout the month to discuss the Organisation's response to the Covid-19 pandemic.

The next meeting of the Executive Council is scheduled for April 6-7 (by conference call).

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

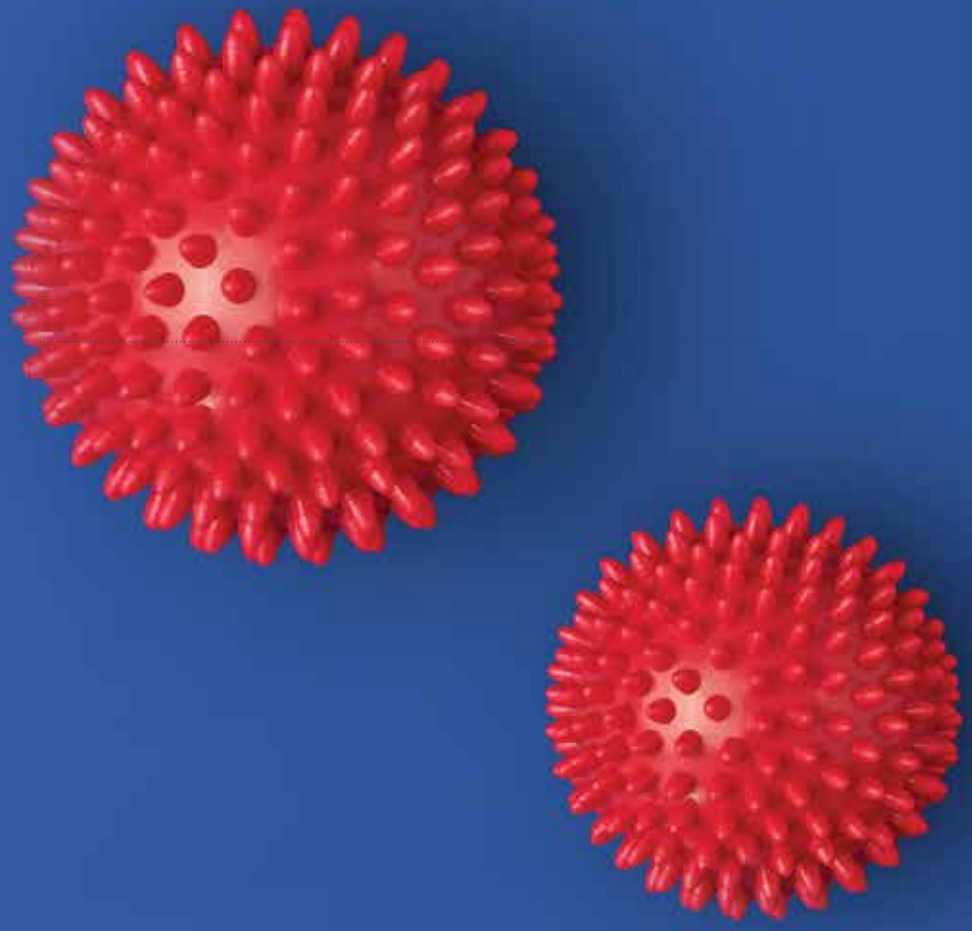
INMO focused on ensuring staff and resources in fight

The INMO is engaging on an ongoing basis with the HSE in respect of provisions for frontline staff in relation to testing and care for suspected and confirmed Covid-19 cases.

The industrial relations team is focused on ensuring that members have the equipment, staff, resources and support they need in the fight against Covid-19.

The situation is changing continuously. For all the latest updates, please visit our regularly updated page: **inmo.ie/COVID19**

There are also student-specific updates at: **inmo.ie/COVIDstudent**



members have equipment, against Covid-19

Issues raised by the INMO with the HSE and government include:

(at the time of going to print, on March 25)

- Personal protective equipment (PPE)
- Improving guidelines on PPE and infection control
- Childcare for health workers
- Parking charges and an end to clamping
- Paid employment for students
- Special leave with pay for those asked to self isolate/quarantine
- Specific guidelines for pregnant, postpartum and immunosuppressed health workers
- An end to the recruitment freeze
- Rapid implementation of outstanding allowance and salary payments under the strike settlement
- Payment for GP and practice nurses
- Specific mirroring of protections for those working in the private sector and in agencies
- Assurances that midwifery staff will not be redeployed
- Temporary removal of re-registration and overseas registration fees at the NMBI
- Scope of practice updates and NMBI guidance
- Additional staff training
- Government provision of flights home for Irish health workers seeking to return to work
- Clarity for students on placements

INMO

Irish **Nurses** and **Midwives** Organisation

Cumann Altraí agus Ban Cabhrach na hÉireann

Working Together

World news

Nurses and midwives in action around the world

Australia
- Rationing care to cope with Covid-19 should never be based on age alone

Canada
- Better protections needed for healthcare workers during Covid-19: advocates
- Saskatchewan nurses' union demands respirators for members

Italy
- Italian nurses share the startling reality of fighting the pandemic

Paraguay
- Doctors and nurses feel unprotected and clamour for equipment

Portugal
- Sixth strike for SAMS do Sul and islands workers is called off

Spain
- Satse warns that there are not enough nurses with ICU experience to open 1,000 new beds

UK
- The UK needs immigrants to work in its health service – the Chancellor just gave them a reason not to come
- RCN cancels representatives' conference because of coronavirus

US
- Hospitals want to quash a policy shielding nurses from Covid19 because there aren't enough masks
- Nurses on the frontlines of coronavirus pandemic demand more protection and Medicare for all

Through history, politics and economics have always played a major role, both in the spread of epidemics and the response to them, writes **Dave Hughes**

The politics of pandemics

THE puzzling sight of the two Northern Irish leaders Michelle O'Neill and Arlene Foster publicly disagreeing in respect of the issue of closing schools and universities as a response to the spread of the coronavirus which leads to Covid-19 raised for many the spectre of politics dominating over public health.

One week later, they jointly announced school closures and the following morning Arlene Foster reminded listeners to *Morning Ireland* on RTÉ Radio 1 that the first case in Northern Ireland had come via Dublin Airport.

The original press conference arose in the context of the decision of the Irish government to close schools and colleges among a range of social distancing measures. The puzzlement among communities living on both sides of the border, which in effect is invisible with free movement, was obvious in their vox-pop reactions. How could Covid-19 become the latest point of disagreement between nationalists and unionists in the six counties?

But in human history, politics and economics have always played a major role, both in the spread of epidemics and the response to them. The Chinese government is now being praised for its effective actions in dealing with Covid-19 and has become the model for other governments in how to curtail or slow down the deadly virus. However, when it was first discovered, the Chinese tried to suppress the information.

The story of a cholera epidemic in Hamburg in 1892 is recounted by Sir Richard J Evans in *Death in Hamburg: Society and Politics in the Cholera Years (1830-1910)*. It was the only epidemic of cholera in a western European city at that time. Cholera had vanished from Europe except tsarist Russia at that point. The last epidemic in Great Britain had ended in 1866, but in a six-week period in 1892 some 10,000 people died in Hamburg from cholera.

Hamburg was the second city in the German Empire and operated as an autonomous city. One of the largest seaports in the world at the time, it was run by merchants, who suppressed the news of the arrival of the disease from Russia, because they thought that quarantines would be imposed, which would damage trade. That approach delayed the appropriate response. It was only when the federal government in Berlin stepped in and sent bacteriologist Robert Koch and a team, who took over the administration of the city of Hamburg, that the lockdown which stopped the disease from spreading took place. The economy of Hamburg took a huge hit which took a long time to recover from, but how Hamburg was administered changed for good.

How governments and administrations respond to emerging epidemics comes down to, firstly, their attitude to uncertainty, secondly to whether they have universal healthcare systems and finally, the trust of the people they represent.

New mutations of coronavirus which emerge create uncertainty – will they become so contagious as to spread rapidly into epidemics? Fear about the economic impact of containment measures leads to delay and inaction. Did this happen in Italy? Is this what happened in the UK, Northern Ireland and the US – where Prime Minister Boris Johnson, First Minister Arlene Foster and President Donald Trump all appeared to suggest they had the situation under control and could curtail the virus without major upheaval? In all three cases the population reacted and self-imposed isolation in schools and public places before their governments decided to do so.

The ability to respond to the crisis is influenced by how a country's healthcare is administered. Therefore, the NHS in the UK, and European and the Irish public health systems are better able, if appropriately directed, to cope than a private system, where who pays becomes an issue even in epidemics. Pandemics overwhelm the best of health systems as we have witnessed in Lombardy, Italy. So, coping in a pandemic is at best mitigating the loss of life.

Populations because of the history of epidemics and pandemics are better informed and more willing to adhere to expert advice. Therefore, access to accurate, honest facts about the spread of a disease from trusted experts is essential if the public are to act in the necessary and only proven method of dealing with pandemics until a vaccine is successfully developed to kill the virus. The alternative is that the virus remains in control and no government or administration can pretend otherwise.

Dave Hughes is INMO deputy general secretary

INMO annual delegate conference postponed until October

INMO ADC 2020 will now take place on Wednesday to Friday, October 7-9, 2020 at the Radisson Blu Hotel, Sligo.

The INMO Executive Council took swift action to reschedule this key event in the Organisation's calendar, following government announcements of restrictions on public gatherings due to Covid-19.

The decision to postpone was taken by the Executive Council under rule 5.1.

The term of the current Executive Council has been extended up to the concluding day of ADC 2020, following a special motion put to a ballot of branch and section delegates.

Elections for president and the two vice-president posts take place at ADC, which now cannot take place until October. Under the rules of the Organisation, the Executive Council must be elected one month in advance of the ADC.

Under the special motion put to branches and sections, it was proposed that the ballot papers for the incoming Executive Council, which were due to be returned by March 24, 2020, would remain sealed and held by the Organisation's solicitor until Monday, September 7, 2020. This was accepted by branches and sections in the ballot which closed on March 20, 2020.

The Executive Council praised the organisational work to date done by the Sligo Branch, particularly under these challenging and unprecedented circumstances.

Dramatic drop in trolley numbers as Covid-19 takes hold

THE number of trolleys with admitted patients in emergency departments and wards nationwide has dropped dramatically over the past month – in direct correlation to the rise in Covid-19 cases in the country.

For the first time since the INMO trolley watch began in 2006, numbers have been consistently below 100 in recent weeks – dropping to as low as 16 trolleys nationwide on March 16.

This is in sharp contrast to the month of February, when the number of admitted patients without beds in Irish hospitals surpassed 10,000.

February 2020 saw a total of 10,446 inpatients on trolleys, which is 23% more than February 2019, when the figure was 8,523 on trolleys.

Among the 10,446 patients on trolleys in February were 87 children. The worst-hit hospitals in February 2020 included:

- University Hospital Limerick – 1,286
- Cork University Hospital – 1,031
- University Hospital Galway – 805
- South Tipperary General Hospital – 653
- St Vincent's University Hospital – 535.

Measures put in place by hospitals due to the Covid-19 outbreak, which are likely to have had a positive effect on trolley figures, include:

- Cancellation of non-urgent outpatient appointments, with some exceptions such as for cancer services and dialysis
- Cancellation of day case and inpatient procedures
- Visitor restrictions.

Table 1. INMO trolley and ward watch analysis (February 2006 – 2020)

Hospital	Feb 2006	Feb 2007	Feb 2008	Feb 2009	Feb 2010	Feb 2011	Feb 2012	Feb 2013	Feb 2014	Feb. 2015	Feb 2016	Feb 2017	Feb 2018	Feb 2019	Feb 2020
Beaumont Hospital	418	632	751	723	841	598	757	611	587	769	658	471	333	339	404
Connolly Hospital, Blanchardstown	264	332	204	253	165	361	375	335	496	502	239	207	324	240	222
Mater Hospital	440	337	498	438	514	296	402	264	299	473	418	438	494	311	502
Naas General Hospital	425	238	231	383	348	457	310	229	245	403	445	314	420	294	193
St Colmcille's Hospital	277	93	45	200	178	268	284	155	n/a	n/a	n/a	n/a	n/a	n/a	n/a
St James's Hospital	456	144	293	247	244	166	178	179	204	234	139	340	216	205	363
St Vincent's University Hospital	369	387	452	465	460	527	382	394	145	532	705	311	369	314	535
Tallaght Hospital	966	437	489	500	589	685	283	250	287	433	450	383	589	274	342
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	18	5	2
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	98	29	41
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	126	34	38
Eastern total	**3,615**	**2,600**	**2,963**	**3,209**	**3,339**	**3,358**	**2,971**	**2,417**	**2,263**	**3,346**	**3,054**	**2,464**	**2,987**	**2,045**	**2,642**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	18	50	92	19	64	93	119
Cavan General Hospital	421	477	177	157	267	372	319	232	47	77	149	11	43	95	227
Cork University Hospital	399	338	375	324	720	710	586	328	317	410	603	720	928	736	1,031
Letterkenny General Hospital	316	292	20	26	44	31	19	65	261	527	154	384	477	407	352
Louth County Hospital	10	15	13	24	13	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo University Hospital	209	347	103	180	164	120	163	200	278	212	232	118	190	171	317
Mercy University Hospital, Cork	178	147	150	187	187	219	190	229	160	299	186	201	366	232	341
Midland Regional Hospital, Mullingar	4	8	7	53	287	253	239	193	365	473	477	473	422	174	226
Midland Regional Hospital, Portlaoise	62	28	24	19	15	179	106	14	202	214	260	406	201	192	87
Midland Regional Hospital, Tullamore	1	5	2	10	27	154	197	67	251	303	359	399	591	329	320
Mid Western Regional Hospital, Ennis	76	224	22	13	53	105	25	56	n/a	3	70	17	26	3	14
Monaghan General Hospital	n/a	56	33	17	n/a	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	22	36	6	8	10	22
Our Lady of Lourdes Hospital, Drogheda	340	336	216	444	237	440	607	332	532	715	530	233	299	198	343
Our Lady's Hospital, Navan	44	101	80	78	73	160	93	71	194	100	46	278	238	33	97
Portiuncula Hospital	46	69	39	47	43	61	102	90	71	210	13	323	102	83	84
Roscommon County Hospital	29	98	79	82	99	76	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sligo University Hospital	64	140	89	87	218	195	110	50	249	196	191	287	447	460	290
South Tipperary General Hospital	75	58	107	38	109	80	161	184	267	267	303	449	584	419	653
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	n/a	26	69	81	255	269	331	253	451	288	219
University Hospital Galway	198	249	285	311	445	484	585	328	441	620	583	583	696	526	805
University Hospital Kerry	85	79	116	38	118	48	42	82	74	121	146	146	357	359	449
University Hospital Limerick	163	200	115	144	389	292	367	329	534	709	630	712	977	973	1,286
University Hospital Waterford	n/a	n/a	n/a	40	89	84	145	124	388	201	354	449	446	475	375
Wexford General Hospital	318	183	107	24	150	282	95	38	72	313	86	89	114	214	147
Country total	**3,038**	**3,450**	**2,159**	**2,343**	**3,747**	**4,371**	**4,220**	**3,093**	**4,976**	**6,311**	**5,831**	**6,556**	**8,027**	**6,470**	**7,804**
NATIONAL TOTAL	**6,653**	**6,050**	**5,122**	**5,552**	**7,086**	**7,729**	**7,191**	**5,510**	**7,239**	**9,657**	**8,885**	**9,020**	**11,014**	**8,515**	**10,446**
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**	**260**	**70**	**87**

Percentage increase/decrease:
2019 compared to 2020: 23%
2018 compared to 2020: -5%
2017 compared to 2020: 16%
2016 compared to 2020: 18%
2015 compared to 2020: 8%
2014 compared to 2020: 44%
2013 compared to 2020: 90%
2012 compared to 2020: 45%
2011 compared to 2020: 35%
2010 compared to 2020: 47%
2009 compared to 2020: 88%
2008 compared to 2020: 104%
2007 compared to 2020: 73%
2006 compared to 2020: 57%

Acting up could not continue forever

INMO secures another win at WRC in Northwest

THE INMO has secured another win at the Workplace Relations Commission adjudication services in the Northwest region, as a result of making a regularisation claim under section 13 the Industrial Relations Act on behalf of a member in the region.

The member had sought confirmation of their appointment as CNM1 on a permanent basis. However, the employer said there was no pathway open to them to process such a claim. The employer engaged in regularisation of acting positions under a 2013 circular but the complainant was not covered by that circular which was finite in its application.

The member had acted up on a continuous basis since November 2015. The employer was obliged to comply with the Public Service Management (Recruitment and Appointments) Act 2004 and could not appoint by designation. The post had been approved as a permanent post and the employer proposed to advertise it as such and open it to other qualified applicants.

Circular letter 17/2013 was designed to regularise the employment of a large number of HSE staff nationwide, who had been in acting or temporary roles for a considerable time. Through this it was the express intention of the employer that there should not be a recurrence of this issue in the future and therefore the application of the circular was not open ended. Had the circular continued to operate, both parties were in agreement that the complainant would, in all likelihood, have been successful in having her position regularised by now.

The aspiration of the employer that there would not be a recurrence of the prevalence of acting up or temporary positions has clearly not been realised. However, nothing has been done to replace the circular or to reactivate it.

Maura Hickey, INMO IRO: *"The adjudicator found that it was unreasonable to expect the acting-up situation to carry on indefinitely with the accompanying uncertainty for the complainant"*

The employer argued that it was not possible to appoint someone by designation. However, many exceptions were made to this general rule under the 2013 circular which was intended to regularise circumstances such as those facing the complainant in this case.

The adjudicator found that the issue was not about appointment or about the appropriate selection process as the complainant had already – by interview – been deemed suitable to carry out the role of CNM1, albeit in an acting/temporary capacity. A permanent vacancy existed and it was unreasonable to expect the acting-up situation to carry on indefinitely with the accompanying uncertainty for the complainant.

The complainant could be held accountable for the failure of the employer to correctly implement the selection procedures and therefore concluded that the complaint was well founded and the member should be appointed to CNM1 on a permanent basis.

– Maura Hickey, INMO IRO

Application of location allowance in ID settings – dispute and resolution

A DISPUTE over the payment of the location allowance to members working at Annalee House Respite Centre, Cavan was heard at the Labour Court last month.

To qualify for this allowance, within intellectual disability services 75% of the clients accessing the service must have a severe or profound intellectual disability.

A protracted process of engagement has been ongoing between the INMO and the employer on this issue, however there has been no resolution to date.

The Department of Health and Children Circular 112/99 and associated Labour Court Recommendations 16261 and 16330 outline the rules for payment of the location allowance to nurses working in recognised areas. This came about on foot of the 1999 nurses dispute.

David Miskell, INMO IRO, said: "The decision to continue to refuse to pay the location allowance to nurses working in this setting is wholly unjustified. We will continue to take whatever steps are necessary to secure our members' entitlements."

Agreement to pay location allowance reached in Louth ID services

Meanwhile, following on from engagement with management in Louth ID Services, agreement has been reached to pay the location allowance to members working in Ravensdale and Point Road disability services in Dundalk, Co Louth.

Noelle Hamilton, industrial relations executive for the northeast region, said that an allowance has never previously been paid in these locations, a situation that is incorrect when the relevant criteria are applied.

Ms Hamilton welcomed the fact that this matter had been addressed and will continue to engage with management to finalise the appropriate retrospection payments.

High demand for information clinics

THE INMO saw a huge increase in demand for information clinics across the Cork region during the month of February. INMO information clinics provide a local onsite platform for members to pose any queries they may have to their IRO and reps, or raise any local or national issues.

Information clinics were held in Cork University Hospital, Cork University Maternity Hospital, Bantry and Mallow General Hospital, Heather House, Kanturk Community Hospital, West Cork CCA, North Lee CCA and to the South Lee immunisation team.

– Liam Conway, INMO IRO

New ANP service in Drogheda ED improves patient experience

AN ENP-led initiative set up under the Emergency Medicine Programme (EMP) at Our Lady's of Lourdes Hospital (OLOL), Drogheda is having a positive impact on the patient journey through the hospital's emergency department.

The EMP encourages ED-based initiatives that are cost efficient and deliverable through re-organisation of existing work practices with the overarching aim of improving the safety and quality of care for patients while reducing waiting times.

Following the publication of the *EMP Report* in 2012, an ANP candidate was appointed to develop an additional service to that of the minor injuries service in the ED at OLOL. Named 'Rapid Assessment and Treatment (RAT)', the service was modelled on a successful service being offered in the ED at St Vincent's University Hospital, Dublin.

The benefits of the service were identified through audit and patient feedback and Drogheda was chosen as a demonstrator site in 2017 for the Department of Health pilot.

Two ANP candidates were recruited in September 2017. In 2018, almost 1,000 patients were seen. In total, since the development of the service in 2013 just over 5,000 patients have been through the service.

The 2019 audit figures identified the service treated a total of 1,597 patients in the year – an increase of 600 since 2018. Three-quarters (75%) of those patients were seen by a healthcare professional with decision-making capabilities within two hours of presentation. This has had a positive impact on patient care, safety and experience within the ED of OLOL.

In addition, 83% of patients have a patient experience time (PET) of less than six hours, with 70% discharged. With an aim of 95% of patients being seen within this timeframe these are very positive results; this compares to approximately 55% at the first service audit in 2013 and 2014.

The improvements in PETs can be attributed to practitioner experience and also two additional candidate ANPs in the service.

The INMO members involved presented their service initiative at the International Nursing and Midwifery Conference in the RCSI in February 2019, at the North East Nursing Research Conference in May 2019 and at the Irish Association of Emergency Medicine annual conference in November 2019.

National and international studies provide evidence that ANPs are safe, effective clinical decision makers who contribute greatly to service delivery and improve patient outcomes.

The INMO extends its congratulations to registered ANPs Catherine Clarke, Dara McGuire and Rebecca Toner on their work and wish the service every success for the future.

– David Miskell, INMO IRO

Labour Court awards €10k compensation to PHN

THE Labour Court has awarded €10,000 to a public health nurse for the manner in which a complaint against her was handled.

The complaint was made by the father of a client with special needs and a local newspaper ran a story to the effect that the HSE had refused to provide treatment to his daughter. The newspaper article criticised the nurse but did not name her. The INMO contended to the Workplace Relations Commission and the Labour Court on appeal that the nurse found herself in the situation where, despite having done nothing wrong, an apology was given by her employer in response to a complaint made against her, and in doing so it was not made sufficiently clear that she had done no wrong.

Management contended that the nurse had the support of management at all stages of the process.

Taking all the arguments into account the Labour Court held that management should confirm in writing that the clinical judgement of the nurse was never in question and that she had acted correctly at all times.

She was awarded €10,000 in compensation for the manner in which the matter was handled.

David Miskell, INMO IRO for the North East Area, said: "Our member did nothing wrong in this case yet was left to face public accusations that were without foundation. It is imperative that appropriate support is provided when complaints are made against frontline staff."

Dispute at Cavan OPD to go to Labour Court

A DISPUTE at the Outpatients Department at Cavan General Hospital has been referred to the Labour Court.

At a recent conciliation conference under the auspices of the Workplace Relations Commission agreement between the employer and the INMO was not possible.

David Miskell, INMO IRO: *"While the role of the HCA is of great value, there cannot be replacement of nurses with other grades"*

The dispute centres around the introduction of the healthcare assistant (HCA) grade to the outpatients department without appropriate discussions with the union, and the replacement of nursing staff with HCAs in a number of clinics.

David Miskell, INMO IRO for Cavan General Hospital, said: "While the role of the HCA is of great value in any setting, there cannot be replacement of nurses with other grades. It is regrettable that resolution could not be reached locally and the INMO now has no option but to progress the matter to the Labour Court."

Section round-up

Care of the Older Person (COOP) Nurses Section

THE COOP Section's educational workshop for 2020 was held on January 28 at the INMO Cork office.

The workshop, entitled 'Enablement of the Older Adult with Chronic disease', was presented and facilitated by Mary J Foley, ANP. Ms Foley is based in the assessment and treatment centre at St Finbarr's Hospital, Cork. Her insightful workshop was well received and generated lively discussion among attendees, particularly around the area of Parkinson's disease.

The Section's AGM followed the workshop, and was also well attended. There were no changes at this time to serving officers, and the roles remain for 2020 with Caroline Gourley as chair, Margot Lydon as vice chair, while Noreen Watts remains as section secretary and Eileen O'Keeffe as education officer.

The Section's conference is scheduled to take place on Tuesday, May 26 at the Midland Park Hotel, Portlaoise, however this may need to be reviewed. See *page 26* for further details.

Emergency Department (ED) Nurses Section

THE ED Nurses Section was scheduled to meet in person on April 15 but will now do so with the use of teleconferencing. Notifications will be issued to the Section to confirm details.

New officers were elected at the AGM in January, namely Mick Schnackenberg, Tullamore ED; Emer Sherman, Portlaoise; Mary Dunne, Waterford University Hospital; and Emma Murphy, Cork University Hospital.

The representation for this section is countrywide, and it is hoped that this will lead to greater national engagement within the Section.

The main topic for discussion at the Section's April meeting, along with a comprehensive review of motions being put forward to the ADC, will be the WRC ED Agreement expert group review of nurse staffing levels in EDs.

Public Health Nurses (PHN) Section

THE PHN Section is marking the International Year of the Nurse and Midwife by hosting a conference entitled 'Celebrating the past, present and future of public health and community nursing'.

The conference is scheduled to take place on Saturday, September 19 at the Richmond Education and Event Centre.

There will be plenary sessions covering Sláintecare, working with marginalised groups, perinatal mental health and caring for transgender people.

The afternoon session will comprise concurrent workshops on topics including breastfeeding, woundcare, the children's nursing strategy and mindfulness/self-care.

The day will conclude with a panel discussion on the future of public health and community nursing in Ireland. See the ad below for more details and visit **www.inmoprofessional.ie** to book your place.

Irish Nurses and Midwives Organisaation

Menopause @Work
Position Statement

The Irish Nurses and Midwives Organisation (INMO) recognises the importance of supporting women in the workplace who are transitioning through menopause. This is an issue that is of particular importance to the INMO as its members are overwhelmingly women, some of whom are experiencing menopause. In addition, as caring professionals, nurses and midwives provide healthcare to menopausal women. The INMO believes that the core values of compassion, care and commitment that underpin nursing and midwifery practice extends to individual nurses, midwives and other healthcare employees – caring for the carers. This is centrally an individual issue, but by supporting nurses and midwives, employers are investing in their workforce. The INMO believes that the investment by healthcare employers in creating healthy workplaces that are menopause friendly will be a contributing factor in retaining nurses and midwives.

The INMO believes that the profile of menopause in the workplace needs to be acknowledged, recognised as an important occupational issue and for resources to be invested in supporting women. The INMO calls on the wider trade union movement to embrace and campaign for greater recognition and support on this issue. The INMO also calls upon all healthcare employers, in both the public and private sectors, to develop menopause friendly workplaces that recognise the importance of menopause. This includes the development of clear policies, training and dedicated resources to support women experiencing the menopause at work.

INMO
Irish Nurses and Midwives Organisation
Working Together
1919 - 2019

Nursing now Ireland

Spotlight on: Catherine Rotte-Murray

Retirement postponed: PHN shows the courage to care

CATHERINE Rotte-Murray is a public health nurse (PHN) in Lismore, Co Waterford, looking after a mixed rural area. Most of her caseload is clinical and includes some child development work through her baby clinic, as well as house calls. She works out of a small health centre with just one GP. Each morning patients come to the practice for dressings, wound management and routine baby development checks. In the afternoons she carries out house calls, checking in on home support and home care packages.

Ms Rotte-Murray was scheduled to retire on Friday, March 20, just before her birthday. She had been looking forward to it and had lots of plans to travel with her husband to visit family scattered around the globe. However, with the onset of the Covid-19 pandemic, their travel plans were cancelled and Ms Rotte-Murray felt it would be a bad time to retire. She spoke with her husband while out cycling and they came to the decision that she would stay on to support her colleagues and patients.

"My husband Jan was 100% supportive. I'm back in work for the foreseeable future. I feel that with the outbreak of Covid-19, the best place I can be is where I am now. I know my patients well and dependency kicks in when you see people three times a week. I sent an email to my director on the Monday morning offering to stay on and she immediately accepted."

Things are very different on the ground now. The clinic has no drop-ins anymore, the baby clinic is closed for the time being and they are prioritising essential contact with patients with chronic wounds. They had to change many of their appointments to home visits as people can't wait in the clinic anymore and need to wait in their cars instead. Staff are wearing aprons and gloves and are being even more conscious of hand hygiene than under normal circumstances.

How does this affect Ms Rotte-Murray's work? "We also have to phone ahead of house visits to check if people have travelled, been in contact with sufferers or have symptoms. We have to mind ourselves. If we can't stay safe then there's no point. We're no good to anyone then. Likewise, in our own families there is a lot of anxiety and uncertainty. In thinking I was going to retire I had done a lot of preparatory work so I'm organised at the moment, which is good in this hectic time."

Becoming a nurse

Ms Rotte-Murray wanted to be a nurse since she had her appendix taken out at the age of 12. She started her training at Jervis Street Hospital in 1972, and after three years of general nursing she worked in older people's services at St Mary's in the Phoenix Park before going on to study midwifery for a year at Holles Street. She did some agency work in London and Dublin while trying to decide what she wanted to do and then applied to volunteer with Concern. She worked for five months in the detox unit at Jervis Street Hospital before heading off to Bangladesh where she worked in primary care, with mother and child health as her main focus.

"Lots of Irish people volunteered with Concern. It was partly altruism, partly adventure. Six students from my Jervis Street class all ended up in Bangladesh with me. I met Jan there. He's Dutch and was volunteering too. We got married and spent the next 15 years working abroad in Tanzania and Laos."

In 1997 Ms Rotte-Murray returned to Ireland and worked as a practice nurse, before applying to study public health at UCC in 2002. She has worked as a PHN ever since, initially just outside Dungarvan and then in her current post in Lismore. The role has combined community development with participatory development, primary care, area profiling and many other skills she developed while working overseas.

Ms Rotte-Murray joined the INMO in 1997. As a practice nurse she felt vulnerable from an employment point of view. She completed several professional development courses around employment rights with the INMO and became involved with the Practice Nurses Section, which she went on to chair. She has spent a lot of time lobbying for improved pay and

Catherine Rotte-Murray: *"The best place I can be is where I am now"*

conditions, as well as establishing NMPDU reps in each area. "After the 1999 strike, we had no rights as private employees. We got huge support from the union."

Career progression

Professional development has come a long way during Ms Rotte-Murray's career. She says it affords nurses and midwives more credibility and professional respect among other healthcare professionals. She stresses the need for career progression options for clinical nurses and feels it is important for nurses to retain the front-line aspect of their jobs.

Ms Rotte-Murray says nurses have a lot to contribute to healthcare management.

"Decision-making at a national level and budgetary control in hospital management needs more input from nurses and midwives. We have so much front-line knowledge that could and should be brought to the table."

The INMO would like to commend Ms Rotte-Murray and all of those who have stepped up and shown the courage to care during this global pandemic.

This article is part of our Nursing Now series. Nursing Now is a worldwide campaign that aims to achieve recognition of nurses' contribution to healthcare, gender equality, the economy and wider society. The aim of the campaign is to improve health globally by raising the profile of nurses worldwide and influencing policymakers and supporting nurses to lead, learn and build a global movement. For more information visit ***www.nursingnowireland.ie***

INMO Professional

Celebrating the nursing and midwifery professions – where to from here?

4th ANNUAL CPC SEMINAR

In this International Year of the Nurse and Midwife the Clinical Placement Co-ordinators (CPCs) Seminar aims to celebrate nursing and midwifery, while exploring the impact of changes and challenges in healthcare for CPCs.

Wednesday, 29 April 2020

The Richmond Education and Event Centre,
North Brunswick Street, Dublin 7

Fee: €90 INMO members; €145 non-members

€70

INMO members only
(before 15 April 2020)

EARLY BIRD DISCOUNT

Awaiting category 1 approval from NMBI

OUTLINE OF DAY

9.00	Registration, Tea/Coffee and Networking	
9.30	Welcome	**Martina Harkin-Kelly**, INMO President
9.40	**"Nurses empowering Patient Safety and Advocacy"**	**Speaker: Elizabeth Adams**, Patient Safety and Advocacy Policy Officer, Department of Health; President of European Federation of Nurses Associations and member of the Nursing Now Board
10.45	Tea/Coffee and Networking	
11.15	**Changing Healthcare - Professional Development of Nurses/Midwives and the impact for Clinical Placement Co-ordinators**	**Speaker: Professor Jonathan Drennan**, Nursing and Midwifery University College, Cork
12.30	Lunch	
13.30	**"The Graduate Voice – Worth Your Weight in Gold"**	**Speaker: Róisín OConnell,** recently graduated from University Hospital Waterford and now working as Staff Nurse in the Surgical Ward
14.00	**"New Directions in Positive Psychology: Optimising Resilience, Mental Health and Well-Being in Training"**	**Speaker: Professor Ciaran O'Boyle,** Director, Centre for Positive Psychology and Health, Royal College of Surgeons of Ireland
15.30	**"2020: International Year of the Nurse and Midwife"**	**Speaker: Steve Pitman,** Head of Education and Professional Development, INMO
16.00	Close of Day	

The above programme is subject to change.

Nursing now Ireland

2020 INTERNATIONAL YEAR OF THE NURSE AND THE MIDWIFE

To book call **01 6640641/18** | email **education@inmo.ie** or visit **www.inmoprofessional.ie**

INMO Professional

RCM i-learn

THE ROYAL COLLEGE OF MIDWIVES

Supporting new mothers with mental health issues

A non-judgemental and empathic approach is needed to support mothers who may be experiencing perinatal mental health difficulties

THIS i-learn module on identifying and supporting mothers with perinatal mental health difficulties provides an understanding of the problem and its scale within pregnancy and the postpartum period. The module will also consider the responsibilities of midwives in identifying women who need support, practical steps to ask about mental wellbeing, women at higher risk of mental illness in pregnancy and why it is important for mental illness to be identified and treated early for both the woman and her unborn child. This module will take approximately 30 minutes to complete.

Objectives

By the end of this module you should be able to:

- Understand that women can be affected by mental illness in pregnancy, either for the first time or due to an ongoing condition, as well as in the postnatal period
- Understand the significance of perinatal health in the antenatal period
- Demonstrate knowledge of a range of perinatal mental health conditions
- Recognise a range of symptoms of common perinatal mental health disorders
- Appreciate and understand that communication with women around their mental health and wellbeing needs a sensitive, non-judgemental approach
- Understand your role in supporting women to get access to appropriate information and support
- Be aware and recognise the sensitive context and stigma around perinatal mental health and actively listen and provide empathy.

What is perinatal mental health?

In a mental health context, perinatal means the period from conception through to one year after the baby is born. Being mentally unwell in pregnancy and in early parenthood affects approximately one in five women. Symptoms can vary enormously from mild to severe. The treatment needed varies accordingly and may be provided by different types of professionals.

Why perinatal mental health matters for women

Mental health problems can impact women in many different ways depending on the condition, and their severity. The feelings and emotions experienced can cause huge distress which can affect her everyday life, the relationships she has with her partner, family, friends and the relationship with her baby. Research also shows that some mental health problems can increase the risks of obstetric complications such as: preterm birth, low birthweight, growth restriction and pre-eclampsia, stillbirth.

Why perinatal mental health matters for the baby

It is important to remember that the vast majority of children are not adversely affected when their mother is mentally unwell. Research shows that for a small number of women, maternal mental health may affect the development of her baby and how she interacts with her baby once he or she is born.

Why it matters for fathers

Evidence identifies that fathers are also at higher risk in the perinatal period of experiencing poor mental health.

Identifying women at risk

Every antenatal and postnatal appointment provides an opportunity to check in with a woman and see how she is feeling. Evidence tells us that the better the relationship with her midwife, the more likely

a woman is to talk about her feelings and concerns.

Feedback from women is that how they are asked and the time taken to hear the response is important. A non-judgemental and empathic approach is needed, and further gentle questioning may be necessary where she responds with "I'm fine!".

Identifying women at risk

Enquiring about mental wellbeing does not need to be formulaic. Weaving enquiry into your conversations with women in a non-judgemental and sensitive way can help a woman to open up about how she is doing. Asking about previous health issues can also help her to open up about possible mental health difficulties in the past or present.

RCM i-learn access for INMO midwife members

If you are interested in learning more about supporting new mothers with mental health issues and completing the module, visit **www.ilearn.rcm.org.uk** Free access is available to all midwife members of the INMO. Email: library@inmo.ie for further information

www.inmoprofessional.ie/RCMAccess

WHO CNO: Frontline Covid-19 workers must be protected

On a recent visit to INMO HQ, Elizabeth Iro said that decent and safe working conditions must prevail in a crisis. Interview by **Michael Pidgeon** and **Freda Hughes**

"NURSES are at the forefront as a response to any emergency or disaster. The Covid-19 outbreak has seen nurses step up again to tackle it."

These were the words of the World Health Organization's chief nursing officer (CNO) Elizabeth Iro who was speaking in Dublin as part of a recent trip to Ireland. She emphasised that being at the front-line not only puts nurses and midwives at high risk of contracting the virus, but also means they may suffer exhaustion and isolation from their families.

She spoke about the outbreak of Covid-19 while she was in Ireland. This outbreak had not yet been upgraded to pandemic status at that time.

"These nurses are taking this on board as part of their role, but nurses who are responding to these emergency situations are at risk. We have an obligation to make sure they are being provided with proper equipment and that they are getting the rest times that they need in terms of a rotational system being put into place. Decent working conditions have to apply right across the board, even in times of crisis. It's about having the right equipment and technologies so that nurses can do their job."

Elizabeth Iro, WHO chief nurse

The role of CNO at the WHO was created in 2017 to advise the director general on issues relating to nursing and to support the priorities of WHO in terms of universal health coverage, population health and primary healthcare issues.

Elizabeth Iro, the first person to fill the post, told *WIN* that the role allows her to bring nursing and midwifery perspectives to WHO policy and strategy development. She has created the WHO nursing and midwifery taskforce. She has also put huge effort into building a global nursing and midwifery network worldwide, linking with global non-profit organisations, universities and professional bodies in order to have nursing and midwifery at the forefront of all policy discussion within healthcare.

> "The Covid-19 outbreak has seen nurses step up to tackle it. Decent working conditions have to apply right across the board, even in times of crisis. It is about having the right equipment and technologies so that nurses can do their job"

The WHO's chief nurse has a first-hand understanding of the role of the nurse and midwife with 30 years of nursing and midwifery experience, having worked both in New Zealand and on the Cook Islands

As a teenager on the Cook Islands, she explained that she was attracted to a career in nursing for the exposure to the world it would offer so she looked to New Zealand for opportunity as it had a great reputation for providing high quality nurse education.

She said that initially she thought that the three-year training seemed manageable and that nursing would open up many opportunities with its registered qualification. "It offered exposure to the world and I knew I would be able to get a job anywhere," she added.

Although Ms Iro entered nursing partly with a view to travel the world, she soon found while registered and working in New Zealand that her skills and knowledge would be better put to use serving the people of the Cook Islands. She returned there to work but later went back to New Zealand to undertake her midwifery training.

After 25 years of working in the health service she became CNO of Hospital Health Services on the Cook Islands before she took up her position as the nation's secretary of health. She was the first nurse to ever hold this position and served from 2012 to 2017.

Despite holding senior and political roles in recent years, she said she still gets "that feel-good feeling when you make a difference to a person's life in hospital or in the community."

Vital role

We asked her about her role as CNO with the WHO. Linking with world government's chief nursing officers to see how best to support them and focus on global health targets through their work in their countries and how it impacts on their populations also forms a big part of Ms Iro's work.

Speaking about the ongoing shortage of nurses and midwives worldwide, Ms Iro stressed the need to invest more in good quality education and professional development for nurses and midwives.

"There are complexities to it but basically, we must invest more in nursing and midwifery education. It's also important to ensure good working conditions in order to retain and recruit nurses worldwide."

Recruitment by wealthier and/or more developed countries poses huge challenges as health workforces migrate away from countries where they trained.

She stressed the need to take an ethical approach to managing that, stating: "You can't stop migration especially if nurses are offered better working conditions abroad. We need to focus on retainment and better working conditions, and more investment in education will help this."

Pictured on the steps of the INMO Richmond Education and Events Centre were: (back row) Catherine Sheridan, first-vice president; Tony Fitzpatrick, INMO director of industrial relations; Niamh Adams, INMO head of library services; Steve Pitman, INMO head of education; Eilish Fitzgerald, INMO second-vice president; (front row) Tania O'Neill, midwife; Phil Ní Sheaghdha, INMO general secretary; Ciara Brennan, nurse; Elizabeth Iro, WHO chief nursing officer; Martina Harkin-Kelly, INMO president; and Edward Mathews, INMO director of professional and regulatory services

Dave Hughes, INMO deputy general secretary; Elizabeth Iro and Phil Ní Sheaghdha

Martina Harkin-Kelly and Edward Mathews pictured presenting Elizabeth Iro with fellowship of the Richmond Education and Event Centre

Phil Ní Sheaghdha and Martina Harkin-Kelly show the INMO's centenary badge to Elizabeth Iro

First-vice president Catherine Sheridan (left) and second-vice president Eilish Fitzgerald (right) present Elizabeth Iro with a copy of 'Century of Service'

Maura Hickey: Farewell but not goodbye

This month we bid farewell to a beloved colleague as Maura Hickey retires from her role as INMO industrial relations officer

MAURA Hickey will retire from her role as industrial relations officer (IRO) in May having served INMO members as an activist and full-time official throughout her career as a nurse and midwife.

Maura is a native Irish speaker, but whether speaking *as Gaeilge* or in English, she has a reputation for straight talking. As a representative for nurses and midwives, she packs a punch when called on.

Maura was born in Co Donegal to parents who were both public servants. Her father was the superintendent environmental health officer for Donegal and her mother was a legendary PHN and midwife renowned for the care and comfort she delivered to patients in North Donegal and the Inishowen peninsula. Maura's father, Paddy Tunney, was a columnist with the *Irish Times*, a national lilting champion and a world-famous traditional Irish singer.

Maura is married to Patrick Hickey, a recently retired schoolteacher at a secondary school in Co Derry. Their five children have grown and flown the nest so now Maura and Patrick can indulge in the success of their twin sons and their three brothers. They are her pride and joy; their sporting interests and triumphs are down in no small measure to the encouragement they've always received from their parents.

After a few student years in Galway, Maura commenced her studies as a registered general nurse in the Meath Hospital, Dublin in 1981. That was the start of a journey that brought her to Derry, initially to qualify as a midwife and later to Alberta, Canada where she worked as an ICU nurse. She also worked in Saudi Arabia for a time.

Maura has never rested in her pursuit of excellence in nursing and midwifery, always seeking a voice for the professions within the health service. Through education and experience, Maura held such roles as acting director of nursing, medical manpower manager, inpatient co-ordinator and bed manager. She served on the Executive Council of the then INO having been a local rep for her colleagues in Co Donegal for many years. She briefly came to work with the INO in a temporary capacity in 2007 and in 2011 she returned to the Organisation, now the INMO, as full-time IRO in the North Western Region.

Right (l-r): *Dave Hughes, INMO deputy general secretary; Maura Hickey, outgoing IRO, North Western Region; Phil Ní Sheaghdha, INMO general secretary*
Middle (l-r): *Anne Burke, IRO, Western Region; Lorraine Monaghan, assistant director of IR, Dublin Mid-Leinster; Maura Hickey; and Mary Power, assistant director of IR, Southern Region*
Below (l-r): *Maura Hickey pictured with Sr Stanislaus Kennedy recently*

Maura excelled in her role as IRO. Her comprehensive knowledge, as well as her experience across the health service, equipped her to make strong cases for those she represented. Her depth of character and ability to fearlessly advocate for members led to many successful outcomes. One Workplace Relations Commission adjudicator recently described her as the most able union official to have ever presented cases on behalf of INMO members.

Maura's record speaks for itself; she never fails to promote the union at every opportunity. From the outset Maura knew the value of union membership and the essential protection the INMO provides to nurses and midwives across Ireland.

So, we say *go n-éirí an bóthar leat*, and wish Maura and Patrick a long and happy retirement. Maura's hobbies have always been basketball (a sport she coaches and referees), canoeing, hiking and bouldering. Perhaps in retirement she will settle for her other great loves – traditional singing and Irish folklore. For her INMO colleagues, it's farewell but not goodbye as the friendships she has built will no doubt endure.

– Dave Hughes

Covid-19: Frontline isolation

An INMO member spoke to Beibhinn Dunne about her experience of self-isolation following exposure to Covid-19 while at work

SEVERAL weeks ago, I did three night shifts. Then, on a Monday morning, I returned to my other job as a mammy. A few days later I received a phone call from my unit telling me a patient I had cared for had tested positive for Covid-19. I had nursed him and reassured him and in doing so had been within two metres of him for more than 15 minutes. I was therefore a close contact.

The sore throat and headache I had barely noticed were now symptoms of Covid-19. I was asked to immediately isolate myself in my bedroom. The following day I drove to the hospital to be swabbed, then returned to my bedroom to await the results. I was relieved to be told the following day that I had tested negative, but as I was so symptomatic the whole family had to self-isolate for 14 days. When I tested negative again, I was allowed to graduate from my bedroom, and I spent the rest of the isolation period with my family.

The hardest part was the dependence on other people. I'm young and fit, and I look after myself. Suddenly I was very dependent on other people. Whether it's neighbours, sisters, parents or whoever, you really see the community spirit shining through. As a nurse you're not used to being the dependent one.

It also makes you consider how vulnerable people are when they come in. People who are coming in to get swabbed have masks on, their head down and feel everyone is looking at them. It reminds you that there's a person behind every diagnosis. It's not simply 'a Covid-19 diagnosis', these are people and they have families, lives and fears the same as anyone else.

Everything has changed in the hospital now compared to two weeks ago. Messaging allowed me to keep up with changes. Being at home during the busiest time for my work environment was challenging, and when I went back on March 13 it felt like returning from maternity leave. It was a completely different place.

I also felt like I had lost some confidence, it was a bit like getting back on a bike. In 20 years I've never got sick from work. It was my first time being affected and it knocked my confidence.

I became so aware of things like door handles, ATM machines, shopping trolleys, how many surfaces you touch and how easily things spread.

Capacity will be the issue in the coming weeks. We are able to mind the sickest of patients. That doesn't daunt us. We have the skills, knowledge and experience. It's a numbers issue.

That's why the public are so important. Social isolation is so important. 'Flattening the curve' really makes a difference. We can care for patients, but we can only do it if the numbers remain manageable. That's where the public come in.

And now, back to the frontline.

Caring for patients and ourselves

As healthcare professionals around the globe battle to combat the Covid-19 pandemic, **Edward Mathews** offers some advice on protecting your practice and maintaining your mental health

AS I write this article we have begun the fight against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) the pathogen which causes coronavirus disease (Covid-19). This is an extraordinary time like no other in living history – there are few terms that can adequately describe the scale of what we are witnessing across the world, or in our own country, however, whatever term we choose we can all agree this is an emergency.

Emergencies can have unusual effects on individuals and systems. They require urgent, yet considered, action, and can bring out the best in us individually and as a community. Our schools and universities are closed, pubs and clubs and non-essential shops have closed with unprecedented job losses and layoffs – yet at the same time nurses and midwives are seeking to return to practice to care for those in need.

We have been called upon to socially distance; we are bombarded with daily news; we are warned that the surge is coming. We have had an address to the nation with a rallying call for solidarity – a call we are answering and will continue to answer.

Challenging times

These are by far the most challenging of times, and nurses and midwives are at the forefront of the response in protecting our community. One area of concern for our members at this time is what they may be called upon to do and whether they may be called upon to work in unfamiliar settings, or care in unfamiliar circumstances.

There are few exact answers to these concerns, however, we have seen statements from the Nursing and Midwifery Board of Ireland (NMBI) in relation to scope of practice and we have also asked the NMBI to provide further guidance in this important area.

The NMBI has encouraged nurses and midwives to assist where they can, to avail of updates or upskilling to maximise their contribution, and to refer to the scope of practice guidance in decision making relating to their practice. These are all important observations, yet still many members will be concerned if asked to practise in unfamiliar areas.

Ultimately, while this is a time of emergency, this is not the time for abandonment of professional principles. The Code and the Scope of Practice guidance remain ever relevant. Yes we may be able to extend through upskilling and refresher training, yes we may be able to make enhanced contributions as a result, but we cannot and must not provide care for which we are not trained and regarding which we are not competent.

Organisations must understand this, and nurses and midwives must be supported organisationally and by their managers to ensure the maintenance of professional principles at all times.

In saying this I in no way wish to discourage nurses and midwives in practice, or those who may return to practice, from making a valuable, extended and effective contribution – but when we care we do so with respect for the dignity of a person and their right to expect a professional service, for which we are willing to be responsible and accountable, and which is of an acceptable quality.

Mindful that these are unprecedented times we should also remember that while we may not be competent in respect of a given task in a given area, nursing and midwifery are not task oriented professions. While there are spheres of activity in a given area where we cannot safely contribute – and thus must not stray – there may well in the very same areas be other nursing and midwifery services which we can provide safely.

Therefore, when asked to work in a different, new or unfamiliar area, we need to consider our knowledge, skills and associated competencies. However, we need to do so in an holistic way – acknowledge that which we can do and care, refrain from that which we cannot do safely and communicate constantly with colleagues and managers to maximise our ability to make a safe and effective contribution.

We must also bear in mind delegation and our obligations in this area and only delegate where we can do so safely in the context of the Scope and Code.

Practising safely

These reflections will, to some, seem insufficient. However, as professionals we make contextual decisions too many and various for exact answers comprehending every scenario. However, in short:

- Organisations and individual managers must support nurses and midwives to maintain professional principles at all times
- With upskilling and updating we may be able to provide care in alternative settings
- If asked to practise in heretofore unfamiliar settings, Scope and Code considerations – such as knowledge, skills, competence, responsibility and accountability – remain relevant and should always be considered
- In considering our Scope and Code we have

an obligation to refrain from acting if it is not in the best interests of the patient
- In considering our Scope and Code we also know that in a given area we still may have a contribution we can make, but that there are areas where we are not competent – we must identify our limitations, make them known to the manager and make a record that you have done so. We may still have a role to play in those areas, but a more limited role, and in some areas our competence may be so limited that we have no effective or safe role we can play – this must be respected
- We can sometimes safely provide care in an area if we are adequately and proximately supported by more senior or experienced colleagues from our professions, or the medical profession. Again record keeping will be important here including limitations acknowledged, advice or instructions received, and guidance sought
- If called on to delegate, we must only delegate safely in the context of the Scope guidance which considers the competence of the person we are delegating to and our ability to supervise thereafter
- Record-keeping is essential. Take care to make adequate notes to reflect instructions received, your observations, actions, decisions, rationale for your decisions, advice sought, advice provided or concerns raised
- Overall, we remain responsible and accountable professionals, who have an important contribution to make, and we must make it within the context of professional principles.

Bearing in mind these reflections, it is important as well to recall that in the event that any concern were raised in relation to a nurse or midwife, the NMBI has publicly stated that: the context and circumstances that prevailed at the time will always be taken into consideration. This would be particularly so in the context of the current public health emergency.

The Board has also emphasised that the Scope of Practice guidance: supports a nurse or midwife taking appropriate action in emergency and/or life threatening situations. At all times, the overall benefit to the patient must be served in these situations.

Having considered the professional concerns that nurses and midwives might have at this anxious time, we must also be conscious of each other's health and welfare in the context of the great demands that have been, and will be, placed on nurses and midwives.

ICN

Annette Kennedy, president of the International Council of Nurses (ICN) and former director of professional development in the INMO, recently reflected on the need for all nurses and midwives to look after themselves and the importance of protecting nurses and midwives in the workplace through the provision of resources, adequate personal protective equipment (PPE) and adequate support.

The INMO has been front and centre in advocating for the physical and psychological protection of nurses and midwives in Ireland and as I write this article we have pursued, and are pursuing, issues as diverse as payment, special leave, PPE supplies, deployment issues, training, workplace support, and support from the regulator.

> Our worth has never been more manifest than at this moment and our members are already displaying the courage to care. Advocating for their safety and interests in this challenging time is one of the most daunting but proudest moments

WHO advice

The World Health Organization, as the body leading the international fight against this pathogen, has particularly recognised the potential psychological demands on the population and I think some of their advice might be helpful for nurses and midwives in the coming times.
- It is a likely experience that nurses and midwives, and many of your health worker colleagues, will be feeling under pressure. It is quite normal to be feeling this way in the current situation. Stress and the feelings associated with it are by no means a reflection that you cannot do your job or that you are weak. Managing your mental health and psychosocial wellbeing during this time is as important as managing your physical health
- Take care of yourself at this time. Try to use helpful coping strategies such as ensuring sufficient rest and respite during work or between shifts, eat sufficient and healthy food, engage in physical activity and stay in contact with family and friends. Avoid using unhelpful coping strategies such as tobacco, alcohol or other drugs. In the long-term, these can worsen your mental and physical wellbeing. This is a unique and unprecedented scenario for almost all nurses and midwives. Even so, using strategies that have worked for you in the past to manage times of stress can benefit you now. You are most likely to know how to de-stress and you should not be hesitant in keeping yourself psychologically well. This is not a sprint; it's a marathon
- Some nurses and midwives may unfortunately experience avoidance by their family or community due to stigma or fear. This can make an already challenging situation far more difficult. If possible, staying connected with your loved ones, including through digital methods, is one way to maintain contact. Turn to your colleagues, your manager or other trusted persons for social support – your colleagues may be having similar experiences to you
- Some nurses and midwives may be required to self-isolate. Stay connected and maintain your social networks. Even when isolated, try as much as possible to keep your personal daily routines or create new routines. You can stay connected via e-mail, social media, video conference and telephone
- A near-constant stream of news reports about an outbreak can cause anyone to feel anxious or distressed. Seek information updates and practical guidance at specific times during the day from health professionals and the HSE/ INMO websites and avoid listening to or following rumours that make you feel uncomfortable.

Collective strength

Overall, and it will no doubt seem an impossible ask in the times ahead, we must care for ourselves so we can care for others. Lean on each other, lean on the INMO and always, always, ask for help. In these unprecedented times it is our collective strength that with allow us to endure and prevail.

Our worth was never more manifest than at this moment and our members are already displaying the courage to care. Seeing our members in action and advocating for their safety and interests at this challenging time is one of the most daunting but proudest moments of my career.

Edward Mathews is INMO director of professional and regulatory services

INMO Professional

National Care of the Older Person Section

ANNUAL CONFERENCE

Tuesday, 26 May 2020

Midland Park Hotel, Portlaoise, Co Laois

Fee: €85 INMO members; €120 non-members | Awaiting category 1 approval from NMBI

OUTLINE OF DAY

Morning Session		
8.30	Registration, Tea/Coffee and Networking	
9.00	**Opening Address**	**President, INMO**
9.30	**Falls and Frailty**	**Elaine Dunne, ANP**
10.15	**Chronic Wounds - Infections or Inflammation**	**Ella Prendergast, Clinical Nurse Advisor**
11.00	Tea/Coffee and Trade Exhibition	
11.30	**The Importance of Nutrition in the Older Person**	**Deirdre McCartin, Dietitian**
12.15	**Tommys Story**	**Tommy Whitlaw**
Afternoon Session		
13.00	Lunch and Trade Exhibition	
14.30	**Living with Lewy Body Dementia**	**Kevin Quaid**
15.30	**End of Life - What to Say if Anything**	**Bruce Pierce, Director of Education, St Lukes, Cork**
16.00	**International Year of the Nurse and the Midwife**	**Steve Pitman, Head of Education, INMO**
16.00	Close of Day	

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Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Query from member

I am a staff nurse working in the public health service and am currently on maternity leave. I have 10 weeks of maternity leave taken so far. I have now fallen ill. Can I postpone my maternity leave and take it later? Would I be able to transfer to sick leave as I feel I am using up my maternity leave while sick?

Reply

If you get ill during a period of maternity leave, there is a provision for transferring to sick leave, subject to meeting conditions. You must be in your last four weeks of maternity leave and have already notified your employer about taking additional unpaid maternity leave or you are already on additional unpaid maternity leave.

Subject to the agreement of your employer you may terminate your additional maternity leave and transfer to a period of sick leave. However, the employee will not be entitled to resume their additional maternity leave after this period of sick leave.

Query from member

I am currently on point three of the staff nurse salary scale and my increment is due in September. I was told by my employer that the new Enhanced Salary Scale is only effective from when my increment was due post March 2019. I was of the opinion that this new salary scale was effective from March 2019. Who is correct?

Reply

As per HSE HR Circular 022/2019 payment of the Enhanced Salary Scale is paid when your next increment is due post March 2019. In your case it will be paid from September 2019.

Nurses and midwives currently on point three will benefit from the revised new entrant measure and, at their next increment after March 1, 2019. Instead of progressing normally to point four, they become eligible to move to point one of the new scale subject to meeting the verification criteria.

Know your rights and entitlements

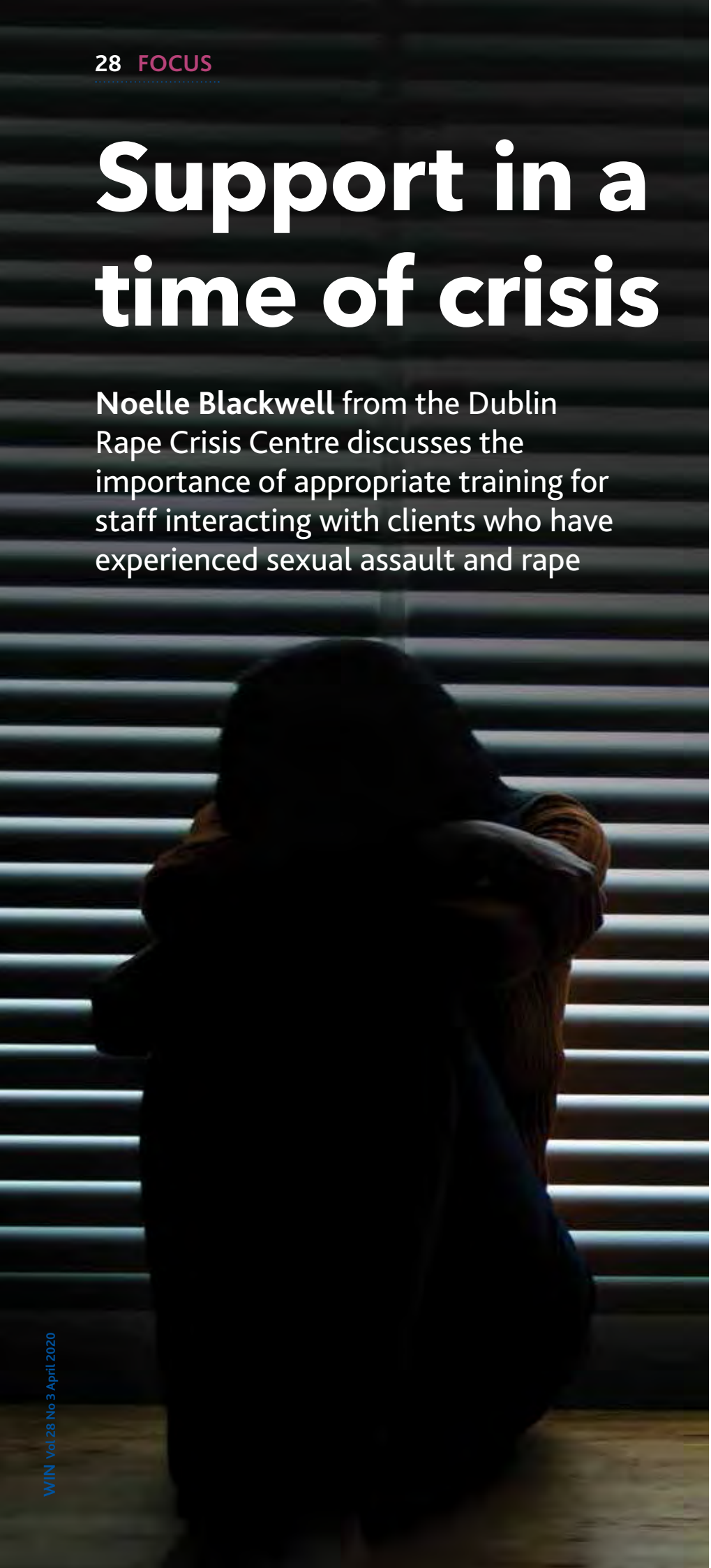
The INMO Information Office offers same-day responses to all questions

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

- 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

Support in a time of crisis

Noelle Blackwell from the Dublin Rape Crisis Centre discusses the importance of appropriate training for staff interacting with clients who have experienced sexual assault and rape



THE Dublin Rape Crisis Centre is the oldest such centre in Ireland, founded in 1979 by a group of women who saw there was no safe space where those who had survived rape and sexual assault and abuse could get help or support.

Over the four decades since then, the Dublin Rape Crisis Centre has remained true to its mission to prevent the harm and heal the trauma of rape and other forms of sexual violence. We operate the 24-hour National Rape Crisis Helpline at Tel: 1800 778888. We provide one-to-one counselling and therapy, including at outreach centres in the greater Dublin area, and offer an accompaniment service to people attending court and/or Garda stations. Our volunteer counsellors are on hand for any person attending the Sexual Assault Treatment Unit (SATU) in the Rotunda Hospital.

The 2002 SAVI (Sexual Abuse and Violence in Ireland) Report is the last comprehensive national report and was commissioned by Dublin Rape Crisis Centre. It found that 42% of women surveyed had experienced sexual abuse or assault over their lifetime, as had 28% of men. In terms of childhood sexual abuse, some 20.4% of women and 16.2% of men had experienced contact sexual abuse in childhood.

More recently, among new Dublin Rape Crisis Centre clients in 2018 where the reporting status of cases was known, just under 30% had been reported to the Gardaí. About 40% of our new clients that year had been subjected to other physical and psychological violence as well as sexual assault or rape. And the national 24-hour helpline had 13,367 contacts in 2018, of which 77.8% were women, 21.6% men and 1.1% identifying as trans or other (noting that 10% of contacts did not disclose their gender).

Furthermore, our society is pervaded by rape myths and social attitudes – many of which we have unconsciously internalised – that blame the victim for their rape or assault and allow abusive behaviours to go unchallenged; these can seriously compound and prolong the impact of sexual violence. The Law Reform Commission recently published a report on rape law that includes a section on such myths, particularly focusing on the consequences for the victim in the justice system (read more at **bit.ly/LRCrep19**).

There is thus a clear need for much greater public awareness and education on the damage caused by rape and sexual

abuse. We need action from the state to prevent sexual violence and deal with its consequences as a matter of public health and justice.

To this end, the Dublin Rape Crisis Centre offers its expertise and knowledge to contribute to more effective public policy and law, such as our analysis of sexual violence for the Department of Health's Women's Health Taskforce, advocating for a focus on the provision of adequate resources for those harmed as well as a comprehensive prevention strategy (see a short video at: **bit.ly/WHTdrcc**).

Our education and training team delivers courses for frontline staff and professionals designed to equip them to better understand and provide support and services to people traumatised by sexual violence. We also offer courses on awareness and prevention of sexual violence aimed at empowering young people as well as talks in schools and to youth groups.

While health professionals will be more aware than most that rape and other sexual violence can be deeply harmful, this article highlights some of its consequences which may in turn impact on how survivors interact with health and other caring services.

Impacts of rape and sexual assault

People have very individual responses to the trauma of rape and sexual assault and the long-term effects also vary widely, thus it is important to respect each person's choice and way of coping. It is also important to note that these impacts may occur many years after a rape or assault as well as in the immediate aftermath.

A person's behaviour in the aftermath of an assault can range from frozen to panicked, from numb to angry, from laughter to tears. Some people can appear calm and rational. Others may feel hyper alert, be unable to eat or sleep; they may blame themselves for the attack, have flashbacks to it, experience confusion or helplessness. They may feel a sense of shame or violation or degradation. They may feel a compulsion to wash, may obsess on details of the rape or assault, or may become suicidal or self-harming.

In the longer-term, trauma may lead to effects across several categories. These can be physical, such as self-neglect, eating disorders, digestive problems, sleep disruption, and stress-related ill health. Emotional impacts include over-reactions to any stimulus or a need to tightly control their environment, mood swings, anxiety, depression, substance abuse, or suicidal thinking.

Cognitive impacts may mean they find it difficult to handle everyday tasks or have impaired memory or concentration, leading to them losing their job or dropping out of education. They may lose the capacity to trust, feel too ashamed or self-blaming to sustain a relationship, or feel unable to be in social situations.

Ways to support survivors

A person may disclose or refer to a rape or sexual assault during an interaction with frontline staff. The following points may be useful to keep in mind when supporting them:

- This may be the first time the person has disclosed or spoken about the rape or assault to anyone. Therefore it is important to be sensitive and caring and offer non-judgemental support
- Whenever appropriate, people should be referred to rape crisis centre support either by direct contact to one of the 16 Centres around the country or to the national 24-hour freephone helpline at Tel: 1800 778888 for signposting, further information and support
- If the person is in ongoing danger of assault, they should be encouraged to consider reporting to the Gardaí – more information at bit.ly/reportSV.
- If the assault is recent, they may need to be referred to a SATU (Sexual Assault Treatment Unit). There are six SATUs around Ireland which provide medical care and support to victims of sexual assault including rape, as well as collecting forensic evidence for possible later court action – for more information see: **bit.ly/HSEsatu**
- If a person reports the rape or assault to the Gardaí, they will arrange to bring the person to SATU. However, the person can directly avail of SATU's comprehensive medical services without going through the Gardaí or making a formal report. It must be their own decision to report the crime
- There may be no need for a support person to know all the details of an assault or rape, just enough to ensure the person is safe and their immediate health needs are met
- A supporter can determine the person's immediate needs, whether it is for medical attention, food, sleep, or just company, and help make that happen
- It is important that the supporter remains grounded and calm, handling practical issues, so that the person in crisis can feel supported and contained
- It's important that the supporter focus on the feelings and reactions of the person rather than their own
- The supporter should ensure the person's privacy as far as possible
- It is important to help the person make their own decisions, rather than decide for them, and that they feel heard and validated.

A rape crisis centre is a holistic safe space where the person can access counselling and therapy to help them move forward from their trauma, as well as receive practical and crisis support and other information. There are 16 rape crisis centres around Ireland – a list is available at: **www.bit.ly/RCClist.**

Self-care and support for staff

Finally, it is very important that those offering support in the course of their professional role take care to mind themselves too. It will not be possible to totally 'fix' the situation for a client – they must simply do their job in a caring and professional manner. In that light, it is very important to manage their boundaries and know what they can and cannot do for a client.

Equally, if a staff member experiences signs of stress or even vicarious, second-hand trauma from supporting survivors as part of their work, it is vital that they take action and seek help to address this, as it may spill over to affect their wider work and personal lives. Remember that it is always possible to call the National Helpline to seek support arising from concerns around sexual violence.

The Dublin Rape Crisis Centre runs specialised courses for people working on the frontline with members of the public. These courses are designed to help them better recognise and support survivors of sexual violence, understand the causes and effects of trauma, and develop techniques for selfcare and resilience. This includes tailored courses for particular roles and client needs and are run either with groups in their workplace or in the Dublin Rape Crisis Centre. We recommend that professionals and staff dealing with clients who need extra support arising from such trauma attend appropriate training, so that they can react in the best way to support their clients and themselves.

For more information see **www.drcc.ie**

Noeline Blackwell is CEO of the Dublin Rape Crisis Centre and a human rights lawyer. She currently chairs the Independent Patient Safety Council and the Child Care Law Reporting Project

Mitigating burnout

Any attempt to reduce burnout among healthcare workers must first address safe staffing, pay and working conditions, writes **Steve Pitman**

BURNOUT is a well-established phenomenon that continues to significantly affect nurses and midwives. The increasing demands of healthcare, coupled with the continuous pressure on resources, create an environment that is a recipe for stress and burnout. The consequences of burnout are experienced primarily by the individual but can cross over into teams and even whole organisations.

Beyond work, the effects of burnout spill over into the personal lives of nurses and midwives, negatively impacting on interpersonal relationships. There is also growing recognition that while burnout has implications for the health of nurses and midwives, it also has implications for patient safety.

A recent UK study found that nurses' symptoms of depression and burnout were associated with perceptions of patient safety.[1]

An understaffed working environment with high staff turnover, coupled with the bed capacity crisis and underdeveloped primary healthcare, provides the precursor to burnout.

There are a number of organisational factors that obstruct healthcare professionals in the delivery of quality care, a selection of which are outlined in *Table 1*.

As emotional labourers, nurses and midwives are susceptible to compassion fatigue. This is defined as "a state of tension and preoccupation with the traumatised patients by re-experiencing the traumatic events, avoidance/numbing of reminders, persistent anxiety associated with the patient… a function of bearing witness to the suffering of others".[3]

Studies have identified burnout in nurses working within emergency departments (EDs) in Irish hospitals. One such study found that 86% of ED nurses had moderate levels of both burnout and compassion fatigue.[5] Following a meta-analysis it was estimated that one-third of ED nurses were affected with at least one of the three dimensions of burnout – exhaustion, cynicism and insufficiency.[6] Significant levels of burnout have also been found within other nursing disciplines.[7,8,9]

Etymology

Our understanding of burnout as a concept has developed over the past 40 years. The term was coined by author Graham Greene in his novel *A Burnt-Out Case,* which described the story of a doctor working in a leper colony in Africa. It is included in the 11th revision of the World Health Organization's (WHO) International Classification of Diseases (ICD-11) as an occupational phenomenon, but it is not considered a medical condition.

As a concept, it was developed by US social psychologist Christina Maslach in the 1980s, who argued that burnout was "a syndrome that can occur among individuals that work with people".[10] This view of burnout makes it especially applicable to nurses and midwives, upon whom much of the research has been conducted.[2] Maslach et al define burnout as "a prolonged response to chronic emotional and interpersonal stressors on the job and consists of three dimensions – exhaustion, cynicism, and inefficiency".[10]

These components are measured using the Maslach burnout inventory, the most widely used measure of burnout.

Table 1. Organisational factors

- Insufficient time to provide quality care
- Not enough time to spend with patients
- Too few nursing staff
- Stressful work environment
- Poor leadership and management
- Lack of control over workload
- Increased patient acuity
- Under-resourcing

Emotional exhaustion: Feelings of being emotionally overextended and exhausted by one's work.

Depersonalisation: An unfeeling and impersonal response toward recipients of one's service, care, treatment or instruction.

Personal accomplishment: Feelings of competence and achievement in one's work with people.

This definition presents a psychological and emotional perspective that is linked to motivation theory. In the 1950s, American psychologist Abraham Maslow was clear that physiological and safety needs must be addressed before an individual can start focusing on establishing relationships, feeling they belong and building confidence and self-esteem. Similarly, Frederick Hertzberg presented a two-factor theory of motivation that was linked to satisfaction and dissatisfaction.

The theory has two components: hygiene factors and satisfiers. Hygiene factors include working conditions, pay, relationships with managers and colleagues, status and job security. When these factors are not in place they result

in dissatisfaction. Hygiene factors are expected and so do not lead to satisfaction when they are in place.

Satisfiers, by contrast, are motivators that are linked to creating work that is challenging and meaningful, where there is recognition, responsibility, an opportunity for growth and development and involvement in decision-making. Importantly, satisfiers can only be developed once the hygiene factors have been addressed and are in place.

Understanding and recognising burnout

Burnout is not a short-term reaction to stress, but rather a result of persistent pressure over time. Freudenberger and North[11] described the 12 stages that lead to burnout. These stages allow us to understand its progression and are listed in *Table 2*. The first few stages reflect the individual's attempt to overcome the additional burden by trying to do more and neglecting their own needs. This leads to a defensive reaction that attempts to protect the individual through denial of problems and increasing withdrawal from activities. These, in turn, lead to increased psychological distress. Depersonalisation was initially included as one of the key elements of burnout, but was later replaced with 'cynicism'.[12] Depersonalisation was seen to include "negative, cynical attitudes and feelings towards one's clients" and can lead to "callous or even dehumanised perceptions of others".[12] This can potentially have serious implications for relationships in the workplace and for patient care.

An understanding of these stages is useful for individual nurses and midwives, as well as for managers, to enable them to identify an emerging problem before it progresses to the later stages of depression and burnout.

Behaviours that may indicate signs of emerging burnout include staying late at work to complete tasks, not taking breaks and nurses going home with unfinished work still on their mind.[2]

Stress is also a determining factor for the development of burnout.[13] Bakker and Demerouti describes the stress demands and resource model. This model enables burnout to be viewed as an imbalance between the demands that an individual is experiencing and the resources that can be drawn upon to meet such demands. Demands and resources can be mental, physical or emotional.[14] They include the tangible resources of staffing, equipment, workload and skill mix, but also social support from managers and colleagues, individual coping strategies and professional development (including clinical supervision). In this model, resources are seen to act as a buffer against increasing demands.[15]

Table 2. Stages of burnout

- Compulsion to prove oneself
- Working harder
- Neglecting one's own needs
- Displacement of conflicts
- Revision of values
- Denial of emerging problems
- Withdrawal
- Obvious behavioural changes
- Cynicism (depersonalisation)
- Inner emptiness
- Depression
- Burnout syndrome

Fearon and Nicol[16] outlined four key areas that help individual nurses and midwives cope with burnout:

- Problem-focused and emotion-focused coping
- Self-awareness and emotional intelligence
- Lifestyle and coping styles
- Clinical supervision.

These strategies can be learned and cultivated by nurses and midwives through training and development and as part of formal organisational processes. It is important that skills in identifying burnout and wider mental health problems are incorporated into pre-registration programmes and that support is provided within the workplace. Employee assistance programmes are available in many organisations and are an excellent resources that nurses and midwives should access when experiencing stress. In the absence of such a programme, employees should contact their occupational health department for support.

Reducing burnout

There is no doubt that building the capacity of individual nurses and midwives to cope with stressful environments will contribute to preventing burnout. However, where the stressor is a product of work any action must be taken primarily by healthcare organisations to change the causes of the stress.

Maslach, when writing about the emerging perspectives on-burnout, called for a more active focus on intervention at an organisational and social level.[17] Six work-life areas[18] were identified as being important for organisations to consider, monitor and develop for the purposes of reducing burnout. These are:

- Work overload
- Staff control
- Insufficient rewards
- Community breakdown
- Unfairness in the workplace
- Value conflict.

Realistically, any attempt to reduce burnout among healthcare workers must first focus on dealing with safe staffing, pay and working conditions. Only then can this be supplemented by team-building and the development of an individual coping strategy.

Burnout continues to be an important issue for nurses and midwives. It needs to be monitored and acted upon in order to reduce its impact on individual nurses and midwives and its negative effect on healthcare provision.

Steve Pitman is the INMO head of education

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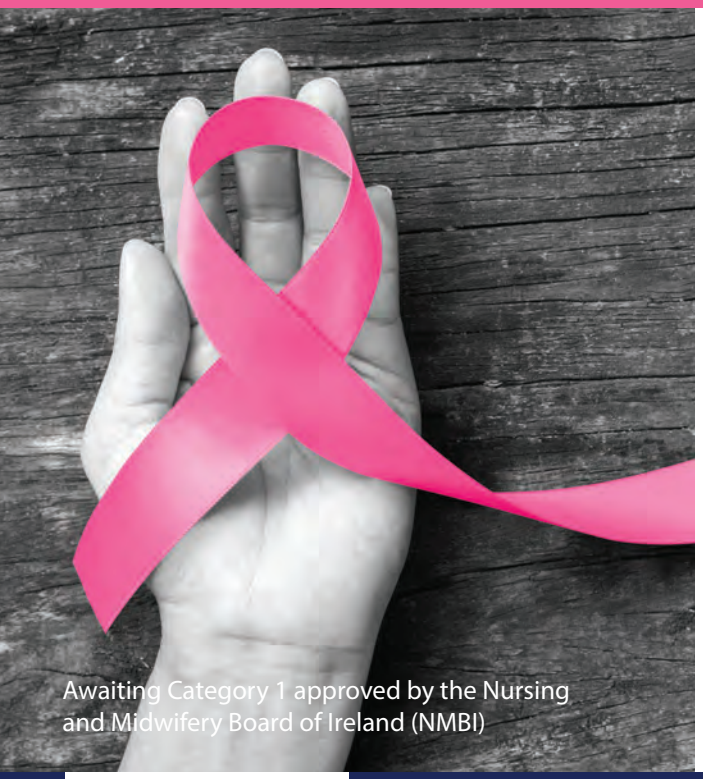
INMO Professional

Upcoming New Oncology Programmes



Awaiting Category 1 approved by the Nursing and Midwifery Board of Ireland (NMBI)

These one-day programmes are intended to give nurses and midwives the knowledge needed to care for cancer patients. An overview of cancer care in Ireland will be provided and key topics discussed. They will also provide nurses and midwives with an opportunity to develop communication skills around cancer discussions with patients.

From Symptom to Specialist

5.5 NMBI CEUs

Tuesday, April 21, 2020

The following topics will be covered on this day:
Introduction to oncology - what is cancer? Carcinogenesis, patient pathway, staging and grading, and preparing a patient for treatment

Solid Tumours and Treatments

5.5 NMBI CEUs

Tuesday, April 28, 2020

The following topics will be covered on this day:
Breast, prostate, colorectal and lung cancer overview, treatment choices, side-effects of treatments, management of side-effects, oncological emergencies

Venue: The Richmond Education and Event Centre, North Brunswick Street, Dublin D07 TH76
Time: 9.15am - 4.30pm
Fee: €95 INMO members; €145 non members per day

Nursing now Ireland

For more information or to book a place, please visit **www.inmoprofessional.ie** or call **01 6640641/18**

2020 INTERNATIONAL YEAR OF THE NURSE AND THE MIDWIFE

INMO Professional

Meaningful Healthcare Risk Management

for Clinical Nurse Managers and Clinical Midwife Managers

Special Programme for Clinical Nurse and Clinical Midwife Mangers

Programme facilitator:
Dr Luke Feeney, Professional Doctorate in Healthcare Risk, Incident and Audit Management, MSc Quality and Safety in Healthcare Management

This programme designed specifically for Clinical Nurse and Midwifery Managers provides a practical, introductory insight, understanding and guidance as front line managers in evidence-based, best practice healthcare risk management principles and practices. At the end of the programme participants should understand how to plan and implementation (with a Team) an evidence-based, best practice risk management process. CNMs and CMMs perform both managerial and leadership functions in order to provide effective healthcare delivery to patients.

All material is 100% evidence based and the frameworks and processes presented have all been implemented in healthcare organisations in Ireland and internationally.

Wednesday, May 27, 2020

Venue: The Richmond Education and Event Centre, North Brunswick Street, Dublin D07 TH76
Time: 10.00am - 4.00pm
Fee: €95 INMO members; €145 non members

Nursing now Ireland

Book Now for Early Bird

For more information or to book a place, please visit **www.inmoprofessional.ie** or call **01 6640641/18**

2020 INTERNATIONAL YEAR OF THE NURSE AND THE MIDWIFE

INMO EDUCATION PROGRAMMES

Continuing professional development for nurses and midwives

INMO Professional

Book your place on this issue's highlighted courses

Programmes Cancelled/Rescheduled

PLEASE NOTE:

INMO Professional is closely monitoring the ongoing coronavirus disease 2019 (Covid-19). As the situation is changing rapidly and is subject to public health advice, please note that if any bookings have to be cancelled, the affected programmes will automatically be rescheduled and participants will be given the option to transfer to the new date(s) or receive a full refund, free of charge. We will continue to update our website in relation to all of our programmes: **www.inmoprofessional.ie** – please do not hesitate to contact us at Tel: 01 6640641/18 or email: education@inmo.ie

Training Delivery and Evaluation – Rescheduled

Module 6N3326 – QQI Level 6; Category 1 approved by NMBI and awarded 34 CEUs

This five-day programme, which was due to commence on the March 24, 2020 was cancelled due to Covid-19. Everyone booked on this programme was offered the option of receiving a full refund or transferring to the following dates:

- Tuesday, Wednesday and Thursday, September 1, 2 and 3 and Thursday and Friday, September 10 and 11, 2020
- Tuesday, Wednesday and Thursday, September 22, 23 and 24 and Tuesday and Wednesday, October 20 and 21, 2020

To book your place, please call at Tel: 01 6640642 or email: marian.godley@inmo.ie
Fee: 550 members; 875 non-members

CPC Annual Seminar

Celebrating the nursing and midwifery professions – where to from here?

The Clinical Placement Co-ordinators (CPC) Section has developed this seminar, which will focus on the transition and growth in undergraduate education and training for nurses and midwives. Participants will hear from a wide range of professional speakers from different backgrounds. Please visit **www.inmoprofessional.ie** for further details or Tel: 01 6640618 to book a place.

Date and time: Wednesday, April 29, 2020
Fee: €90 INMO members; €145 non-members
Early bird discount: €70 (for members only when booked before April 15)

Book now for early bird discount

Steve Pitman
Head of Education and Professional Development

NURSES and midwives have always been at the forefront of delivering health services to the population. Today nurses and midwives are on the frontline of delivering care and managing the containment of Covid-19 at a national and global level. It is significant that this is the Year of the Nurse and Midwife, which is centred on raising the profile of nurses and midwives. The aim of the campaign is to celebrate members of both professions, highlight the challenging conditions they often face, and advocate for increased investment in the nursing and midwifery workforce. The current emergency puts into sharp focus the vital role and contribution of nurses and midwives in the war against the novel coronavirus. The public recognises nurses and midwives as highly competent professionals who act in the best interest of patients and service users. This trust has been built over generations of commitment by nurses and midwives in delivering compassionate care to individuals and families for the benefit of society.

A call has been made by the HSE to nurses, midwives and other healthcare professionals around the country to support the Irish health service. The HSE's *'Be on call for Ireland'* campaign has already received a significant response from healthcare professionals. The campaign is asking healthcare professionals not currently working in the public service to register to be on call during this crisis. This exemplifies the commitment and dedication of healthcare workers to supporting the health service in Ireland and ensuring its sustainability. The NMBI has joined the call and has highlighted that there are a possible 20,000 individuals currently on the register who can present themselves for work. A call has also been made for those previously on the register to apply for restoration, the fee for which has been waived. Further information is available at **www.nmbi.ie**

Nurses and midwives have a personal responsibility to maintain their own safety and the safety of their family and community. The current situation requires co-operation and flexibility. Nurses and midwives will be expected to respond to the unfolding needs of the health service and so it is important to remember that your professional practice is underpinned by the *Code of Professional Conduct and Ethics and Scope of Nursing and Midwifery Practice Framework*. The NMBI has emphasised that this is an enabling document that should inform decision-making, including in emergency situations. The NMBI states: "In the event of any concerns being raised about actions or decisions taken by a nurse or midwife we wish to reiterate that the scope of practice framework supports nurses and midwives taking appropriate actions provided the overall benefit to the patient is being served."

It is essential that healthcare workers are supported by employers, the government and broader society. It is imperative that they are provided with the necessary personal protective equipment and that the supply of such equipment is secured and maintained. Steps must be taken to prevent and deal with work-related exhaustion. Employers need to ensure that nurses and midwives take adequate rest breaks during and between shifts. The need to rest, rehydrate and refuel while at work has never been more critical to ensuring the health and wellbeing of the nursing and midwifery workforce.

This is without a doubt a stressful time; support from colleagues, friends and family will play a crucial role at this time. Employers also need to be aware of and prepare for the psychological and emotional impact of the crisis on individuals and teams. Support must be available and properly resourced to help all healthcare workers to deal with the stress, anxiety and other psychological problems that develop as a result of such an emergency.

These are difficult times, and the strength of collective solidarity is the key to defeating the coronavirus and dealing with its economic and social impact. The values of nursing and midwifery in Ireland have never been more relevant than they are now – care, compassion and commitment.

INMO Professional courses

INMO Professional courses have been rescheduled in response to the Covid-19 pandemic. Courses will be reinstated based on public health advice.

RCM resources available to INMO members

Don't forget to sign up for free access to the full range of updated Royal College of Midwives (RCM) professional development resources. If you are a midwife, public health nurse, practice nurse or student and would like to register for access to the RCM's online resources, visit **www.inmoprofessional.com/RCMAccess**

Onsite education

INMO Professional offers an extensive range of onsite programmes facilitated by expert practitioners. If you are interested in booking CPD courses for your organisation for a future date, please contact Marian Godley by email: marian.godley@inmo.ie or at Tel: 01 6640642.

Delivering courses and writing for *WIN*

INMO Professional is eager to offer members the opportunity to work with us in developing and delivering education courses. If you are an advanced nurse/midwife practitioner or a clinical nurse/midwife specialist with expertise in clinical or management practice, we are interested in hearing from you.

We are also interested in hearing from members who are interested in writing professional or clinical articles for *WIN*. Please email me at steve.pitman@inmo.ie

Education Programmes

All programmes have Category 1 approval from the Nursing and Midwifery Board of Ireland (NMBI) with Continuing Education Units (CEUs).

Venue: INMO Professional,
The Richmond Education and Event Centre,
North Brunswick Street, DO7 TH76
Dublin 7
Tel: 01 664 0618
Email: pdc@inmoprofessional.ie

Check out our new courses by logging onto www.inmoprofessional.ie or calling Tel: 01 664 0618

Date	Programme	Fee	CEUs
Apr 16 Postponed – to be rescheduled	**Strategies for Managing Conflict**	**€90 members; €145 non-members**	**6**
	Using group work, self-evaluation and case-study based discussion, this course will demonstrate the knowledge, skills and confidence needed to intervene at an early stage to resolve conflict situations before they escalate. Managed in the wrong way, real and perceived differences between people can spiral out of control. Conflict is not necessarily destructive; managing conflict effectively may result in positive outcomes such as new ideas and the development of positive communication, active listening and problem solving skills. Developing and maintaining positive relationships and the ability to deal with difficult people and situations is an essential skill for the work environment.		
Apr 21	**Peripheral Intravenous Cannulation**	**€90 members; €145 non-members**	**4**
	This course will provide instruction on the sites used for peripheral intravenous cannulation, identification of the criteria for evaluating a vein, and guidance on adhering to the principles of an aseptic technique and techniques for reassuring the individual in relation to the procedure and to gain their consent. It will be necessary for each nurse and midwife attending to ensure that they abide by their local policy in their workplace on peripheral intravenous cannulation and hold the following certificates: hand hygiene training, management and administration of intravenous drugs and the management of anaphylaxis (all within the last two years).		
Apr 21	**Introduction to Oncology – From Symptom to Specialist**	**€90 members; €145 non-members**	**TBC**
	This programme empowers nurses to care for cancer patients by advancing their existing knowledge and offering guidance on how to integrate this knowledge into practice. A combination of theoretical learning and case study presentations makes this programme an enjoyable learning experience. The programme aims to meet the learning needs of nurses who do not have specialist cancer postgraduate education who are caring for cancer patients. An overview of cancer care in Ireland will be provided and key topics discussed. The programme will explore the patient pathway from diagnosis to treatment as well as carcinogenesis, the causes of cancer and the metastatic process.		
Apr 22	**Incident Reporting and Investigation**	**€90 members; €145 non-members**	**6.5**
	This programme enables participants to implement an effective system of incident reporting and investigation. Participants will be shown how to complete accurate incident reports and investigations using tools such as the '5 whys' and root cause analysis. The programme will cover analysis of incidents on a scheduled basis as part of a continuous improvement approach. Professional and legal requirements for incident reporting and investigation will be outlined in detail. The programme will include a group exercise wherein participants can practise completing an incident report.		
Apr 23	**Leg Ulcer Study Day**	**€90 members; €145 non-members**	**5.5**
	This programme enables participants to distinguish between the different causes of ulceration and associated pathophysiology and also epidemiology, risk factors and assessment. It provides participants with an opportunity for continuing professional development to ensure that their practice is founded on the latest research and guidance. The programme will involve a practical aspect whereby various compression bandages and techniques will be presented as well as a demonstration on the use of a Doppler for assessment of the lower limbs. Psychosocial issues and the impact of living with a leg ulcer on the person's day-to-day life will also be explored.		
Apr 28	**Introduction to Oncology – Solid Tumours and Treatments**	**€90 members; €145 non-members**	**5.5**
	This programme empowers nurses to care for cancer patients by advancing existing knowledge and integrating that knowledge into clinical practice. A combination of theoretical learning and case study presentations will make this course an enjoyable learning experience. The programme will focus on solid tumours and treatments. It will provide nurses with an opportunity to develop communication skills around cancer discussions with patients. There will be discussion on major tumours and how these are treated collectively and specifically. Breast cancer, colorectal cancer, lung cancer and prostate cancer will be discussed in detail, as well as cancer treatments and treatment side effects.		

Date	Programme	Fee	CEUs
Apr 28	**Understanding and Managing Burnout and Work Engagement for Nurses and Midwives**	**€90 members; €145 non-members**	**TBC**
	Do you understand the nature of change or how to effectively manage change to ensure the best possible outcomes? This course introduces participants to key concepts and approaches to change. It explores the importance of managing people and understanding resistance.		
Apr 29	**CPC Annual Seminar**	**€90 members; €145 non-members**	**TBC**
	Details of this seminar are available on **www.inmoprofessional.ie** – Special members only early bird discount of €70 if you book before April 15.		
Apr 29	**Mindfulness and Meditation for Holistic Nursing and Midwifery Care**	**€90 members; €145 non-members**	**5.5**
	We invite all nurses and midwives to learn mindfulness for their personal and professional use. Many scientific researches have proven across the globe that practice of mindfulness brings measurable physiological changes in the brain called neuroplasticity. Practitioners report improved general sense of wellbeing and less stress and pain. We will explore the process of psychosomatic illnesses and how we can help our patients during difficult times. Therapeutic use of mindfulness techniques such as turning towards the symptoms, pain, anger, fear, anxiety, depression, discomfort, instead of fighting the pain and wishing it goes away experiencing the pain as it is without adding or trying to subtract the pain. Mindfulness based practices are part of national healthcare system in many countries. Let's reduce suffering and bring peace in our health care system.		
Apr 30	**Falls: Prevention, Management and Review**	**€90 members; €145 non-members**	**5**
	This programme promotes a consistent approach to falls reduction and management for older people through risk assessment, individualised care planning and post-falls review. It will outline causes and risks for falls and will assist participants to identify those patients or residents who are at risk of falls. Risk assessment tools such as FRAISE, FRAT and STRATIFY will be explored. There will be a focus on individualised care planning to mitigate falls and promote patient safety, and falls reduction techniques, with the aim of improving patient safety and minimising injuries in the older population. Participants will practise completing a post-falls review.		
Apr 30	**'Time is Brain' – A Guide to Nursing Management, Assessment & Treatment of Acute Stroke**	**€90 members; €145 non-members**	**5.5**
	Two million brain cells die every minute, increasing the risk of permanent brain damage, disability, or death. When a patient presents with stroke symptoms, every minute counts. This course involves knowledge and skills around stroke assessment, treatment and management for nurses during the acute phase and rehabilitation stage.		
May 7	**Phlebotomy**	**€90 members; €145 non-members**	**4**
	This programme provides participants with the skill and theory to perform phlebotomy in a competent and safe manner. It will cover topics such as sites used for phlebotomy, criteria for evaluating a vein, principles of an aseptic technique as well as complications that may arise during and after the procedure. Guidance will be given on how to reassure the individual in relation to the procedure and on gaining their consent. While this course will provide the necessary knowledge and skills to undertake phlebotomy, it will be necessary for each nurse and midwife attending to ensure that they abide by their local policy on phlebotomy in their place of work and hold an up to date hand hygiene training certificate (within the last two years).		
May 11	**Nursing the Cardiac Patient**	**€90 members; €145 non-members**	**6.5**
	This programme provides a forum to update nurses on national and international trends in the holistic management of patients with cardiac disease. A particular focus of the course is to ensure that content is based on current evidence-based practices within the field of cardiology. The programme is designed to examine new developments in cardiac nursing, particularly in the area of medications and chronic heart failure. Other key topics which will be covered include; cardiac anatomy and physiology, cardiac tests and assessments. The programme promotes the delivery of quality care for patients which is based on current evidence-based practice.		
May 12	**ECG Interpretation**	**€90 members; €145 non-members**	**6**
	This programme enhances knowledge of cardiac electrophysiology. It will provide participants with knowledge of cardiac rhythms, rhythm analysis and ECG interpretation. It will explore monitoring for arrhythmias and such topics as sinus rhythm, sinus bradycardia, atrial flutter, atrial fibrillation and AV block. The interpretation of P wave, QRS complex, ST segment, T wave and the identification of abnormal features will also be covered. The 3 lead, 5 lead and 12 lead ECG will be explained and illustrated with examples. Lead placement and position will be explored, as well as how to systematically read an ECG. Note that this study day may be taken as either a follow-on from the study day 'Nursing the Cardiac Patient' or as a stand-alone day. It is advisable to complete the previous study day before participating in this one.		

Date	Programme	Fee	CEUs
May 13	**Management of Adult Tracheostomy**	**€90 members; €145 non-members**	**6**
	This programme will give nurses who encounter tracheostomies in their workplace the skills to care for their patients safely and provide evidence based care for their patients. It will give nurses confidence in managing all aspects of tracheostomy care.		
May 19	**Epilepsy – Its Presentation and Management**	**€90 members; €145 non-members**	**6**
	Topics covered during this one-day programme will include seizure classification/recognition, demonstration of buccal midazolam through the use of dummies, epilepsy treatment and management, as well as medication side effects, seizure triggers and epilepsy in women, teens and people with intellectual disabilities.		
May 20	**Principles and Practice of Risk Management in Residential Care Settings**	**€90 members; €145 non-members**	**6**
	This course will outline the principles of risk management and how to apply them to residential care settings. The workshop will encompass requirements and guidance from HIQA as well as the ISO Australian/New Zealand international standard for risk management.		
May 21	**Wound Care Management**	**€90 members; €145 non-members**	**5**
	This programme will allow participants to ensure professional competency in the area of wounds as per the NMBI Code of Professional Conduct and Scope of Practice for Nursing and Midwifery, which states that nurses must work within their competence. Furthermore, it will provide participants with the knowledge to ensure that their practice is founded in the latest research and guidance.		
May 21	**Diabetes Management for Healthcare Professionals**	**€90 members; €145 non-members**	**5**
	The increased prevalence of diabetes presents significant challenges for healthcare planners and providers in terms of resource allocation and appropriately skilled staff. This course aims to prepare nurses/midwives with the theoretical knowledge and clinical skills required to facilitate diabetes care consistent with best practice recommendations and meet participants' expectations.		
May 26	**Basic Life Support for Healthcare Providers**	**€135 members; €195 non-members**	**6**
	This healthcare provider CPR and AED course provides the information, rational and practical skills training for the 2015 CPR and ECC guidelines. The two-year certification period for both basic and advanced life support is recommended by ILCOR.		
May 26 & 27	**Management in Practice** *(two-day workshop)*	**€230 members; €350 non-members**	**11**
	In the current dynamic nursing and healthcare environment, nurses and midwives are taking on an influential role in restructuring existing and new healthcare services in Ireland. To achieve this management, development is critical for those who direct and organise both work and employees. This training programme will guide nurses, midwives and other healthcare professionals in how best to deal with people and drive them to realise their potential so that standards, competency and skills are maintained and exceptional care is provided at all times. This is an intense, comprehensive and participative workshop developed to ensure improved effectiveness in management in all participants		
May 27	**Meaningful Healthcare Risk Management**	**€90 members; €145 non-members**	**5**
	This day is designed specifically for CNM/CMMs to give a practical introductory insight into evidence-based best practice healthcare risk management principles and practices. The day will be facilitated by Dr Luke Feeney, PhD in healthcare risk, incident and audit management, MSc in quality and safety in healthcare management. See *page 32* for more details. Book now for a special €65 members-only early bird rate.		
May 28	**Caring for Patients with Renal Impairment**	**€90 members; €145 non-members**	**7**
	This education programme is aimed at all registered nurses and focuses on developing competency in the assessment and management of patients presenting with impaired renal function. The programme will assist participants in implementing evidence-based practice while caring for this cohort of patients in the clinical setting. Common causes of acute kidney injury and chronic renal failure include sepsis, diabetes and hypertension, all of which are extremely prevalent in the acute, older person and community patient populations. It is envisaged that this programme will both inform and equip nurses to more comprehensively assess and care for patients with renal dysfunction.		
May 28	**Decision Making and Restraint Use in Residential Care Settings for Older People**	**€90 members; €145 non-members**	**6**
	This is a one-day education programme that outlines the requirements of the national policy, national standards and professional requirements for the use of restraint. Against this backdrop, the workshop outlines the decision-making process for consideration of the use of restraint as a therapeutic intervention for individual residents.		

Date	Programme	Fee	CEUs
Jun 11	**Preventing and Responding to Responsive Behaviours in the Older Person**	**€90 members; €145 non-members**	**5.5**
	This education programme is aimed at registered nurses and outlines a person-centred approach to preventing and responding appropriately to responsive behaviours in residents. The programme includes assessment and care planning for residents with responsive behaviours.		
Jun 16	**Competency-based Interview Skills**	**€90 members; €145 non-members**	**5**
	This programme assists participants to prepare for a competency-based interview, which is based on the premise that past experience can predict future behaviour. This is an increasingly common style of interviewing that enables candidates to show how they would demonstrate certain behaviours and skills in the workplace by answering questions about how they have reacted to and dealt with previous workplace situations. The programme will provide an overview of CV development and outline the steps in the interview process. Role play will be used to ensure that participants are able to communicate their knowledge and experiences effectively for any future interviews.		
Jun 17	**Best Practice in Medication Management**	**€90 members; €145 non-members**	**5**
	This education programme supports nurses and midwives in providing safe, evidence-based practice in the area of medication management. The programme will cover key topics such as: the key principles of medication management, the medication management cycle, management of controlled drugs and medication safety. Furthermore, it will explore relevant policy and legislation and will present scenarios in order to illustrate the various principles. Participants will have the opportunity to update their knowledge in line with the most up-to-date Nursing and Midwifery Board of Ireland and Health Information and Quality Authority requirements for medication management.		
Jun 17	**Getting the Most from Your Library: Advanced Library Searching Techniques**	**€90 members; €145 non-members**	**5**
	This programme is aimed at nurses and midwives who would like to develop their information-seeking skills in order to avail of the most up-to-date information for clinical practice, reflection and policy development. This programme will assist participants who are undertaking academic programmes and will provide them with valuable lifelong skills in information literacy. Guidance will be provided on the use of keywords, Boolean logic and limiting and broadening of results. The programme involves a practical element whereby participants will have the opportunity to develop a search strategy and use it to search a database. Strategies for the evaluation and critique of online resources will be discussed.		
Jun 18	**Management Skills for Clinical Nurse Managers and Staff Nurses**	**€90 members; €145 non-members**	**5.5**
	This programme outlines the competencies required for ward managers to be effective as leaders in healthcare delivery. Clinical managers perform both managerial and leadership functions in order to provide effective healthcare delivery to patients. The programme will explore both management and leadership functions and how these are applied in practice so as to promote quality and safety of care. Key topics covered include: management principles and competencies, team building, delegation and clinical supervision. Participants will gain effective management competencies that can be applied in the workplace to promote quality and safety in healthcare delivery.		
Jun 23 & 24	**Communicating Effectively in the Caring Environment**	**€230 members; €350 non-members**	**11**
	Quality patient care is determined by the quality of the communications between the care providers involved. Internal communications are also critical given the complexities of the multicultural care givers and the challenges in the healthcare sector. This course is suitable for personnel at all levels, especially those dealing directly with patients and their families from the director of nursing to HCAs.		
Jun 25	**Nursing and Midwifery Documentation**	**€90 members; €145 non-members**	**5**
	This programme will provide an opportunity for nurses and midwives to avail of the most up-to-date approach to appropriate documentation and record keeping. The programme will explore a range of topics pertinent to documentation such as accountability and duty of care, and will offer guidance on best practice in documentation. The programme will illustrate the importance of documentation as a basis for assessment, planning and evaluation of care, and its role as credible evidence in the event of legal proceedings. There will be a practical session where participants will be given the opportunity to apply what they have learned by working through some examples.		
Jun 30	**Strategies for Managing Conflict**		
	This programme presents a practical approach for dealing with conflict. Using group work, self-evaluation and case-study based discussion, it will demonstrate the knowledge, skills and confidence needed to intervene at an early stage to resolve conflict situations before they escalate. Managed in the wrong way, real and perceived differences between people can spiral out of control. Conflict is not necessarily destructive; managing conflict effectively may result in positive outcomes such as new ideas and the development of positive communication, active listening and problem solving skills. Developing and maintaining positive relationships and the ability to deal with difficult people and situations is an essential skill for the work environment.		

Education programmes coming to our Cork office

Date	Programme	Fee	CEUs
Apr 7 Postponed – to be rescheduled	**Phlebotomy** This programme provides participants with the skill and theory to perform phlebotomy in a competent and safe manner. It will cover topics such as sites used for phlebotomy, criteria for evaluating a vein, principles of an aseptic technique as well as complications that may arise during and after the procedure. Guidance will be given on how to reassure the individual in relation to the procedure and on gaining their consent. While this course will provide the necessary knowledge and skills to undertake phlebotomy, it will be necessary for each nurse and midwife attending to ensure that they abide by their local policy on phlebotomy in their place of work and hold an up to date hand hygiene training certificate (within the past two years).	€90 members; €145 non-members	4
Apr 22	**Assessment and Care Planning in Residential Care Settings for Older People** This programme provides nurses caring for older persons with the most up-to-date information regarding policy and standards. It will focus on the need for comprehensive assessment, including risk assessment and care planning for older people in residential care settings. Participants will be provided with practical tips on how to prepare for and carry out a comprehensive assessment of a new resident in a nursing home, enabling them to develop a person-centred care plan. The programme will outline the appropriate steps for writing a person-centred care plan, how to conduct a review of an individual's care plan, and how to update it in accordance with changing needs.	€90 members; €145 non-members	6
May 7	**Wound Care Management** This programme will allow participants to ensure professional competency in the area of wounds as per the NMBI Code of Professional Conduct and Scope of Practice for Nursing and Midwifery, which states that all nurses must work within their competence. Furthermore, it will provide participants with the knowledge to ensure that their practice is founded and based in the latest research and guidance.	€90 members; €145 non-members	5
May 12	**Introduction to Clinical Audit** This programme equips participants with the necessary skills to implement clinical audit in their practice and enable them to deliver evidence of improved performance for safer and better care for patients. Participants will be provided with an overview of clinical audit and be informed about each stage in the clinical audit cycle: topic selection, standards development, data collection, data analysis, reporting, implementing changes and re-audit. A detailed overview will be given on the characteristics and dimensions of quality as well as how best to measure and monitor quality in the workplace. There will be an emphasis on continuous quality and safety improvement in healthcare.	€90 members; €145 non-members	5
May 21	**Delegation and Clinical Supervision** This programme is aimed at all nurses, midwives and clinical nurse and midwife managers who work with health care assistants. It explores the issues surrounding delegation and decision making, including appropriate clinical supervision for delegated functions. Participants will learn the difference between clinical and managerial delegation and how delegation differs from assignment of a task. Guidance will be provided on the assessment of a delegate's experience and role, and how best to match appropriate clinical supervision to a specific delegated function. The professional, legal and quality of care issues involved when deciding to delegate a function will also be explored.	€90 members; €145 non-members	5
July 13 & 14	**Management in Practice** *(two-day workshop)* In the current dynamic nursing and healthcare environment, nurses and midwives are taking on an influential role in restructuring existing and new healthcare services in Ireland. To achieve this management, development is critical for those who direct and organise both work and employees. This training programme will guide nurses, midwives and other healthcare professionals in how best to deal with people and drive them to realise their potential so that standards, competency and skills are maintained and exceptional care is provided at all times. This is an intense, comprehensive and participative workshop developed to ensure improved effectiveness in management in all participants	€230 members; €350 non-members	11
Oct 7	**Decision-Making and Restraint Use in Residential Care Settings for Older People** This is a one-day education programme that outlines the requirements of the national policy, national standards and professional requirements for the use of restraint. Against this backdrop, the workshop outlines the decision-making process for consideration of the use of restraint as a therapeutic intervention for individual residents.	€90 members; €145 non-members	5.5

Book online at inmoprofessional.ie or Tel: 01 01 6640618

COVID-19 resources and literature update

Coronavirus (COVID-19) resources

The Lancet Resource Centre brings together novel coronavirus disease (COVID-19) resources from across The Lancet journals as they are published. All content listed on this page is free to access and provides useful links and audio material.

The World Health Organization (WHO) is gathering all scientific data and research and has built a database of literature, which is being updated regularly. The WHO has also developed online training courses such as an introduction to emerging respiratory viruses, including novel coronavirus, a course on critical care for patients with severe acute respiratory infection and a health and safety briefing for respiratory diseases known as ePROTECT.

The Royal College of Midwives (RCM), in collaboration with a number of other UK organisations, has developed a guidance document, *Coronavirus (COVID-19) Infection in Pregnancy*. This can be downloaded from the RCM website: **www.rcm.org.uk**

Information and advice for INMO members can be found on the INMO website: **www.inmo.ie/Covid19**

Evidence-based practice articles

Surgical patients

- Lizarondo L. Surgical Patients: Pain Assessment. JBI Evidence Summary 2019.
  PICO question: what is the best available evidence regarding the assessment of pain in surgical patients?

Hospital discharge – acute coronary patients

- Effectiveness of discharge education strategies versus usual care on clinical outcomes in acute coronary syndrome patients: a systematic review. JBI Evidence Synthesis, February 2020 Systematic Review
  PICO question: to systematically review studies that evaluated the clinical effectiveness of hospital discharge education strategies provided to patients with acute coronary syndrome (ACS)

Transitional care for older people

- Transitional care for older people from hospital to home: a best practice implementation project. JBI Evidence Synthesis 2020. Implementation Report
  PICO question: to promote evidence-based practice of transitional care for older people from hospital to home

Hypertension

- Hypertension: Diagnosis. JBI Recommended Practice 2019
  PICO Question: What is the best available evidence regarding diagnosing hypertension in adults attending a clinic?

Midwifery – breastfeeding

- Dornan L et al. Breastfeeding, motivation and culture: an exploration of maternal influences within midwife-led instruction in an Asian setting. MIDIRS 2020; 30(1): 11-19
- Uddin Z et al. Midwives' experiences of the Perineal Assessment and Repair Longitudinal Study (PEARLS) training package. Narrative literature review. MIDIRS 2020 30(1): 11-19

Cancer nursing – chemotherapy

- Fathi M et al. Exploring patients' lived experiences and perceptions of chemotherapy. Cancer Nurs Pract 2020; doi: 10.7748/cnp.2020.e1636
- Lawlor J et al. Understanding the demand and unmet need for psychological cancer care in the community. Cancer Nurs Pract 2020 doi: 10.7748/cnp.2020.e1680

Intellectual disability and developmental disorders

- Henderson-Laidlaw M et al. Using cognitive behavioural therapy in individuals with intellectual disability. Learn Disabil Pract 2020; doi: 10.7748/ldp.2020.e2013
- Schopf D et al. An alternative admission process for patients with an autism spectrum disorder and/or an intellectual disability. Learn Disabil Pract 2020; doi: 10.7748/ldp.2020.e2026

School nurses – mental health

- Smith S et al. Role of school nurses in identifying and supporting children and young people with mental health issues. Nurs Child Young People 2020; doi: 10.7748/ncyp.2020.e1253

Nursing management – policy and politics

- Benton D et al. Exploring the influence of the nursing and medical professions on policy and politics. Nursing Management 2020; doi: 10.7748/nm.2020.e1896
  Nursing older people – sexual health
- White I et al. Sexual health and well-being in later life. Nurs Older People 2020; doi: 10.7748/nop.2020.e1227

Emergency nursing – medication errors

- George J. Exploring common prescribing errors that occur in the emergency department. Emerg Nurs 2020; doi: 10.7748/en.2020.e1975

Enteral feeding

- McLauren S et al. Providing optimal nursing care for patients undergoing enteral feeding. Nursing Standard 2020; doi: 10.7748/ns.2020.e11520

Continuing professional development (CPD) survey

The INMO is undertaking a survey to find out members' views and experiences of CPD as part of their professional practice. The survey is available at www.inmo.ie and on the INMO Professional website at **www.inmoprofessional.ie/Course**

For assistance email: library@inmo.ie or call at Tel: 01 6640614/625

Getting the most from your library: Advanced Library Searching Techniques

Next course dates: Tuesday, June 17, 2020

Venue: The Richmond Education and Event Centre, North Brunswick Street, Dublin 7

Fee: €90 INMO members; €145 non-members

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

On-site Education

Bringing INMO Professional Development Education Programmes to YOUR workplace

- More than 100 tailored education programmes
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- Provided throughout Ireland
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- Category 1 approved by the NMBI with CEUs
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The Professional Development Centre has an extensive range of quality education programmes provided by expert facilitators that can be delivered to you directly on-site. On-site education is a more cost and time effective solution for your educational needs. Our fees are based on 'per day' rather than 'per person', with no other additional costs, which makes our education affordable and available to all.

For more information contact: marian.godley@inmo.ie | 01 6640642

Retirement Planning Seminar

This day, designed specifically for nurses and midwives, offers the most up to date information if you are contemplating retirement. The programme covers superannuation, AVCs, investments, tax and money saving tips.

Please see our website **www.inmoprofessional.ie** for details and venues coming soon.

Wednesday, 13 May	Donegal
Thursday, 14 May	Sligo
Friday, 15 May	Galway
Wednesday, 8 July	Dublin
Monday, 27 July	Castlebar
Thursday, 13 August	Roscommon

Time:
9.15am - 2.30pm
(registration 9.00am)

Fee:
€10 for INMO members:
€45 for non-members

Topics include:
Superannuation, Retirement Benefits, Planning your Finances, Personal Taxation and Budgeting and Money Saving Tips

For more visit www.inmoprofessional.ie/course or call 016640641/18

Tools for Safe Practice

FREE FOR INMO MEMBERS 01 6640618 | www.inmoprofessional.ie

FREE Practical Advice Workshop for INMO members. This short workshop will provide you with safe practice tools to protect you and the patient within current healthcare settings. If you would like to arrange this workshop for yourself and your colleagues in your workplace, please contact your Industrial Relations Officer. There is a fee of €150 for non-members. We require a minimum of 25 participants to provide this training. This programme is Category 1 approved by NMBI with 4 CEUs.

This can be booked through your Industrial Relations Officer.

For more information visit www.inmoprofessional.ie or call 01 6640618

Nursing now Ireland

2020 INTERNATIONAL YEAR OF THE NURSE AND THE MIDWIFE

Quality & Safety

A column by Maureen Flynn

Blood clot/VTE alert card

THIS month's column introduces a practical tool to help patients keep safe. Venous thromboembolism (VTE, or blood clots) led to or occurred during hospitalisation for 6,025 patients in Ireland in 2018.

Risk of Blood Clots: Over 60% of blood clots occur in people during or in the 90 days after a hospital admission. The risk declines after 90 days even if mobility is still impaired. Other groups at higher risk of developing a blood clot are those with cancer, who are pregnant or have recently given birth and those with lower limb immobilisation.

Blood clot alert cards were distributed to all acute hospitals by the HSE National Quality Improvement Team in February 2020. They have been issued so that hospitals can provide essential safety information to every patient in the following in-patient and out-patient groups:

- All adult medical, surgical and maternity in-patients
- All people with lower limb immobilisation, eg. a leg cast
- All people who have active cancer or are receiving cancer treatment
- All women who are pregnant or have had a baby in the last six weeks

Blood clot alert cards

The alert cards are wallet-sized, laminated cards. They give people key information to inform them about the increase in risk of blood clots/ venous thromboembolism (VTE) associated with a hospital in-patient episode. They also provide important information for certain out-patient groups. The alert cards outline:

- Risk factors for Blood Clots/ VTE
- Steps for people to take to reduce their risk
- Signs and symptoms to watch out for and the need to act quickly if symptoms occur

Why are cards being issued?

- There is low public awareness of the symptoms of blood clots/ VTE and many people in the groups above are not aware that they are at much higher risk of a blood clot.
- Effective treatments are available if a blood clot is identified and treated promptly. Delays in seeking medical assistance can result in greater harm from VTE
- Healthcare professionals also need to recognise the signs and symptoms of VTE and be aware of the patient groups at higher risk.

The cards were developed following a year-long HSE national quality improvement collaborative "Preventing Blood Clots in Hospitals" (**www.safermeds.ie**) which delivered improvements in the proportion of patients receiving appropriate blood clot/ VTE prevention. The cards have been developed in collaboration with a patient charity, Thrombosis Ireland, with input from haematology and other specialists.

Using the cards in practice

It is important to consider and plan the best way to distribute the cards effectively in each setting so that all patients in the four high risk groups receive one and have an opportunity to ask questions if needed. This can become part of routine practice so that this is a permanent change, reaching every patient in the higher risk groups. Hospitals have been asked to ensure that responsibility and governance of implementation of this patient safety initiative is agreed in each hospital, reporting to the individual or committee that oversees venous thromboembolism (VTE, blood clots) prevention efforts. This may be a thrombosis committee, quality and safety committee or drugs and therapeutics committee.

Get involved

If you are working in an acute hospital, discuss the blood clot alert cards with your manager and find out about your hospital's plans for roll out of the cards. Nurses and midwives will have many ideas about how best to ensure all the relevant patients receive a card in their area of work, eg. including it in a discharge information pack, if one is in regular use.

If the cards are not yet in use in your area of work and you care for patients who are in these higher risk groups, you may wish to use a quality improvement approach to the roll out of the cards. See this column in *WIN* November 2019 to find tools and templates on **www.qualityimprovement.ie**

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

Acknowledgements: Thank you to members of the VTE Collaborative for generously sharing information. A particular thanks to Muriel Pate and Ciara Kirke from the National QI Team for preparing this column

Explaining payslips

Catherine O'Connor gives an overview on how to understand your payslip

I HAVE received some questions regarding understanding payslips. There are several acronyms and they can be confusing to read, but it is important to fully understand your payslip so that you can ensure that you are being paid the appropriate amount.

All employees have a right to a payslip under Section 4 of the Payment of Wages Act 1991. Payslips are a written statement outlining the total pay before tax and all details of any deductions. They are important and confidential documents and should be kept safe. They can be either in paper or electronic format, and while the layout of payslips may vary slightly from area to area, the same general information should be included. The main differences between public and private sector payslips are the pension contributions.

Basic information/your details

Your payslip will generally state your employer, your employee number, and your position, eg. staff nurse/staff midwife. It will also state the period of time for which you are being paid, eg. week of the year if being paid weekly/fortnightly, or a number if paid monthly, eg. period 3 would be March. Your payslip will also contain your PPS number, which is a unique reference number used for tax purposes in addition to allowing you to access social welfare benefits and public services in Ireland. Payslips are divided into two columns with payments on the left-hand side, and deductions on the right-hand side.

Pay

Gross pay: Your gross pay is the total amount paid before any deductions are made in that pay period.

Net pay: Your net pay is the total amount paid once all deductions are made in that pay period.

Basic pay: Your basic pay is the standard amount paid before additional payments such as premiums or allowances are made. It is important to keep an eye on your basic pay to ensure that it is increasing in line with your increments. In order to roughly calculate your salary point from your hourly rate of pay, multiply your hourly rate of pay by 39 to give you your weekly rate, and then again by 52.18 to give you an estimate of your yearly salary. It is important for 2019 graduates to remember that after working for 16 weeks post finishing their internship, they can skip point 2 of the salary scale and proceed directly to point 3. After one year, they will move to the next point of the scale at which point they are eligible to apply for the enhanced nurse/midwife contract to avail of the higher rate of pay.

Premium pay: Premium pay includes night duty pay, Saturday pay, Sunday and bank holiday pay, and time plus one-sixth. They are itemised separately from your basic pay.

Allowances: Some nurses and midwives will also be eligible to receive allowances such as the location allowance (€2,230 per annum) or the specialist qualification allowance (€3,349 per annum). Further information on salary scales and allowances is available at: **www.inmo.ie/Salary_Information**

Deductions

Tax: Pay As You Earn (PAYE) is a form of income tax that is deducted by the employer on behalf of the government and is calculated as percentage of your gross income. Registering for tax credits for which you are eligible reduces the amount of tax you need to pay during the year. Tax credits are specific to your personal circumstances; to examine your own tax and tax credits please visit: **www.revenue**.ie. It is important to remember that your employer applies PAYE based on the information they receive from Revenue, so be sure to update Revenue of any relevant changes that may affect your tax credits, eg. marital status or having dependants.

USC: The Universal Social Charge (USC) is another form of tax. The current rates of USC are shown in the *Table*. Please note that these rates/bands may change yearly depending on the budget.

PRSI: Your Pay Related Social Insurance (PRSI) class will be stated in your payslip and specifies what mandatory PRSI contributions you are paying. Generally speaking, most employees are Class A. These contributions determine future eligibility to access social insurance payments (provided you meet the qualifying criteria). PRSI contributions are calculated as 4% on your total earnings.

Table: USC explained

Rate of USC	Year 2020
0.5%	First €12,012
2%	Next €8,472
4.5%	Next €49,560
8%	Balance

Pension deductions: Nurses and midwives who entered employment in a pensionable public service post on or after January 1, 2013 are members of the Single Public Service Pension Scheme, also known as the 'Single Scheme'. The rules of the Single Scheme are set out in the Public Service Pensions (Single Scheme and Other Provisions) Act 2012. Further details of this scheme are available at: **www.hse.ie/eng/staff/benefitsservices/pension-management/single-scheme/**

Union membership: Undergraduate students have free INMO membership, but once you graduate there is a fee for membership (please see details at **www.inmo.ie/Membership_Fees**). If you choose to pay for your membership through deduction at source, the fee will come directly from your salary and will be listed as a deduction in your payslip.

If you experience any issues or have general questions, please do not hesitate to get in touch. If your queries relate to your pay, please contact your salaries department/payroll first.

Get in touch

If you would like to get in touch with Catherine O'Connor, email: catherine.oconnor@INMO.ie or Tel: 01 6640684.

Paperless healthcare

Nurses and midwives need to be at the forefront of the transition to paper-free healthcare, writes **Loretto Grogan**

INFORMATION and communication technology (ICT) is evolving at a rapid pace, becoming a fundamental aspect of healthcare settings, with increasing use of smartphone apps, wearables, telehealth and virtual clinics. Progress is also being made towards the implementation of an electronic health record (EHR), with the Maternal and Newborn Clinical Management System (MN-CMS), the Epilepsy Electronic Patient Record (EPR), the EPR at St James's Hospital and further planned implementations.[1] Sláintecare outlines clear goals for the eHealth agenda to digitally connect the health service as well as the citizen. The EHR is the cornerstone of this programme.

The HSE has recognised the importance of planning for EHR implementation nationally, and the Office of the Nursing and Midwifery Services Director (ONMSD) has commissioned a literature review.

From the international and national literature, as well as from the experiences of a multidisciplinary advisory group, two reports were published and are freely available: *Factors for success in EHR implementation* and *Clinical information capture in the EHR*.[4,5] The findings of these reports have significant implications for nurses and midwives, so it is critical that members of both professions contribute to the implementation of EHRs in Ireland on a national and local level to ensure the system will be fit for purpose.

Key factors for a successful EHR implementation

Organisational factors

- EHR implementation is a clinical and cultural transformation, not just an IT project
- Representation of each group of end users by a clinical leader or 'champion' throughout each stage of implementation (ie. development, testing, optimisation) helps to ensure that the EHR meets their needs and fits in with their workflow
- Workflows are the building blocks of the EHR and need to be identified, optimised for patient safety and efficiency, standardised where possible, communicated to IT developers, tested and reviewed on an ongoing basis
- Basic computer literacy training should be offered prior to the EHR-specific training, which should be completed as close as possible to the system going live (within six weeks)
- Even the most adept computer user requires training and support, as well as time to practise a new and unfamiliar system to optimise their use of it with 'shortcuts', 'personalisation' and use of 'favourites'
- Appointing and training peers within the department as support staff and trainers ensures that they understand the clinical workflows. It also facilitates ongoing training and support of new and rotating staff after the system has gone live.

Human factors

- The individual's skills and personal characteristics have an impact on their openness to change and their competence with the EHR. This can be improved with basic computer training and change management
- Benefits of an EHR may not be seen at first and to drive some of the desired benefits (eg. reports, improved efficiency), there may be a need to adapt some practices (eg. data collection methods)
- Involving end users in the decision-making process of the EHR allows them to understand the benefits of change and to have their concerns addressed.

Technological factors

- Ensuring a usable, intuitive and safe EHR system requires a substantial amount of stakeholder consultation, workflow identification and testing
- To ensure the EHR can 'talk' effectively with existing systems, and other organisations, interoperability is required, meaning IT systems will have to be adapted
- To facilitate interoperability, national standardisation is required for the software and potentially the workflows and terminologies utilised by the end user
- Infrastructure for inputting data (eg. stationary computers, mobile workstations) will be required and the compatibility of existing hardware and software with the EHR will need to be assessed, as well as the infrastructure of the organisation (eg. WiFi, power outlets, physical space).

Clinical information capture

Clinical data types (text)

EHRs usually facilitate entry of unstructured (free text), structured (checkbox or template), coded (standardised terminology) or semi-structured data (combination of the above). Advantages and disadvantages exist with the use of these. This should be considered when determining the most appropriate data type for each

Table: Key factors in EHR implementation

Organisational factors	Human factors	Technological factors
Governance, leadership and culture	Skills and characteristics	Usability
End user involvement		Interoperability
Training	Perceived benefits and incentives	Infrastructure
Support		Regulation, standards and policies
Resourcing	Perceived changes in health ecosystem	Adaptability
Workflows		Testing

clinical scenario during EHR development and optimisation.

Unstructured data is often more familiar and less restrictive, but it can obscure critical information and render data-retrieval more difficult unless accurate natural language processing is used.

Information can be more easily retrieved when structured data is used. A structured template prompts the end user to collect more comprehensive information, but it is often considered restrictive.

Certain standardised terminologies associated with codes have the added benefit of promoting consistent collection and understanding of clinical information and thus aggregation of data and use of clinical decision-support software. However, the terms available need to be usable and applicable to the clinical setting in which they are being used.

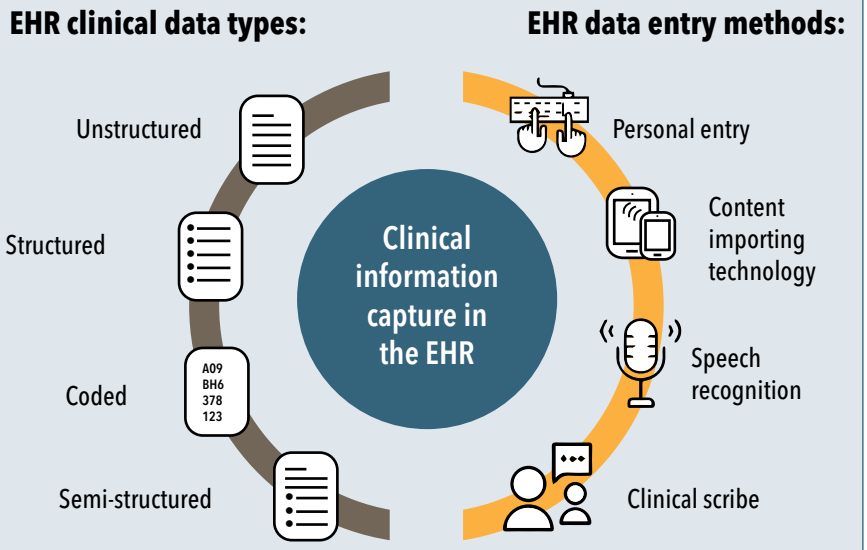
Semi-structured data entry enables the benefits of coded and/or structured data while also allowing free text to be entered when clinically relevant data does not fit into the structured template, or where additional context is needed.

While standardised terminologies promote high quality data within the EHR, they also benefit healthcare professionals and patients as consistent clinical terms are used with the same meaning across different organisations and geographic boundaries, irrespective of language. However, the purpose of using a standardised terminology may vary and thus different types of standardised terminologies exist:

- Aggregation terminology – often utilised for audit purposes as it enables the classification of diagnoses or procedures into broad categories (eg. ICD-10)
- Reference terminology – this is more sensitive and specific to all aspects of clinical practice and thus contains far more terms than the aggregation terminology (eg. SNOMED-CT, which is recommended by HIQA for use in Ireland[6]
- Interface terminology – this captures more detailed clinical content specific to a discipline or speciality (eg. nursing and dietetics use standardised terminologies in Ireland.[7,8] These terminologies can again be mapped to the reference and aggregation terminologies.

This poses the question of nursing and midwifery using a standardised interface terminology within the EHR. Interpretability by other professions and possibly by patients is one of the significant considerations. Irrespective of whether a standardised terminology is used, we will need to determine which type of data will be most appropriate for each clinical scenario. Key considerations were developed in the report to facilitate this process.

Figure: Clinical data types and entry methods used in an EHR



Clinical data entry methods

Personal entry via typing or touch screens will likely either solely be utilised by the end user or in conjunction with content-importing technology (eg. patient-generated data, autofill from other fields in the EHR), speech recognition or clinical scribes. However, the type of data being entered may influence the selection of a mobile or stationary data entry-device. Where structured tick boxes are being filled in, touch screen tablets can be useful, whereas clinicians tend to prefer a stationary device for longer narrative notes.

Content-importing technology (eg. copy and paste, autofill, barcode scanning and integrated devices) can improve the end user's efficiency and the accuracy and availability of data (eg. patient-generated information from wearables). However, overuse of such functions can result in 'note bloat' or redundant and outdated information obscuring the relevant and critical information. Therefore, all information imported from within or outside the EHR should be attributed to its source, reviewed for accuracy and interpreted by a healthcare professional.

Speech recognition directly translates the spoken work into the EHR and can improve the efficiency of the end user by replacing personal entry of long narrative notes, as has been seen in some radiology departments in Ireland. However, this is an expensive technology and needs to be conditioned to the individuals' dialect, accent and speciality to mitigate critical safety errors.

Clinical scribes transcribe the verbally stated notes of clinicians in real time and have been employed in healthcare settings across the US, Canada and Australia to reduce the burden of typing long narrative notes. However, this role would result in additional costs and regulatory issues. Developing a user-friendly system should negate any need for the existence of such a role in Ireland.

Going paperless

Transition from the paper age to the electronic age is already underway within the Irish health service; nurses and midwives need to be at the forefront of its implementation. As nursing and midwifery leaders, we need to engage with this work to ensure it delivers for patients, the nursing and midwifery workforce and the broader health service. Planning and communication at a local and national level will be paramount to ensure we obtain all the potential benefits in the most resource-efficient way. This will be a cultural and clinical transformation for all, and will require us to adapt some of our practices to improve the quality of care for our patients.

Loretto Grogan is the national clinical information officer for nursing and midwifery with HSE ONMSD

Acknowledgements
The reports described in this article were written by Dr Orna Fennelly, School of Public Health, Physiotherapy and Sports Science and the Insight Centre for Data Analytics, University College Dublin

References are available on request by email to nursing@medmedia.ie (Quote Grogan L. WIN 2020; 28(3):44-45)

DO YOU HAVE SEVERE ASTHMA PATIENTS WHO ARE STILL SYMPTOMATIC ON ICS/LABA?

SPIRIVA® Respimat® (tiotropium) is the only LAMA licensed for asthma

GINA recommends tiotropium by mist inhaler as an option for add-on treatment at step 4 or 5 for asthma patients ≥6 years with a history of exacerbations[1]

The Respimat® inhaler was used successfully by children as young as 6 years old[3,4]

SPIRIVA® Respimat® (tiotropium) is indicated as add-on maintenance bronchodilator treatment in patients aged 6 years and older with severe asthma who experienced one or more severe asthma exacerbations in the preceding year[2]

GINA: Global Initiative for Asthma, **ICS:** inhaled corticosteroids, **LABA:** long-acting β2-agonist, **LAMA:** long-acting muscarinic antagonist

SPIRIVA® RESPIMAT® (tiotropium)

References: 1. GINA: Pocket guide for asthma management & prevention. Revised 2019. Available at: https://ginasthma.org/wp-content/uploads/2019/04/GINA-2019-main-Pocket-Guide-wms.pdf (accessed May 2019). **2.** SPIRIVA® Respimat® 2.5 µg Summary of Product Characteristics. **3.** Kamin W *et al. Pulm Ther* 2015;1:53–63. **4.** Kamin W *et al. Pulm Ther* 2015;1:53–63. Supplementary appendix.

Prescribing Information (Ireland) SPIRIVA® RESPIMAT® (tiotropium) Inhalation solution containing 2.5 microgram tiotropium (as bromide monohydrate) per puff. **Indication:** COPD: Tiotropium is indicated as a maintenance bronchodilator treatment to relieve symptoms of patients with chronic obstructive pulmonary disease (COPD). Asthma: Spiriva Respimat is indicated as add-on maintenance bronchodilator treatment in patients aged 6 years and older with severe asthma who experienced one or more severe asthma exacerbations in the preceding year. **Dose and Administration:** COPD Adults only age 18 years or over: 5 microgram tiotropium given as two puffs from the Respimat inhaler once daily, at the same time of the day. Asthma Adults and patients 6 to 17 years of age: 5 microgram tiotropium given as two puffs from the Respimat inhaler once daily, at the same time of the day. In adult patients with severe asthma, tiotropium should be used in addition to inhaled corticosteroids (≥ 800 µg budesonide/day or equivalent) and at least one controller. In adolescents (12 - 17 years) with severe asthma, tiotropium should be used in addition to inhaled corticosteroids (> 800 - 1600 µg budesonide/day or equivalent) and one controller or in addition to inhaled corticosteroids (400 - 800 µg budesonide/day or equivalent) with two controllers. For children (6 - 11 years) with severe asthma, tiotropium should be used in addition to inhaled corticosteroids (> 400 µg budesonide/day or equivalent) and one controller or in addition to inhaled corticosteroids (200 - 400 µg budesonide/day or equivalent) with two controllers. **Contraindications:** Hypersensitivity to tiotropium bromide, atropine or its derivatives, e.g. ipratropium or oxitropium or to any of the excipients; benzalkonium chloride, disodium edetate, purified water, hydrochloric acid 3.6 % (for pH adjustment). **Warnings and Precautions:** Not for the initial treatment of acute episodes of bronchospasm or for the relief of acute symptoms. Spiriva Respimat should not be used as monotherapy for asthma. Asthma patients must be advised to continue taking anti-inflammatory therapy, i.e. inhaled corticosteroids, unchanged after the introduction of Spiriva Respimat, even when their symptoms improve. Immediate hypersensitivity reactions may occur after administration of tiotropium bromide inhalation solution. Caution in patients with narrow-angle glaucoma, prostatic hyperplasia or bladder-neck obstruction. Inhaled medicines may cause inhalation-induced bronchospasm. Tiotropium should be used with caution in patients with recent myocardial infarction < 6 months; any unstable or life threatening cardiac arrhythmia or cardiac arrhythmia requiring intervention or a change in drug therapy in the past year; hospitalisation of heart failure (NYHA Class III or IV) within the past year. These patients were excluded from the clinical trials and these conditions may be affected by the anticholinergic mechanism of action. In patients with moderate to severe renal impairment (creatinine clearance ≤ 50 ml/min) tiotropium bromide should be used only if the expected benefit outweighs the potential risk. Patients should be cautioned to avoid getting the spray into their eyes. They should be advised that this may result in precipitation or worsening of narrow-angle glaucoma, eye pain or discomfort, temporary blurring of vision, visual halos or coloured images in association with red eyes from conjunctival congestion and corneal oedema. Should any combination of these eye symptoms develop, patients should stop using tiotropium bromide and consult a specialist immediately. Tiotropium bromide should not be used more frequently than once a day. **Interactions:** Although no formal drug interaction studies have been performed, tiotropium bromide has been used concomitantly with other drugs commonly used in the treatment of COPD and asthma, including sympathomimetic bronchodilators, methylxanthines, oral and inhaled steroids, antihistamines, mucolytics, leukotriene modifiers, cromones, anti-IgE treatment without clinical evidence of drug interactions. Use of LABA or ICS was not found to alter the exposure to tiotropium. The co-administration of tiotropium bromide with other anticholinergic-containing drugs has not been studied and is therefore not recommended. **Fertility, Pregnancy and Lactation:** Very limited amount of data in pregnant women. Avoid the use of Spiriva Respimat during pregnancy. It is unknown whether tiotropium bromide is excreted in human breast milk. Use of Spiriva Respimat during breast feeding is not recommended. A decision on whether to continue/discontinue breast feeding or therapy with Spiriva Respimat should be made taking into account the benefit of breast feeding to the child and the benefit of Spiriva Respimat therapy to the woman. Clinical data on fertility are not available for tiotropium. **Effects on ability to drive and use machines:** No studies have been performed. The occurrence of dizziness or blurred vision may influence the ability to drive and use machinery. **Undesirable effects:** COPD: Common (≥ 1/100 to < 1/10) Dry mouth. Uncommon (≥ 1/1,000 to < 1/100) Dizziness, headache, cough, pharyngitis, dysphonia, constipation, oropharyngeal candidiasis, rash, pruritus, urinary retention, dysuria. Rare (≥1/10,000 to <1/1,000): Insomnia, glaucoma, intraocular pressure increased, vision blurred, atrial fibrillation, palpitations, supraventricular tachycardia, tachycardia, epistaxis, bronchospasm, laryngitis, dysphagia, gastrooesophageal reflux disease, dental caries, gingivitis, glossitis, angioneurotic oedema, urticaria, skin infection/skin ulcer, dry skin, urinary tract infection. Not known (cannot be estimated from the available data): Dehydration, sinusitis, stomatitis, intestinal obstruction including ileus paralytic, nausea, hypersensitivity (including immediate reactions), anaphylactic reaction, joint swelling. Asthma: Uncommon (≥ 1/1,000 to < 1/100) Dizziness, headache, insomnia, palpitations, cough, pharyngitis, dysphonia, bronchospasm, dry mouth, oropharyngeal candidiasis, rash. Rare (≥1/10,000 to <1/1,000): Epistaxis, constipation, gingivitis, stomatitis, pruritus, angioneurotic oedema, urticaria, hypersensitivity (including immediate reactions), urinary tract infection. Not known (cannot be estimated from the available data): Dehydration, glaucoma, intraocular pressure increased, vision blurred, atrial fibrillation, supraventricular tachycardia, tachycardia, laryngitis, sinusitis, dysphagia, gastrooesophageal reflux disease, dental caries, glossitis, intestinal obstruction including ileus paralytic, nausea, skin infection/skin ulcer, dry skin, anaphylactic reaction, joint swelling, urinary retention, dysuria. Serious undesirable effects consistent with anticholinergic effects: glaucoma, constipation, intestinal obstruction including ileus paralytic and urinary retention. An increase in anticholinergic effects may occur with increasing age. Prescribers should consult the Summary of Product Characteristics for further information on undesirable effects. **Pack sizes:** Single pack: 1 Respimat inhaler and 1 cartridge providing 60 puffs (30 medicinal doses). **Legal category:** POM. **MA number:** PA 775/2/2. **Marketing Authorisation Holder:** Boehringer Ingelheim International GmbH, D-55216 Ingelheim am Rhein, Germany. Prescribers should consult the Summary of Product Characteristics for full prescribing information. Additional information is available on request from Boehringer Ingelheim Ireland Ltd, The Crescent Building, Northwood, Santry, Dublin 9. **Prepared in** October 2018.

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PC-IE-100359 V1
Date of preparation: June 2019

Boehringer Ingelheim

New approach to mild asthma management

Diarmuid Glavin and Dermot Nolan outline major changes in GINA guidelines that will affect asthma management

THE most recent strategy report from the Global initiative for Asthma (GINA) has recommended a major change to the management of mild asthma. It recommends no longer initiating treatment with the sole use of short-acting beta agonists (SABA-only treatment) and instead recommends that all adults and adolescents with asthma receive inhaled corticosteroid (ICS) containing a controller treatment such as budesonide/formoterol.

This, according to the guidelines, reduces the risk of asthma-related exacerbations and death, including in those with mild asthma. The cost of this new regimen may be a factor for some patients initially, but this should be offset by reduced morbidity. Initial correct diagnosis of asthma is required as it is estimated that up to 30% of patients are misdiagnosed with asthma.

Why the concerns over SABA-only treatment?

Regular use of SABA increases allergic responses and airway inflammation. Overuse of SABA (more than three canisters dispensed in a year) is associated with an increased risk of severe exacerbations and the dispensing of more than 12 canisters in a year per patient is associated with increased risk of asthma-related death.

About GINA

GINA was established in 1993 in collaboration with the World Health Organization, the National Institute of Health, and the National Heart, Lung and Blood Institute in the US, with the objective of reducing the prevalence of asthma and its related morbidity and mortality rates. Every year, the GINA scientific committee publishes free updates on asthma management from the most up-to-date evidence-based literature. The Irish College of General Practitioners has agreed to implement these recommendations.

Table 1: Preferred controller treatment

Step 1	• As-needed low-dose ICS-formoterol • Other controller options: low-dose ICS taken whenever SABA is taken
Step 2	• Daily low-dose ICS or as-needed low-dose ICS-formoterol • Other controller options: LTRA or low-dose ICS whenever SABA is taken
Step 3	• Low-dose ICS-LABA • Other controller options: medium-dose ICS, or low dose ICS+LTRA
Step 4	• Medium-dose ICS-LABA • Other controller options: high-dose ICS, add on tiotropium or LTRA
Step 5	• High-dose ICS-LABA. Refer for phenotypic assessment +/- add-on therapy tiptropium, anti-IgE, anti-IL5/5R, anti-IL4R • Other controller options: add low dose ICS, but consider side effects

Diagnosis of asthma

The classic presenting symptoms of asthma are:

- Recurrent episodes of wheezing, shortness of breath, chest tightness and coughing
- Symptoms vary in intensity and may vary over time
- Symptoms are generally worse at night and on waking in the morning
- Symptoms are triggered by viral infections, exercise, cold air, allergens and laughing.

Spirometry

- Bronchodilator reversibility: FEV1 increases by > 12% (or > 200mL) from the baseline value after inhalation of a bronchodilator
- Variability: average daily diurnal PEF variability is > 10% (> 13% in children). This is calculated on twice daily readings (best of three each time). PEF should be measured first thing in the morning, before treatment is taken, when values are at their lowest and just before bedtime when values are usually higher
- Preferred reliever treatment: as-needed low dose ICS-formoterol

Monitoring to maintain control

- Review of patient one to three months after starting treatment and every three to 12 months after that
- Following an exacerbation, a review visit should occur within a week
- Asthma should be reviewed every four to six weeks in pregnancy
- The frequency of review will depend on the level of symptom control, patient risk factors and patient engagement with the self-management action plan.

Diagnostic challenges

- Children under five years old: diagnosis is largely based on clinical judgement
- The elderly: new onset, undiagnosed asthma is a frequent cause of treatable respiratory symptoms in older people. The presence of co-morbid disease may complicate diagnosis, eg. left ventricular failure, use of beta-blocker
- Occupational asthma: detailed occupational exposure history is required to identify potential sensitising agents. Monitor PEF at least four times per day at work for two weeks and for a similar period away from work.

Escalation of asthma treatment

- Sustained step-up: if symptoms persist despite two to three months of controller treatment; assess inhaler technique, adherence, modifiable risk factors such as smoking and co-morbid conditions such as allergic rhinitis
- Short-term step up: a one-to-two-week increase, eg. during an allergen exposure or viral illness.

De-escalation of asthma treatment

- Consider stepping down treatment once good control has been achieved and maintained for three months in order to determine the lowest treatment that still controls symptoms and exacerbation and minimises side effects
- Choose appropriate time for step-down, eg. not pregnant, no respiratory infection or no travel planned
- Step down ICS dose by 25-50% at two to three month intervals
- Document baseline status prior, monitor closely, book a follow-up visit and provide a written asthma action plan
- Do not completely stop ICS with an asthma diagnosis unless it is needed to temporarily confirm the diagnosis.

Identify and reduce exposure to risk factors

- Smoking: avoidance of passive and active smoking is the most important measure for both adults and children
- Rhinitis
- Indoor and outdoor allergens: house dust mites, animals with fur, fungi, pollen
- Obesity/reflux/foods
- Drugs: aspirin, non-steroidal anti-inflammatory drugs and beta-blocker drugs may exacerbate bronchospasm
- Flu vaccine: recommended yearly for moderate to severe asthma.

Acute asthma exacerbation

Bronchodilators – repeated administration of rapid-acting beta2-agonist: Bronchodilator therapy delivered via a metered-dose inhaler (MDI), ideally with a spacer, produces at least an equivalent improvement in lung function as the same dose delivered via a nebuliser. This route of delivery is considered the most cost-effective, provided patients are able to use an MDI.

For mild exacerbations, two to four puffs every 20 minutes for the first hour are recommended, followed by two to four puffs every three to four hours. For moderate exacerbations, two to four puffs every 20 minutes for the first hour are recommended, followed by six to 10 puffs every one or two hours.

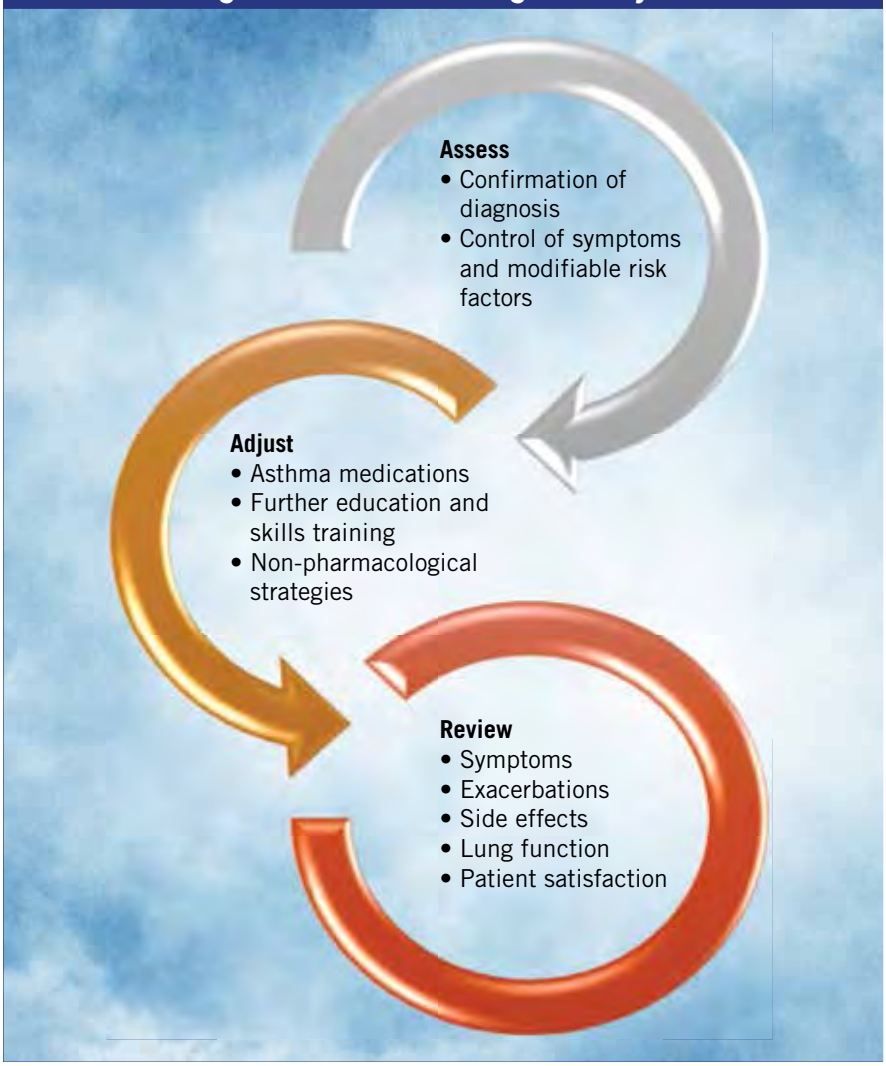
No additional medication is necessary if the rapid-acting inhaled beta2-agonist produces a complete response (FEV1 or PEF returns to > 80% of predicted or personal best) and the response lasts for three to four hours.

Glucocorticosteroids: Oral glucocorticosteroids (0.5-1mg of prednisolone/kg or equivalent during a 24-hour period) should be used to treat exacerbations, especially if they develop after instituting other short-term treatment options recommended for loss of control.

If the patient fails to respond to bronchodilator therapy, as indicated by persistent airflow obstruction, prompt transfer to an acute care setting is recommended, especially if the patient is in a high-risk group.

Patients with a severe exacerbation often present with dyspnoea at rest, can be hunched forward with an audible loud wheeze, look agitated or drowsy and confused and, usually, have a tachypnoea and tachycardia and FEV1 or PEF < 60% predicted or personal best (< 100L/min adults) or a beta2-agonist response which lasts for less than two hours. Severe exacerbations are potentially life-threatening and require close supervision.

Figure 1: Asthma management cycle



Diarmuid Glavin works in geriatric medicine (geriatric staff grade at the South West Acute Hospital, Enniskillen) and Dermot Nolan is the national clinical lead for asthma

Reference
Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention, 2019. Available from: www.ginasthma.org

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Cumann Altraí agus Ban Cabhrach na hÉireann

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INVOKANA*® (canagliflozin) 100 mg & 300 mg film-coated tablets. PRESCRIBING INFORMATION. Republic of Ireland Please refer to Summary of Product Characteristics (SmPC) before prescribing. INDICATIONS:** The treatment of adults with insufficiently controlled type 2 diabetes mellitus as an adjunct to diet and exercise as monotherapy when metformin is considered inappropriate due to intolerance or contraindications, or in addition to other medicinal products for the treatment of diabetes. **DOSAGE & ADMINISTRATION: Adults:** recommended starting dose: 100 mg once daily. In patients tolerating this dose and with eGFR ≥ 60 mL/min/1.73 m^2 needing tighter glycaemic control, dose can be increased to 300 mg once daily. For oral use, swallow whole. Caution increasing dose in patients ≥ 75 years old, with known cardiovascular disease or for whom initial canagliflozin-induced diuresis is a risk. Correct volume depletion prior to initiation. When add-on, consider lower dose of insulin or insulin secretagogue to reduce risk of hypoglycaemia. **Children:** no data available. **Elderly:** consider renal function and risk of volume depletion. **Renal impairment:** not to be initiated with eGFR < 60 mL/min/1.73 m^2. If eGFR falls below this value during treatment, adjust or maintain dose at 100 mg once daily. Discontinue if eGFR persistently < 45 mL/min/1.73 m^2. Not for use in end stage renal disease or patients on dialysis. **Hepatic impairment:** mild or moderate; no dose adjustment. Severe; not studied, not recommended. **CONTRAINDICATIONS:** Hypersensitivity to active substance or any excipient. **SPECIAL WARNINGS & PRECAUTIONS:** Not for use in type 1 diabetes. **Renal impairment:** eGFR < 60 mL/min/1.73 m^2: higher incidence of adverse reactions associated with volume depletion particularly with 300 mg dose; more events of elevated potassium; greater increases in serum creatinine and blood urea nitrogen (BUN); limit dose to 100 mg once daily and discontinue when eGFR < 45 mL/min/1.73 m^2. Not studied in severe renal impairment. Monitor renal function prior to initiation and at least annually. **Volume depletion:** caution in patients for whom a canagliflozin-induced drop in blood pressure is a risk (e.g. known cardiovascular disease, eGFR < 60 mL/min/1.73 m^2, anti-hypertensive therapy with history of hypotension, on diuretics or elderly). Not recommended with loop diuretics or in volume depleted patients. Monitor volume status and serum electrolytes. **Diabetic ketoacidosis (DKA):** rare DKA cases reported, including life-threatening and fatal. Presentation may be atypical (blood glucose <14mmol/l). Consider DKA in event of non-specific symptoms. If DKA is suspected or diagnosed, discontinue ***Invokana treatment immediately. Interrupt treatment in patients who are undergoing major surgical procedures or have acute serious medical illnesses. Monitoring of (preferably blood) ketone levels is recommended in these patients. Consider risk factors for development of DKA before initiating ***Invokana*** treatment. **Elevated haematocrit:** careful monitoring if already elevated. **Genital mycotic infections:** risk in male and female patients, particularly in those with a history of GMI. **Lower limb amputation:** Consider risk factors before initiating. Monitor patients with a higher risk of amputation events. Counsel on routine preventative foot care and adequate hydration. Consider discontinuing ***Invokana*** when events preceding amputation occur (e.g. lower-extremity skin ulcer, infection, osteomyelitis or gangrene). **Urine laboratory assessment:** glucose in urine due to mechanism of action. **Lactose intolerance:** do not use in patients with galactose intolerance, total lactase deficiency or glucose-galactose malabsorption. **Necrotising fasciitis of the perineum (Fournier's gangrene):** post-marketing cases reported with SGLT2 inhibitors. Rare but serious, patients should seek medical attention if experiencing symptoms including pain, tenderness, erythema, genital/perineal swelling, fever, malaise. If Fournier's gangrene suspected, ***Invokana*** should be discontinued, and prompt treatment instituted. **INTERACTIONS: Diuretics:** may increase risk of dehydration and hypotension. **Insulin and insulin secretagogues:** risk of hypoglycaemia; consider lower dose of insulin or insulin secretagogue. **Effects of other medicines on *Invokana*:** Enzyme inducers (e.g. St. John's wort, rifampicin, barbiturates, phenytoin, carbamazepine, ritonavir, efavirenz) may decrease exposure of canagliflozin; monitor glycaemic control. Consider dose increase to 300 mg if administered with UGT enzyme inducer. Cholestyramine may reduce canagliflozin exposure; take canagliflozin at least 1 hour before or 4-6 hours after a bile acid sequestrant. **Effects of *Invokana* on other medicines:** Monitor patients on digoxin, other cardiac glycosides, dabigatran. Inhibition of Breast Cancer Resistance Protein cannot be excluded; possible increased exposure of drugs transported by BCRP (e.g. rosuvastatin and some anti-cancer agents). **PREGNANCY:** No human data. Not recommended. **LACTATION:** Unknown if excreted in human milk. Should not be used during breast-feeding. **SIDE EFFECTS: Very common (≥1/10):** hypoglycaemia in combination with insulin or sulphonylurea, vulvovaginal candidiasis. **Common (≥1/100 to <1/10):** constipation, thirst, nausea, polyuria or pollakiuria, urinary tract infection (including pyelonephritis and urosepsis), balanitis or balanoposthitis, dyslipidemia, haematocrit increased. **Uncommon (<1/100) but potentially serious:** anaphylactic reaction, diabetic ketoacidosis, syncope, hypotension, orthostatic hypotension, urticaria, angioedema, necrotising fasciitis of the perineum (Fournier's gangrene) (frequency not known), bone fracture, renal failure (mainly in the context of volume depletion), lower limb amputations (mainly of the toe and midfoot, incidence rate of 0.63 per 100 subject-years, vs 0.34 for placebo). **Refer to SmPC for details and other side effects. LEGAL CATEGORY:** POM. **PACK SIZES & MARKETING AUTHORISATION NUMBER(S): *Invokana* 100 mg film-coated tablets:** 30 tablets; EU/1/13/884/002. ***Invokana* 300 mg film-coated tablets:** 30 tablets; EU/1/13/884/006. **MARKETING AUTHORISATION HOLDER:** Janssen-Cilag International NV, Turnhoutseweg 30, B-2340 Beerse, Belgium. ® INVOKANA is a registered trade mark of Janssen-Cilag International NV and is used under licence. © 2017 Napp Pharmaceuticals Limited. **FURTHER INFORMATION IS AVAILABLE FROM:** Mundipharma Pharmaceuticals Limited, Millbank House, Arkle Road, Sandyford, Dublin 18. For medical information enquiries, please contact medicalinformation@mundipharma.ie **IRE/INV-19401 Date of Preparation** November 2019

Adverse events should be reported to: HPRA Pharmacovigilance, Earlsfort Terrace, IRL - Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517. Website: www.hpra.ie; E-mail: medsafety@hpra.ie. Adverse events should also be reported to Mundipharma Pharmaceuticals Limited on drugsafetyJNJ@mundipharma-rd.eu or by phone on 01 2063800 (1800 991830 outside office hours).

References: 1. INVOKANA SmPC www.medicines.ie November 2019. **2.** Afkarian M, *et al. Journal of the American Society of Nephrology.* 2013;24(2):302-3082. **3.** Perkovic V. *et al. Lancet Diabetes Endocrinol.* 2018 Sep;6(9):691-704. **4.** Neal B. *et al. N Engl J Med* 2017; 377:644-657.

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INVOKANA is indicated for the treatment of adults with insufficiently controlled type 2 diabetes mellitus (T2DM) as an adjunct to diet and exercise.[1]

Improvements in renal outcomes with INVOKANA are additional benefits only and not licensed indications.

Did you know...

"Kidney disease predominantly accounts for the increased mortality observed in type 2 diabetes"[2]

Improved renal outcomes

47% relative risk reduction in time to first adjudicated nephropathy event (doubling of serum creatinine, need for renal replacement therapy, and renal death) HR 0.53 (95% CI 0.33-0.84), compared with placebo and SoC.

Absolute risk reduction: 1.3 fewer major adverse renal events per 1000 patient-years.[3]

27% reduction in the progression of albuminuria in patients with normo- or micro-albuminuria HR 0.73 (95% CI 0.67-0.79), compared with placebo and SoC.

Absolute benefit: 39.3 fewer instances of albuminuria progression per 1000 patient-years.[4]

The recommended starting dose of INVOKANA is 100mg once-daily.

SoC - *Standard of Care*

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The renal reason to intensify

Diabetes focus

Type 2 diabetes risk factors could be identified earlier in children due to genetic insight – *WIN* takes a look at some recent diabetes research

CHILDREN at high risk of developing type 2 diabetes in adulthood could be identified earlier due to new insights into the genetic factors behind the emergence of the condition. Researchers from the University of Plymouth, UK say they have pinpointed the biological and physiological factors in children that lead to the development of type 2 diabetes in adult life.

Dysfunction of the insulin-producing beta cells was found to be the earliest indicator of diabetes risk, with this factor being independent of body weight. Beta-cell dysfunction was linked to the presence of genetic factors previously associated with type 2 diabetes, according to the research.

The findings, from the EarlyBird study first published in *Diabetes Care*, involved the tracking of 300 healthy children from Plymouth over the course of 15 years to examine their risk of developing type 2 diabetes. The children were monitored from the age of five into early adulthood, with the researchers investigating how their metabolism changed during growth.

Prof Jon Pinkney, professor of endocrinology at the University, said: "The rapidly rising prevalence of type 2 diabetes is one of the biggest global health challenges and there is an urgent need to develop effective strategies for early intervention and prevention."

François-Pierre Martin, Nestlé research, who collaborated on the study, said: "This study shows that beta-cell dysfunction is an early event in the onset of prediabetes in children and that this effect is body weight independent. However, we also report that subsequent weight gain during puberty aggravates the progression from prediabetes to diabetes. This stresses the importance of lifestyle and nutritional interventions in childhood to reduce the risks to develop diabetes."

Bariatric surgery

Bariatric surgery can keep type 2 diabetes in remission for up to five years after the operation, according to research published in the journal *Diabetes/Metabolism Research and Reviews*. The study's authors concluded that bariatric surgery was associated with increased remission of diabetes and hyperlipidaemia and reduction in body weight, BMI, HbA1c and LDL-C in five-year post-surgery. The researchers looked at a population of Chinese patients who were obese or had type 2 diabetes before undergoing bariatric surgery. It was found that 66.7% of people with type 2 diabetes managed to keep their condition at bay for up to five years. In addition, the authors found the surgery was highly effective at keeping blood pressure low among 38.2% of people with hypertension. Around 60.4% of people with dyslipidaemia were also found to have achieved remission for five years.

Insulin capsule

Researchers at the Massachusetts Institute of Technology (MIT) in the US have developed a capsule that can carry an amount of insulin similar to that found in an injection. The capsule works by releasing insulin into the bloodstream via the gut when swallowed. The researchers hope this development will eventually allow patients with type 1 diabetes to avoid injecting insulin altogether.

Insulin breaks down quickly upon contact with gastric acid and this makes it challenging to develop a capsule that can survive the acidic environment of the stomach while still only releasing the insulin once it reaches the intestine. The capsule is designed with a gastric acid-resistant enteric coating and is triggered to break open once it reaches the less acidic environment of the small intestine.

When the capsule opens, it releases three folded arms coated with minuscule needles 1mm in length. These needles penetrate the top layer of the walls of the small intestine and dissolve, releasing the insulin into the blood. The timing of the capsule's arrival in the intestine, however, depends on how quickly a person digests their food and therefore this could make dosing for meals a significant challenge.

Lead author of the study Prof Robert Langer ,from the David H Koch Institute at MIT, said: "We are really pleased with the latest results of the new oral delivery device our lab members have developed with our collaborators, and we are looking forward to hopefully seeing it help people with diabetes and others in the future."

New form of insulin

Using a novel glycosylation technique, researchers at the Florey Institute of Neuroscience and Mental Health have successfully synthesised an insulin analogue called glycoinsulin that demonstrates the same glucose-lowering effects as native insulin in preclinical studies without fibril formation.

According to the researchers, whose findings were published recently in the *Journal of the American Chemical Society,* glycoinsulin could prevent the formation of fibrils and improve the delivery of insulin for patients who rely on pump infusions.

Although considered a more convenient form of insulin delivery than a pen or injection, insulin pumps can still experience problems; blockages in the insulin delivery line represent a common issue with these pumps. The fibrils that the researchers set out to prevent the formation of are among the main causes of insulin pump blockages. They can impede the normal delivery of insulin and lead to under-dosing.

Akhter Hossain, associate professor at the Florey Institute, said: "Not only did our research demonstrate that glycoinsulin does not form fibrils, even at high temperature and concentration, but also that it is more stable in human serum than native insulin.

"Together these findings could position glycoinsulin as an excellent candidate for use in insulin pumps and a way to improve the shelf life of insulin products.

"We now hope to streamline the manufacturing process for glycoinsulin so this compound can be further investigated in larger clinical studies."

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If the interval between doses exceeds 8 weeks, the second dose should be given as soon as possible. **CONTRAINDICATIONS** History of hypersensitivity to any varicella vaccine, to any of the excipients or to gelatin or neomycin. Blood dyscrasias, leukaemia, lymphomas of any type, or other malignant neoplasms affecting the hemic or lymphatic systems. Individuals receiving immunosuppressive therapy. Severe humoral or cellular immunodeficiency. Individuals with a family history of congenital or hereditary immunodeficiency unless immune competence has been demonstrated. Active untreated tuberculosis. Any illness with fever >38.5°C. Pregnancy. Furthermore, pregnancy should be avoided for 1 month following vaccination. **PRECAUTIONS AND WARNINGS** Appropriate medical treatment and supervision should always be available in the rare event of anaphylaxis. Vaccine recipients should avoid salicylates for 6 weeks after vaccination. Vaccination may be considered in patients with selected immune deficiencies where the benefits outweigh the risks. Immunocompromised patients who have no contraindication for this vaccination may not respond as well as immunocompetent subjects; therefore, some of these patients may acquire varicella in case of contact, despite appropriate vaccine administration. These patients should be monitored carefully for signs of varicella. Transmission of the vaccine virus may rarely occur between healthy vaccinees who develop or do not develop a varicella-like rash and healthy susceptible contacts, pregnant contacts and immunosuppressed contacts. Vaccine recipients should therefore avoid close association with susceptible high-risk individuals for up to 6 weeks after vaccination. If varicella vaccine (live) (Oka/Merck strain) is not given concomitantly with measles, mumps, and rubella virus vaccine live, a 1-month interval between the 2 live virus vaccines should be observed. **PREGNANCY AND LACTATION** Pregnant women should not be vaccinated with VARIVAX. Studies have not been conducted with VARIVAX in pregnant women. However, foetal damage has not been documented when varicella vaccines have been given to pregnant women. It is not known whether VARIVAX can cause foetal harm when administered to a pregnant woman or can affect reproduction capacity. Pregnancy should be avoided for 1 month following vaccination. Women who intend to become pregnant should be advised to delay. VARIVAX is not generally recommended for breastfeeding mothers. **SIDE EFFECTS Healthy individuals 12 months to 12 years of age (1 dose):** Very common side effects: Fever. Common side effects: Upper respiratory infection, rash, measles /rubella-like rash, varicella-like rash (generalised median 5 lesions), injection site erythema, rash, pain/tenderness/soreness, swelling and varicella-like rash (injection site median 2 lesions), irritability. **Healthy individuals 12 months to 12 years of age (2 doses received ≥ 3 months apart):** The following serious side effects temporally associated with the vaccination were reported in individuals 12 months to 12 years of age given varicella vaccine (live) (Oka/Merck strain): Diarrhoea, febrile seizure, fever, post-infectious arthritis, vomiting. **Healthy individuals 13 years of age and older (majority received 2 doses 4 to 8 weeks apart):** Very common side effects: Fever ≥ 37.7°C oral, injection-site erythema, soreness and swelling. Common side effects: varicella-like rash (generalised median 5 lesions), injection-site rash, pruritus and varicella-like rash (injection site median 2 lesions). Other reported adverse events (during post-marketing surveillance) that may potentially be serious include thrombocytopenia, pneumonia, encephalitis, anaphylaxis, cerebrovascular accident, febrile and non-febrile convulsions, Guillain-Barré syndrome, transverse myelitis, ataxia, Stevens-Johnson syndrome, erythema multiforme Henoch-Schönlein purpura and herpes zoster. Varicella (vaccine strain) has been reported during marketed use of the vaccine. The vaccine virus may rarely be transmitted to contacts of vaccinees who develop or do not develop a varicella-like rash. Complications of varicella from vaccine strain, including herpes zoster and disseminated disease such as aseptic meningitis and encephalitis, have been reported in immunocompromised or immunocompetent individuals. Necrotizing retinitis has been reported post-marketing in immunocompromised individuals. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **PACKAGE QUANTITIES** Single vial of vaccine and prefilled syringe of diluent with two unattached needles. **Legal category:** POM **Marketing authorisation number:** PA 1286/057/001 **Marketing Authorisation holder:** Merck Sharp & Dohme Ireland (Human Health) Limited, Red Oak North, South County Business Park, Leopardstown, Dublin 18, Ireland. **Date of revision:** November 2018. Further information is available on request from: MSD, Red Oak North, South County Business Park, Leopardstown, Dublin 18 D18 X5K7 or from www.medicines.ie. Date of Preparation: March 2020.

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Focus on: Varicella zoster virus

VARICELLA (chickenpox) is an acute infectious disease caused by varicella-zoster virus. It causes a blister-like rash, itching, tiredness and fever. Only hospitalised varicella cases are notifiable in Ireland.

Symptoms

Individuals incubating varicella may have a temperature and feel non-specifically unwell in the one to two days before rash onset. In children, rash is often the first sign of the disease.

The rash starts off as red spots that typically develop into small fluid-filled blisters (vesicles) that then crust over before healing. The rash usually appears on the head and then the trunk, followed by the arms or legs. Successive crops appear over several days.

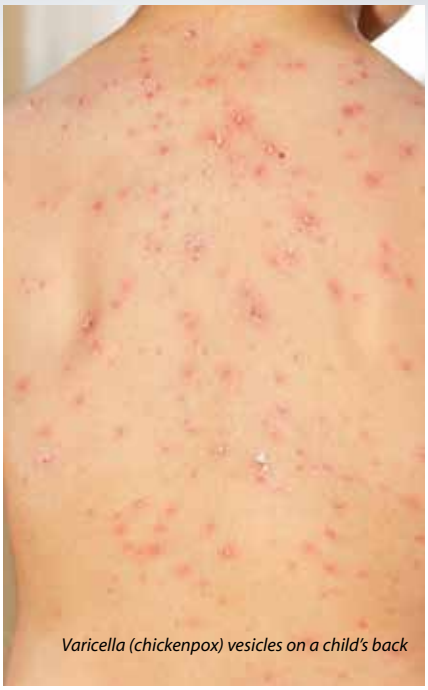
The clinical course is generally mild in healthy children with malaise, itching and temperature for two to three days. Adults and children with immunocompromising conditions are more likely to have severe disease and more complications.

Varicella-zoster virus is spread through the respiratory tract (airborne droplet) and direct contact or inhalation of aerosols from vesicular lesions of acute varicella or zoster with skin lesions.

The incubation period of the virus, to the development of the typical rash, is from 14-16 days (range 10-21 days). The incubation period may be prolonged in immunocompromised individuals or those who have received immunoglobulin with antibodies to varicella zoster.

Transmission

Varicella is highly infectious – less contagious than measles but more than rubella or mumps. Secondary attack rates among non-immune household contacts can be as high as 90%. Individuals with varicella infection are most infectious for one to two days before rash onset through to the first four to five days or until the lesions have formed crusts. Shingles is less infectious.



Varicella (chickenpox) vesicles on a child's back

Complications

The risk of complications from varicella varies with age. Complications are infrequent among healthy children but occur much more frequently in those older than 15 years of age and infants younger than one year of age. Most commonly reported complications include:

- Secondary bacterial infection of skin lesions
- Pneumonia (viral or secondary bacterial)
- Neurological complications include meningitis, encephalitis (1.8/100,000 cases)

Death-rate varies by age group and immunologic status

- 1/100,000 among children one to 14 years of age
- 2.7/100,000 among individuals 15 to 19 years of age
- 25.2/100,000 among adults who are aged from 30 to 49.

Varicella in pregnancy

Infection with varicella in the first 20 weeks of pregnancy can cause a variety of abnormalities in the foetus, including: low birth weight, underdevelopment of limbs, skin scarring, poor development of localised muscles, brain abnormality. The mortality rate ranges from 1-2%.

Maternal varicella infection from five days before to two days after delivery may result in overwhelming infection in the infant and a fatality rate as high as 30%. This severe disease is believed to result from foetal exposure to varicella virus without the benefit of passive maternal antibody.

Diagnosis

Varicella zoster infection can usually be diagnosed based on clinical presentation (typical rash). Laboratory diagnosis is sometimes sought to confirm diagnosis. The virus can be demonstrated in vesicular fluid in chickenpox and shingles lesions. Serology tests are available and can be used to demonstrate immunity.

Prevention

Varicella infection is prevented using a live attenuated vaccine or varicella zoster immunoglobulin (VZIG). Two doses of varicella vaccine are recommended in both children and adults in specific risk groups, including non-immune healthcare workers, laboratory staff at risk of exposure, household contacts of immunocompromised patients, children in residential units for severe disability and non-immune women of child-bearing age.

Under specialist hospital supervision and protocols, certain categories of immunocompromised patients may be vaccinated.

All women of childbearing age without a history of varicella infection should have their immunity checked. Women with negative serology should be vaccinated prior to pregnancy, if no contraindications exist. Pregnancy should be avoided for three months following the last dose of varicella vaccine.

See the HSE's immunisation guidelines for more specific information on varicella vaccination at: **www.hse.ie**

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Date of preparation: October 2019
Job code: EN/3.2kcal.005.19

Improving nutritional care in acute settings

Carmel O'Hanlon and **Barbara Gillman** discuss the importance of improving outcomes in nutritional care in acute care settings

IMPROVING nutritional care in the acute care setting was featured in the HSE symposium at the Federation of European Nutrition Society conference, which took place in Dublin in late 2019. Two key quality improvement initiatives relevant to all acute hospitals were highlighted. Both initiatives will result in significant improvements to service users.

- A National Clinical Guideline (NCG) on nutrition screening and use of oral nutrition support for adults in the acute care setting[1] (due to be published early this year), outlines a strategy to identify inpatients at risk of malnutrition, together with prevention and treatment of malnutrition risk
- The Food Nutrition and Hydration Policy (FNHP) for Adult Patients in Acute Hospitals (HSE, 2018)[2] provides a framework for a standardised patient-centred approach to providing food and nutritional care to hospitalised adults.

What do we know about malnutrition?

We know that one in three patients admitted to Irish hospitals are at risk of malnutrition, with 74% of these being at high risk. This is based on two major studies conducted in 27 Irish hospitals in 2010[3] and 2011.[4] Malnutrition risk was common in all age groups and increased with age. Malnutrition was seen in patients with all types of diagnoses and in both men and women.

We know that inpatients with malnutrition spend an estimated 30% longer in hospital compared with patients not at risk, have more complications such as infections and delayed wound healing, and are more likely to be re-admitted once discharged home.[5] Risk of dying is also significantly higher in patients who are malnourished compared with patients who are not.

Table 1: Care pathways available in the NCG and FNHP

Titles
• Care pathway for identification of food, nutrition and hydration need on admission to acute hospitals
• HSE malnutrition risk management pathway for hospitalised adults
• Inpatient malnutrition risk screening and treatment pathway
• Inpatient malnutrition risk and dysphagia pathway

We know that malnutrition is associated with increased costs. It is estimated that the yearly public healthcare cost of disease-related malnutrition in Ireland is €1.42 billion, or more than 10% of the total annual healthcare budget.[6] Acute care costs account for over 60% of this total.

We know that intervening is both cost effective and improves outcomes.[7] Left untreated, approximately two-thirds of patients with risk of malnutrition will experience a further decline in their nutritional status during their inpatient stay.[8]

What are we doing about this?

Prevention of malnutrition by establishing risk as early as possible is essential to avoid adverse consequences and reduce costs. An objective of the NCG is the early identification of malnutrition risk in hospitalised adult patients through nutrition screening. This must be followed by the provision of timely and appropriate nutrition support to those patients who are malnourished or identified as at risk of malnutrition. Nutrition screening for malnutrition is a key recommendation in the FNHP: "All patients on admission should be screened. Screening should be repeated weekly for inpatients".

To select the most suitable nutrition screening tool (NST) for Irish hospitals, a systematic review of the evidence was undertaken by the Health Research Board-Collaboration in Ireland for Clinical Effectiveness Reviews (HRB-CICER),[9] on behalf of the NCG Guideline Development Group (GDG). Results showed that the most studied NSTs for hospitalised adults were MUST[10] (Malnutrition Universal Screening Tool) and NRS-2002[11] (Nutrition Risk Score). However, no ideal single NST emerged from this review.

Table 2: Oral nutrition support methods*

• Diet
• Dietary counselling/advice
• Food fortification
• Oral nutritional supplements
• Snacks
**listed alphabetically*

The results were considered by the GDG and were used to inform an evidence-to-decision process to determine the NST(s) which could provide the best fit for Irish hospitals. Taking into consideration a number of factors, the GDG selected MST[12] (Malnutrition Screening Tool) and MUST as the two tools for use in general medical and surgical adult patients in Irish hospitals.

Choosing a nutrition screening tool to screen for malnutrition risk is only the first step in the nutrition care process for each patient. Where risk of malnutrition is identified, nutrition assessment and intervention is needed.

Both the NCG and the FNHP outline key elements of prevention and treatment strategies that relate to oral nutrition support. A range of prevention and treatment options is presented in the NCG and the FNHP care pathways. Implicit in implementing these pathways is the importance of a multidisciplinary team approach to the nutritional management of patients in acute care.

Enteral tube feeding and parenteral nutrition are other key nutrition support strategies that are not covered by the current NCG or the FNHP, but may be the focus of future guidelines.

How can we treat malnutrition and risk of malnutrition?

Both the NCG and FNHP highlight the importance of oral nutrition support to treat those patients identified as at risk of malnutrition; see *Table 2* for types of support covered. The FNHP also provides nutrition standards for diets and snacks. It recommends that hospitals promote and maintain an environment that is conducive to people eating their meals and having appropriate levels of assistance to safely consume optimal amounts of food and drink.

The strongest evidence for use of oral nutrition support in malnourished hospitalised patients, or those at risk of malnutrition, comes from studies conducted with Oral Nutritional Supplements (ONS). This is described in the NCG and supported by evidence tables developed by HRB-CICER[13] that build on previously developed NICE evidence tables.[14] The evidence behind other forms of oral nutrition support is also outlined in the NCG. For instance, dietary counselling has shown benefit and is recommended for older people or patients with cancer, at risk of malnutrition.[15,16,17]

Food fortification is recognised as a method of increasing energy and protein intakes in patients at risk of malnutrition and is recommended by the European Society for Clinical Nutrition and Metabolism (ESPEN).[16,17,18] A combination of strategies is usual in clinical practice.

Recommendations for the NCG were adapted from NICE Clinical Guideline 32[19] using the formal ADAPTE process.[20] Related recommendations in the FNHP are aligned with the NCG.

The ideal duration of oral nutrition support provision is largely unknown, but is likely influenced by patient-specific and condition-dependent factors and should be based on ongoing monitoring.[21] Both the NCG and FNHP give recommendations for discharging patients to the community on oral nutrition support.

What about implementation?

An implementation plan is provided in the NCG that also applies to the FNHP. This includes:

- An education framework to support implementation
- Annual malnutrition awareness days
- A self-assessment tool for hospitals to facilitate local audit
- An outline of staff roles and responsibilities (similar to FNHP)
- Provision of pathways to aid implementation
- A service-user version of the guideline
- A summary of the main guideline for hospital staff
- A budget impact analysis (BIA) that outlines the additional resources and costs for the healthcare system with full implementation of the guideline
- An outline of relevant national key performance indicators and the need for national oversight.

A separate toolkit is provided to support implementation of the FNHP.[22] Tools encompass:

- Identification of food, nutrition and hydration needs on admission to hospital – including checklist
- Menu planning guidance to implement the nutrition standards, including standard portions, sample meal plans, and a sample hydration plan. This includes regular diet and energy dense diet menu planning guidance
- Food-based menu planning guidance for texture modified diets
- Making mealtimes matter tools, including a 'special assistance at mealtimes' checklist for patients with compromised function and a supporting poster
- Audit tools
- Patient information leaflets.

The BIA that accompanies the NCG23 demonstrates that the guideline implementation has the potential to produce an annual net cost saving of €24 million, largely due to improvements in bed capacity in acute hospitals.

Carmel O'Hanlon is a clinical specialist dietitian at Beaumont Hospital and Barbara Gillman is a clinical specialist dietitian at the Mater Hospital

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Breastfeeding: The best start

Health benefits for infants

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

Long-term benefits for children

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

Benefits for mothers

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

Support for mothers is essential

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

Work and breastfeeding

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

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The Irish Nurses and Midwives Organisation supports breastfeeding

For more information log onto www.breastfeeding.ie

Research focus

This month we take a look at some new findings from recent research in the area of gastroenterology

Diarrhoea-causing bacteria has adapted to spread in hospitals

Scientists have discovered that the gut-infecting bacterium *Clostridium difficile* is evolving into two separate species, with one group highly adapted to spread in hospitals. Researchers at the Wellcome Sanger Institute at the London School of Hygiene and Tropical Medicine and collaborators identified genetic changes in the newly emerging species that allow it to thrive on the Western sugar-rich diet, evade common hospital disinfectants and spread easily. Able to cause debilitating diarrhoea, they estimated this emerging species started to appear thousands of years ago, and accounts for over two-thirds of healthcare *C. difficile* infections.

Published in *Nature Genetics*, the largest ever genomic study of *C. difficile* shows how bacteria can evolve into a new species, and demonstrates that *C. difficile* is continuing to evolve in response to human behaviour. The results could help inform patient diet and infection control in hospitals.

C. difficile bacteria can infect the gut and are the leading cause of antibiotic-associated diarrhoea worldwide. While someone is healthy and not taking antibiotics, millions of 'good' bacteria in the gut keep the *C. difficil*e under control. However, antibiotics wipe out the normal gut bacteria, leaving the patient vulnerable to *C. difficile* infection in the gut. This is then difficult to treat and can cause bowel inflammation and severe diarrhoea.

Often found in hospital environments, *C. difficile* forms resistant spores that allow it to remain on surfaces and spread easily between people, causing a significant burden on the healthcare system. To understand how this bacterium is evolving, researchers collected and cultured 906 strains of *C. difficile* isolated from humans, animals, such as dogs, pigs and horses, and the environment. By sequencing the DNA of each strain, and comparing and analysing all the genomes, the Wellcome Sanger Institute researchers discovered that *C. difficile* is currently evolving into two separate species.

"Our large-scale genetic analysis allowed us to discover that *C. difficile* is currently forming a new species with one group specialised to spread in hospital environments. This emerging species has existed for thousands of years, but this is the first time anyone has studied *C. difficile* genomes in this way to identify it. This particular bacteria was primed to take advantage of modern healthcare practices and human diets, before hospitals even existed," said Dr Nitin Kumar, joint first author from the Wellcome Sanger Institute.

The researchers found that this emerging species, named *C. difficile* clade A, made up approximately 70% of the samples from hospital patients. It had changes in genes that metabolise simple sugars. They then studied *C. difficile* in mice, and found that the newly emerging strains colonised mice better when their diet was enriched with sugar. It had also evolved differences in the genes involved in forming spores, giving much greater resistance to common hospital disinfectants. These changes allow it to spread more easily in healthcare environments.

Dating analysis revealed that while *C. difficile* clade A first appeared about 76,000 years ago, the number of different strains of this started to increase at the end of the 16th century, before the founding of modern hospitals. This group has since thrived in hospital settings with many strains that keep adapting and evolving.

"Our study provides genome and laboratory-based evidence that human lifestyles can drive bacteria to form new species so they can spread more effectively. We show that strains of *C. difficile* bacteria have continued to evolve in response to modern diets and healthcare systems and reveal that focusing on diet and looking for new disinfectants could help in the fight against this bacteria," said Dr Trevor Lawley, the senior author from the Wellcome Sanger Institute.

"This largest ever collection and analysis of *C. difficile* whole genomes, from 33 countries worldwide, gives us a whole new understanding of bacterial evolution. It reveals the importance

of genomic surveillance of bacteria. Ultimately, this could help understand how other dangerous pathogens evolve by adapting to changes in human lifestyles and healthcare regimes which could then inform healthcare policies," said Prof Brendan Wren, an author from the London School of Hygiene and Tropical Medicine.

– DOI: 10.1038/s41588-019-0478-8

Benefits of cognitive behavioural therapy for IBS continue two years after treatment

Irritable bowel syndrome (IBS) is a common gastrointestinal disorder affecting as many as 10-20% people around the world. The associated abdominal pain, bloating and altered bowel habit significantly affect a patient's quality of life and can force them to take days off work at a time.

Previous research (the ACTIB trial) led by Prof Hazel Everitt at the University of Southampton in collaboration with researchers at King's College London, showed that cognitive behavioural therapy (CBT) tailored specifically for IBS and delivered over the telephone or through an interactive website is more effective in relieving the symptoms of IBS than current standard care one year after treatment.

This 24-month follow-up research published recently in *Lancet Gastroenterology and Hepatology* has shown that benefits continue two years after treatment despite patients having no further therapy after the initial CBT course. These results are important as previously there was uncertainty whether the initial benefits could be sustained in the long term.

Currently, there is limited availability of CBT for IBS in resource-constrained health services but this research indicates that easily accessible treatment could be provided to a large number of patients and provide them with effective, long-term relief.

"The fact that both telephone and web-based CBT sessions were shown to be effective treatments is a really important and exciting discovery. Patients are able to undertake these treatments at a time convenient to them, without having to travel to clinics and we now know that the benefits can last long term," Prof Everitt said.

The study was funded by the Health Technology and Assessment Programme of the National Institute for Health Research (NIHR).

– DOI: 10.1016/S2468-1253(19)30243-2

Combination therapy advisable for bowel disorder IBS

The more abnormalities in intestinal and brain function that those with IBS have, the more severe their symptoms of this functional bowel disorder, and the more adversely their everyday life is affected. This was the finding from a study at the Sahlgrenska Academy at the University of Gothenburg, Sweden. The researchers believe that their findings indicate that patients with IBS should get treatments for different abnormalities simultaneously, to improve both bowel function and signalling from the brain to the gut.

IBS is very common. Diagnostic criteria for an IBS diagnosis include abdominal pain, constipation or diarrhoea, and irregular bowel activity over a long period. The underlying causes are not entirely known, but abnormalities both locally in the intestines and in the central nervous system are thought to be implicated.

Currently, there is no available treatment to cure IBS, but its symptoms can be alleviated. There are drugs that can improve intestinal function in various ways, and in some cases brain-directed therapy is also given.

"There are studies showing that hypnosis, cognitive behavioural therapy and antidepressants can all have an effect against IBS. The view of the gut and brain working together in IBS is beginning to be increasingly accepted, so many gastroenterology clinics are striving to work holistically, in multiprofessional teams, to manage their IBS patients," says Prof Magnus Simrén of Sahlgrenska Academy, who led the work on the new study.

The study, published in the journal *Gastroenterology*, comprised 400 people with IBS and also healthy controls. The scientists measured intestinal abnormalities relating to sensitivity and motility, and the study participants were asked to reply to a questionnaire to capture signs of abnormal functioning of the central nervous system.

"We investigated several abnormalities at various levels in the nerves that connect the intestines and the brain, which is known as the 'gut-brain axis'. The questionnaires used are established for demonstrating incidence of anxiety and depression, which in our study served as a marker for abnormal functioning in the central nervous system," said Prof Simrén.

The study shows that the people who had many different abnormalities considered to have a bearing on the symptoms of IBS, in both the gastrointestinal tract and the brain, were also those patients who reported the most severe symptoms and experienced the lowest quality of life. The association was linear: as the number of abnormalities rose, a gradual worsening in symptom severity was also observed.

"In the study, it's striking how the burden of disease increases successively the more abnormalities the patient has. This means that we must probably focus the treatment on several of these at the same time to get a better effect. So this implies that a combination of different treatments tackling factors in the gut and the brain can have a positive effect. But this hypothesis must be investigated in clinical trials first," Prof Simrén added.

The study was a collaboration among some of the world's leading IBS researchers, at Sweden's University of Gothenburg, Belgium's Catholic University of Leuven, and the University of North Carolina at Chapel Hill in the US.

– DOI: https://doi.org/10.1053/j.gastro.2019.04.019

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Buscopan® 10mg Coated Tablets Product Information
Presentation: Tablets containing hyoscine butylbromide 10mg. **Indications:** Relief of spasm of the gastrointestinal tract and for the symptomatic relief of Irritable Bowel Syndrome. **Dosage and administration:** For spasm of the gastrointestinal tract: adults and children over 12 years: 2 tablets four times daily. For Irritable Bowel Syndrome: initially 1 tablet three times daily, increasing if necessary to 2 tablets four times a day. **Contraindications:** hypersensitivity to any component, myasthenia gravis, mechanical stenosis in the gastrointestinal tract, paralytical or obstructive ileus, megacolon, narrow angle glaucoma. **Warnings and precautions:** In case severe, unexplained abdominal pain persists or worsens, or occurs together with symptoms like fever, nausea, vomiting, changes in bowel movements, abdominal tenderness, decreased blood pressure, fainting or blood in stool, medical advice should be sought immediately. Buscopan should not be taken for extended periods without investigating the cause of abdominal pain. Use with caution in conditions characterised by tachycardia; those susceptible to intestinal or urinary outlet obstruction; pyrexia. Warn patients to seek medical advice if they develop a painful red eye with loss of vision whilst or after taking Buscopan 10mg Coated Tablets. Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take Buscopan 10mg Coated Tablets since the tablet coat contains sucrose. Advise patients to consult their doctor before taking if: this is the first time they have symptoms of IBS, age over 40 years and some time since the last attack of IBS or the symptoms are different; recent rectal bleeding; severe constipation; nausea or vomiting; loss of appetite or weight; difficulty or pain passing urine; fever; recent travel abroad. Advise patients to consult their doctor if they develop new symptoms, or if symptoms worsen, or if they do not improve after 2 weeks of treatment. **Interactions:** The anticholinergic effect of drugs, e.g. tri- and tetracyclic antidepressants, antihistamines, quinidine, amantadine, antipsychotics (e.g. butyrophenones, phenothiazines), disopyramide and other anticholinergics (e.g. tiotropium, ipratropium, atropine-like compounds) may be intensified by Buscopan 10mg Coated Tablets. Co-administration with a dopamine antagonist may diminish the effect of both medicines. The tachycardic effects of beta-adrenergic agents may be enhanced by Buscopan 10mg Coated Tablets. **Pregnancy and lactation:** Use during pregnancy and breastfeeding is not recommended. **Side effects:** Uncommon: dry mouth, tachycardia, skin reactions (e.g. urticaria, pruritus), dyshidrosis, constipation. Rare: urinary retention. Not known: anaphylactic shock, anaphylactic reactions, dyspnoea, rash, erythema, other hypersensitivity, visual accommodation disturbances. **Pack sizes:** 20 and 40. **Legal category:** P. **Product authorisation number:** PA 540/181/2. **Product authorisation holder:** sanofi-aventis Ireland Ltd., Citywest Business Campus, Dublin 24, Ireland. Tel 01403 5600, email: IEmedinfo@sanofi.com. For further information please see Summary of Product Characteristics. **Date of revision:** January 2020.
Adverse events should be reported. Reporting forms and information can be found at www.hpra.ie. Adverse events should also be reported to Sanofi Ireland Ltd. on 01403 5600 or email IEPharmacovigilance@Sanofi.com

1: IMS data - April 2019

SAIE.BUSC.17.11.0234(2) - February 2020

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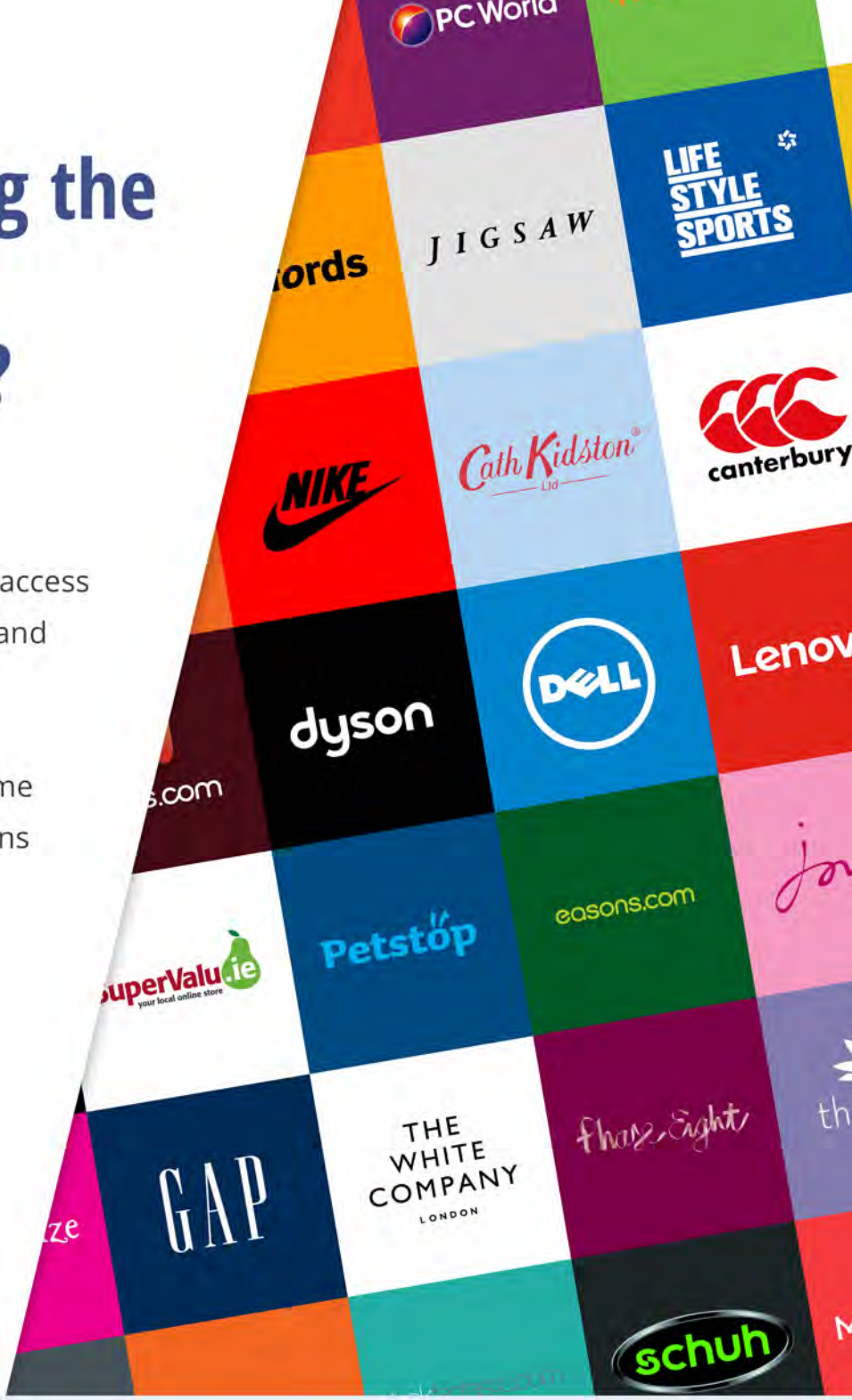

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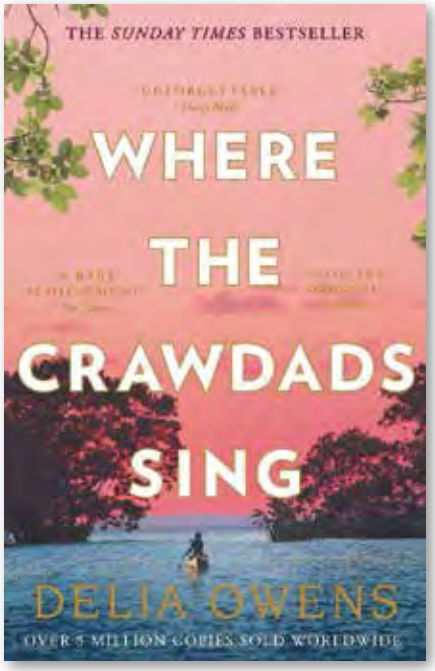
Survival of the marsh girl

DELIA Owens is the co-author of three best-selling nonfiction books about her life as a wildlife scientist. Her expertise in wildlife has heavily influenced the backdrop to her first novel *Where the Crawdads Sing* which is set deep in the marshland of North Carolina in the American south.

We first meet the central character Kya Clark as a young child in the 1940s. The youngest of her siblings by some distance, she lives with her family in an isolated shack out in the marsh near a town called Barkely Cove. Early on, her beloved mother abandons the family home and is soon followed by each of the older siblings in turn, leaving Kya at the mercy of her neglectful, abusive and drunken father.

Driven by the need to survive, Kya learns to look after herself, how to stretch the meagre rations her father leaves her, and later how to survive alone in the marsh when he too disappears. Left alone she does not attend school, instead taking to the marsh every day. The locals largely look down at her. Naming her 'the marsh girl', she is treated with suspicion on the occasions she comes to town. However, a small but important few show her kindness and friendship, thus ensuring her survival.



As Kya grows and learns more about life through her interactions with the flora and fauna of the marshlands, two young men enter her life. First Tate, who teaches her to read, shows her acceptance and happiness, but also hurts her deeply. Later, Chase brings her hope of a future but is it sincere as he keeps their relationship hidden from those in town?

When Chase is found dead rumours abound as to motive and possible suspects. Was it the marsh girl? Could she be his killer? This question is at the very crux of the novel and makes you alternatively question your own and the townspeople's bias.

This book is beautifully written. The language is poetic and offers evocative descriptions of the marsh land, especially of its many birds on which Kya is an expert. While it leans toward a slower pace this lends itself to the setting of the story.

There is so much at stake for this beautiful soul that you will be turning pages regardless.

– Alison Moore

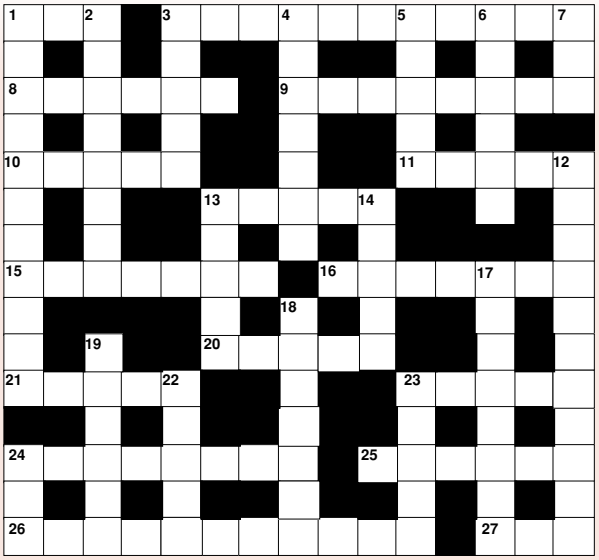
Where the Crawdads Sing by Delia Owens is published by Corsair ISBN-13: 978-1472154668 RRP €12.99

CROSSWORD Competition

WIN a €50 gift voucher

Across
1 Wicked (3)
3 Rip latchkey asunder, causing a cutaneous eruption (7,4)
8 Cooking directions (6)
9 Popular card game (3,5)
10 Islamic method of slaughter involving hot aluminium (twice) (5)
11 Air-filled cavity in the skull associated with the nose (5)
13 Get Fr Crilly back an bovine type for a thorough clean out! (5)
15 Produced without the use of chemicals (7)
16 Bird of prey that nests in farm buildings (4,3)
20 Use these to achieve efficient driving (5)
21 Serious injury (5)
23 Measure how heavy something is (5)
24 Sligo boxes identify an ancient Greek philosopher (8)
25 One embraced by a bird to get a drug (6)
26 Regalia (5,6)
27 Organ of sight (3)

Down
1 What bloomer might this apostle provide? (11)
2 Young waddling bird (8)
3 & 19d Legate from the Vatican (5,6)
4 Such youngsters just swan about (7)
5 World War I battle featuring in one's history presentation (5)
6 White fur (6)
7 The longest river in Scotland (3)
12 There's little alteration in one's loose coins (5,6)
13 Performing (5)
14 Diagnostic images (1-4)
17 Creature that eats both meat and vegetable food (8)
18 Cutting tool the group espied (7)
19 See 3 down
22 Waste water channel (5)
23 Breaking news about the right birds (5)
24 It holds fluid within the body (some are cysts, initially) (3)



March crossword solution

Across: 1 Laparotomy 6 Slap 10 Dread 11 Exchequer 12 Widower 15 Yahoo 17 Epic 18 Hair 19 Libya 21 Riposte 23 Manse 24 Dove 26 Fauna 28 Lambada 33 Cochineal 34 Idyll 35 Dirk 36 Brent geese
Down 1d& 5a Lady Gaga 2 Precision 3 Rodeo 4 Theme 5 Mace 7&29d Lough Allen 8&27d Perforated ulcer 9 Recycle 13 Wadi 14 Removal 16 Shamefaced 20 Blood type 21 Regalia 22 Tuam 30 Bling

The winner of the March crossword is: Teresa McCarthy Leixlip, Co Kildare

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: Monday, April 20, 2020
If preferred you can post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin, A96E096

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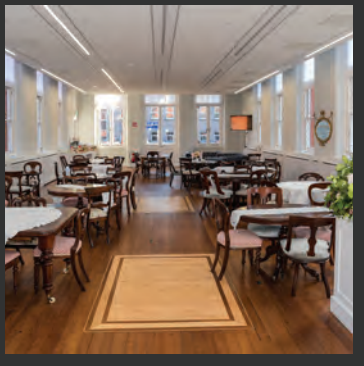

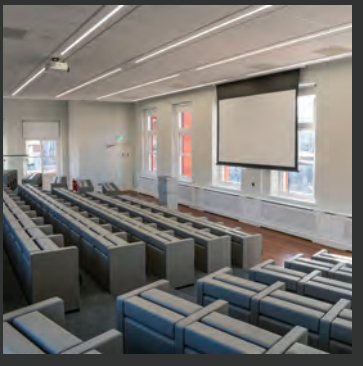

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WIT to collaborate on ID nursing with prestigious US college

THE Waterford Institute of Technology (WIT) has signed a memorandum of understanding to work in the field of intellectual disability nursing alongside the Golisano Institute for Developmental Disability Nursing, St John Fisher College in the US.

The signing took place on February 20, 2020 at a symposium on intellectual disability nursing at WIT and will see faculty members from WIT's intellectual disability nursing programme visit St John Fisher College on an exchange basis to offer guidance in curriculum development and to share best practices in creating models of inclusive nursing care.

Dr Sara Kennedy, head of the Department of Nursing and Healthcare, WIT, said: "This marks a hugely significant collaboration between WIT and St John Fisher College. Intellectual disability is a multi-pronged, complex issue and through collaboration between the organisations we hope to further the treatment and understand the unique needs of people with intellectual disability. We are honoured to play a part in the transformation of the nursing domain of training, care and support for people with developmental and intellectual disabilities in the US."

Pictured were (standing, l-r): Dr Sara Kennedy, head of the Department of Nursing and Healthcare, WIT; Dr Richard Hayes, vice president for strategy, WIT; Dr Michael Harrison, head of Department of Sport and Exercise Science, WIT; Prof John Nolan, Nutrition Research Centre, WIT; Ann Costello, Golisano Foundation; Prof John Wells, Head of School of Health Sciences, WIT; and Dr Dianne Miner, dean of the Wegmans School of Nursing, St John Fisher College; (seated, l-r): Jim Moore, chairperson of the governing body, WIT; and Gerard Rooney, president of St John Fisher College

ICN urges action to reduce occupational risks to nurses caring for Covid-19 patients

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Their meeting followed the news that a number of nurses around the world have recently died from as a result of the virus.

Ms Kennedy said: "It is with great sorrow that we have heard of the deaths of nurses working with Covid-19 patients. Nursing has always contained an element of selflessness, and it has never been without risk, but it is particularly saddening to hear that nurses have lost their lives in the line of duty at this time of crisis.

"Despite these deaths, that spirit of selflessness continues, and all around the world nurses are carrying on their vital work caring for patients, regardless of the very real personal risks they face.

"As the global voice of nursing, the ICN sends its condolences and best wishes to the families and loved ones of nurses who have made the ultimate sacrifice in their efforts to do their best to help others."

Unacceptable

The ICN says it will continue to urge governments and organisations to fulfil their obligations to protect nurses and other healthcare staff. It says there are still reports of shortages of personal protective equipment, and that this is unacceptable.

ICN CEO Howard Catton said: "The ICN has been vocal from the very beginning of the Covid-19 crisis, calling for governments to prioritise the support of nurses and ensure that essential personal protective equipment and psychological support is being provided.

"Myself and our president personally raised the issue with the WHO director general and we have continued to support the WHO in getting the message out to both governments and the public through the media and other channels."

Perinatal mental health app for healthcare staff

A NEW app has been launched to assist healthcare staff in the area of perinatal mental health. It is aimed at providing information on perinatal mental health problems, teams providing services and information and contacts for related areas.

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For privacy reasons ,the app does not store personal information and is not available through traditional app stores.

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Patient groups come together to demand action on rare diseases

TO MARK Rare Diseases Day on February 29, several patient groups collaborated to publish a document urging the government to fully implement the National Rare Diseases Plan, increase the number of rare diseases that are screened for in Ireland and appoint an additional 11 consultant geneticists to tackle growing waiting lists.

An Easyguide to Rare Diseases and Consensus for Action, launched in the presence of Minister for Health Simon Harris at Mansion House on February 29, outlines the 10 priorities identified by Rare Diseases Ireland (RDI), Health Research Charities Ireland (HRCI) and the Irish Platform for Patient Organisations, Science and Industry (IPPOSI):

- The extension of the newborn screening programme to more than double the number of rare diseases screened from eight to a minimum of 20 in the short-term to enable treatment at birth and to avoid unnecessary delays in care
- Adequate staffing for genetic diagnostics and counselling. International standards determine that Ireland needs 15 consultant geneticists for the population. Currently Ireland has just four such consultants. Likewise Ireland currently has only five genetic counsellors as opposed to the recommended 38 for the population of 4.8 million
- The full implementation of the National Rare Disease Plan and additional resources for National Centres of Expertise and European Reference Networks – a series of networks that bring together experts on rare diseases across Europe
- The development of a national patient registries strategy that would capture disease demographics, clinical outcomes and survival rates, as well as support patient recruitment for clinical research
- Better funding support for patient groups advocating on behalf of patients, including Rare Diseases Ireland.

Rare Diseases Ireland board members pictured at the launch of the guide (l-r): Anne Lawlor; Paula Guerin; Kevin Whelan, chair; Mairead Hennessy; Dr David Barton; Mary Kearney; and Patricia Towey

Speaking at the launch, Vicky McGrath, CEO, Rare Diseases Ireland, said:

"Ireland lags behind our neighbours in Northern Ireland, the UK and Europe in resourcing genetic services. The clinical medical genetics waiting list was 3,021 in December 2019, an increase of 14.5% on the same figure for December 2018.

"A third of these patients have been on the waiting list for more than a year. A failure to provide adequate genetic services means a delay in diagnosis, a lack of appropriate treatment, and probable disease progression. We need to tackle growing genetics waiting lists over the next two years, and increase the number of consultant geneticists from 4 to 15. Likewise, genetic counselling services are enormously under-resourced and must be addressed in the short-term; it is inhumane to provide a genetic diagnosis over the phone or via post with no follow-up counselling services, as is happening today."

Nursing stalwarts turn out for international conference in Dublin

Pictured at the ceremony to launch the 39th annual International Nursing and Midwifery Research and Education Conference at the Royal College of Surgeons Ireland in February were (l-r): Prof Ronan Patrick O'Connell, vice president, RCSI; Vivien Lusted, Irish Red Cross nurse; Dr Teresa Frawley, dean of the RCSI Faculty of Nursing and Midwifery; Elizabeth Iro, chief nursing officer, WHO; Lord Nigel Crisp, co-chair of the Nursing Now campaign and former CEO of the UK's National Health Service (NHS); and Prof Thomas Kearns, executive director, RCSI Faculty of Nursing and Midwifery

Breast is best

Over the past decades, evidence for the health advantages of breastfeeding and recommendations for practice have continued to increase. WHO can now say with full confidence that breastfeeding reduces child mortality and has health benefits that extend into adulthood.

On a population basis, exclusive breastfeeding for the first six months of life is the recommended way of feeding infants, followed by continued breastfeeding with appropriate complementary foods for up to two years or beyond.

To enable mothers to establish and sustain exclusive breastfeeding for six months, WHO and UNICEF recommend:

- Initiation of breastfeeding within the first hour of life
- Exclusive breastfeeding - that is, the infant only receives breastmilk without any additional food or drink, not even water
- Breastfeeding on demand - that is, as often as the child wants, day and night
- No use of bottles, teats or pacifiers.

INMO The Irish Nurses and Midwives Organisation supports breastfeeding

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- The development of a national patient registries strategy that would capture disease demographics, clinical outcomes and survival rates, as well as support patient recruitment for clinical research
- Better funding support for patient groups advocating on behalf of patients, including Rare Diseases Ireland.

Rare Diseases Ireland board members pictured at the launch of the guide (l-r): Anne Lawlor; Paula Guerin; Kevin Whelan, chair; Mairead Hennessy; Dr David Barton; Mary Kearney; and Patricia Towey

Speaking at the launch, Vicky McGrath, CEO, Rare Diseases Ireland, said:

"Ireland lags behind our neighbours in Northern Ireland, the UK and Europe in resourcing genetic services. The clinical medical genetics waiting list was 3,021 in December 2019, an increase of 14.5% on the same figure for December 2018.

"A third of these patients have been on the waiting list for more than a year. A failure to provide adequate genetic services means a delay in diagnosis, a lack of appropriate treatment, and probable disease progression. We need to tackle growing genetics waiting lists over the next two years, and increase the number of consultant geneticists from 4 to 15. Likewise, genetic counselling services are enormously under-resourced and must be addressed in the short-term; it is inhumane to provide a genetic diagnosis over the phone or via post with no follow-up counselling services, as is happening today."

Nursing stalwarts turn out for international conference in Dublin

Pictured at the ceremony to launch the 39th annual International Nursing and Midwifery Research and Education Conference at the Royal College of Surgeons Ireland in February were (l-r): Prof Ronan Patrick O'Connell, vice president, RCSI; Vivien Lusted, Irish Red Cross nurse; Dr Teresa Frawley, dean of the RCSI Faculty of Nursing and Midwifery; Elizabeth Iro, chief nursing officer, WHO; Lord Nigel Crisp, co-chair of the Nursing Now campaign and former CEO of the UK's National Health Service (NHS); and Prof Thomas Kearns, executive director, RCSI Faculty of Nursing and Midwifery

Covid-19 notice

The following meetings have been scheduled. However, pending further developments, we are keeping matters under constant review and unless there is a significant change in the public health situation, it is probable that all meetings, should they go ahead, will be conducted by teleconference. **For more details on any listed meetings, contact jean.carroll@inmo.ie (unless otherwise indicated)**

April

Wednesday 8 *(to be rescheduled)*
RNID Section meeting.
The Richmond. 11am

Wednesday 15 *(to be rescheduled)*
ED Section meeting.
The Richmond. 11am

Thursday 16 *(to be rescheduled)*
Retired Section meeting.
The Richmond. 11am

Tuesday 21
International Nurses Section meeting. INMO HQ. 5pm

Thursday 23
Assistant Directors Section meeting. The Richmond. 11am

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

Saturday 25
PHN Section meeting. 11am.
The Richmond

Saturday 25
Community RGN Section meeting.
The Richmond. 11am

Wednesday 29
CPC Section seminar.
See *page 18* for further details

May

Thursday 14
Student Allocation Liaison group.
INMO Whitworth Building.
12-2pm

Saturday 16
School Nurses Section meeting.
The Richmond. 10am

Saturday 23
ODN Section meeting. Limerick (venue to be confirmed). 11.30am

Saturday 23
Midwives Section meeting. Galway (venue to be confirmed). 2pm

Tuesday 26
National Care of the Older Person Section conference. Midland Park Hotel, Portlaoise

INMO Membership Fees 2020

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

Golf Society

❖ Nurses and Midwives Golf Society at Adare Manor Golf Club. Friday, May 29, 2020. Tee times: 9am-4.30pm. Fee: €50 (non-refundable)

WIN Recruitment & Training

Mailed directly to Irish nurses and midwives every month

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

Irish Nurses Rest Association

A Committee of Management representing the Guild of Catholic Nurses of Ireland, the INMO, the Association of Irish Nurse Managers and Director of Public Health Nursing exists to administer the funds of the Irish Nurses Rest Association.

It's open for applications from nurses in need of convalescence or a holiday for a limited period who are unable to defray expenses they may incur, or for the provision of grants to defray any other expenses incurred in purchase of a wheelchair or other medical aids.

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

Ms Éilis Carroll, Shalom Nursing Home, Kilcock, Co Kildare.
email: ecarroll@shalomnh.ie

Advertising in *WIN*

World of Irish Nursing & Midwifery remains open for advertisement bookings throughout this difficult period.

Next issue: May 2020

Booking deadline: Monday, April 20

Tel: 01 271 0218

email: leon.ellison@medmedia.ie

• Don't forget to mention *WIN* when replying to advertisements.

INMO Professional

Tell us about your Continuing Professional Development (CPD)

Nursing and Midwifery Continuing Professional Development Survey

The INMO is undertaking a survey to find out your views and experiences of CPD as part of your professional practice.

The survey is available on the **INMO website (https://inmo.ie)** and the **INMO Professional Website (https://inmoprofessional.ie/Course).**

Nursing now Ireland

2020 INTERNATIONAL YEAR OF THE NURSE AND THE MIDWIFE

INMO Professional DEVELOPMENT CENTRE

THE ROYAL COLLEGE OF MIDWIVES

RCM i-learn

NOW AVAILABLE AT

https://inmoprofessional.ie

MedMedia Publications
is working as normal during this difficult period.

With teleworking within our company for many years, we are in a position to produce our usual range of publications and websites.

More than ever, reliable health media is vital to inform health professionals and the general public of the latest thinking on the COVID-19 situation and general arrangements.

We are working with our allied medical organisations to bring up-to-date information and research to health professionals.

medmedia publications

If you have any queries contact:
MedMedia Publications Commercial Director:
Leon Ellison at Tel: 01 2710 218 or Mobile: 087 247 1620
Email: leon.ellison@medmedia.ie
Visit **www.medmedia.ie/publications**

ONE DEVICE | TWO POWERFUL INGREDIENTS[1-3] | THREE SIMPLE STEPS[1]

1 INSERT CAPSULE

2 PIERCE & RELEASE

3 INHALE DEEPLY

CHECK[1]

ONCE DAILY[1]

MADE IN IRELAND

Ultibro® Breezhaler®
ABBREVIATED PRESCRIBING INFORMATION
Please refer to Summary of Product Characteristics (SmPC) before prescribing
Presentation: Ultibro Breezhaler 85mcg / 43mcg inhalation powder hard capsules containing indacaterol maleate and glycopyrronium bromide respectively and separate Ultibro Breezhaler inhaler. **Indications:** A maintenance bronchodilator treatment to relieve symptoms in adult patients with chronic obstructive pulmonary disease (COPD). **Dosage and administration:** Recommended dose is the inhalation of the content of one capsule once daily, administered at the same time of the day each day, using the Ultibro Breezhaler inhaler. Capsules must not be swallowed. No dose adjustment required in elderly patients, for patients with mild and moderate hepatic impairment or for patients with mild to moderate renal impairment. No data available for use in patients with severe hepatic impairment and should only be used in patients with severe renal impairment or end-stage renal disease requiring dialysis if the expected benefit outweighs the potential risk. No relevant use in the paediatric population. **Contraindications:** Hypersensitivity to the active substances or to any of the excipients. **Warnings/Precautions:** Not to be administered concomitantly with medicinal products containing other LABA's or LAMA's. ***Asthma:*** ♦ULTIBRO BREEZHALER SHOULD NOT BE USED FOR TREATMENT OF ASTHMA. ***Acute use:*** ♦Not indicated for treatment of acute episodes of bronchospasm. ***Hypersensitivity:*** ♦Immediate hypersensitivity reactions have been reported after administration of indacaterol or glycopyrronium. If signs suggesting allergic reactions occur (in particular, angioedema, difficulties in breathing or swallowing, swelling of the tongue, lips and face, urticaria or skin rash), treatment should be discontinued immediately and alternative therapy instituted. ***Paradoxical bronchospasm:*** ♦If paradoxical bronchospasm occurs, Ultibro Breezhaler should be discontinued immediately and alternative therapy instituted. ***Anticholinergic effects related to glycopyrronium:*** ♦To be used with caution in patients with narrow-angle glaucoma and in patients with urinary retention. ***Patients with severe renal impairment:*** ♦Should only be used in patients with severe renal impairment, including those with end-stage renal disease requiring dialysis, if the expected benefit outweighs the potential risk. These patients should be monitored closely for potential adverse reactions. ***Cardiovascular effects:*** ♦To be used with caution in patients with cardiovascular disorders (coronary artery disease, acute myocardial infarction, cardiac arrhythmias, hypertension), in patients with known or suspected prolongation of the QT interval or patients treated with medicinal products affecting the QT interval and in patients with unstable ischaemic heart disease, left ventricular failure, history of myocardial infarction, arrhythmia (excluding chronic stable atrial fibrillation), a history of long QT syndrome or whose QTc (Fridericia method) was prolonged. ♦LABA's may produce a clinically significant cardiovascular effect in some patients as measured by increases in pulse rate, blood pressure, and/or symptoms, ECG changes. In case such effects occur, treatment may need to be discontinued. ***Hypokalaemia:*** ♦LABA's may produce significant hypokalaemia in some patients, which has the potential to produce cardiovascular effects. In patients with severe COPD, hypokalaemia may be potentiated by hypoxia and concomitant treatment which may increase the susceptibility to cardiac arrhythmias. ***Hyperglycaemia:*** ♦Inhalation of high doses of LABA's may produce increases in plasma glucose. Upon initiation of treatment with Ultibro Breezhaler plasma glucose should be monitored more closely in diabetic patients therefore caution and appropriate monitoring are advised in such patients. ♦Ultibro Breezhaler has not been investigated in patients for whom diabetes mellitus is not well controlled. ***General disorders:*** ♦To be used with caution in patients with convulsive disorders or thyrotoxicosis, and in patients who are unusually responsive to LABA's. ***Excipients:*** ♦This medicinal product contains lactose. Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicine. ***Pregnancy and Lactation:*** ♦Ultibro Breezhaler should only be used during pregnancy if the expected benefit to the patient justifies the potential risk to the foetus. ♦Not known whether indacaterol, glycopyrronium and their metabolites are excreted in human milk. Use of Ultibro Breezhaler by breast-feeding women should only be considered if the expected benefit to the woman is greater than any possible risk to the infant. **Interactions:** ♦Concomitant use is not recommended with beta-adrenergic blockers, anticholinergics or sympathomimetics. ♦Concomitant hypokalaemic treatment with methylxanthine derivatives, steroids, or non-potassium-sparing diuretics may potentiate the possible hypokalaemic effect of beta$_2$-adrenergic agonists, therefore use with caution. ♦Inhibition of the key contributors of indacaterol clearance, CYP3A4 and P-gp, does not raise any safety concerns given the safety experience of treatment with indacaterol. ♦No clinically relevant drug interaction is expected when glycopyrronium is co-administered with cimetidine or other inhibitors of the organic cation transport. **Adverse reactions:** ♦Very common: upper respiratory tract infection. ♦Common: nasopharyngitis, urinary tract infection, sinusitis, rhinitis, hypersensitivity, hyperglycaemia and diabetes mellitus, dizziness, headache, cough, oropharyngeal pain including throat irritation, dyspepsia, dental caries, bladder obstruction and urinary retention, pyrexia, chest pain. ♦Uncommon: angioedema, insomnia, glaucoma, ischaemic heart disease, atrial fibrillation, tachycardia, palpitations, paradoxical bronchospasm, dysphonia, epistaxis, gastroenteritis, dry mouth, pruritus / rash, musculoskeletal pain, muscle spasm, myalgia, pain in extremity, oedema peripheral and fatigue. ♦Please refer to SmPC for a full list of adverse events for Ultibro Breezhaler. **Legal Category:** POM. **Pack sizes:** Cartons containing 10 capsules (1x10 capsule blister strips) and one Ultibro Breezhaler inhaler or 30 capsules (3x10 capsule blister strips) and one Ultibro Breezhaler inhaler. **Marketing Authorisation Holder:** Novartis Europharm Limited, Vista Building, Elm Park, Merrion Road, Dublin 4, Ireland. **Marketing Authorisation Numbers:** EU/1/13/862/007 & 003. Full prescribing information is available on request from Novartis Ireland Ltd, Vista Building, Elm Park Business Park, Dublin 4. Tel: 01 2601255 or at www.medicines.ie **Date of Revision of API Text:** June 2019.

REFERENCES: 1. Ultibro Breezhaler Summary of Product Characteristics. www.medicines.ie. Accessed on January 2020. **2.** Donohue JF, et al. *Int COPD* 2017;12:367-381. **3.** Miravitlles M, et al. *Clin Invest (Lond)* 2014;4(12);1095-1111.

ADVERSE EVENT REPORTING
Reporting suspected adverse reactions of the medicinal product is important to Novartis and the HPRA. It allows continued monitoring of the benefit/risk profile of the medicinal product. All suspected adverse reactions should be reported via www.hpra.ie or email to medsafety@hpra.ie. Adverse events could also be reported to Novartis preferably via www.report.novartis.com or by email: drugsafety.dublin@novartis.com or by calling 01 2080 612.

Date of Preparation: January 2020
IE02/ULT19-CNF027a

NOVARTIS