€5.75 Vol 30 No 3 April 2022

WIN

INMO
Journal of the
Irish Nurses and
Midwives Organisation

World of Irish Nursing & Midwifery

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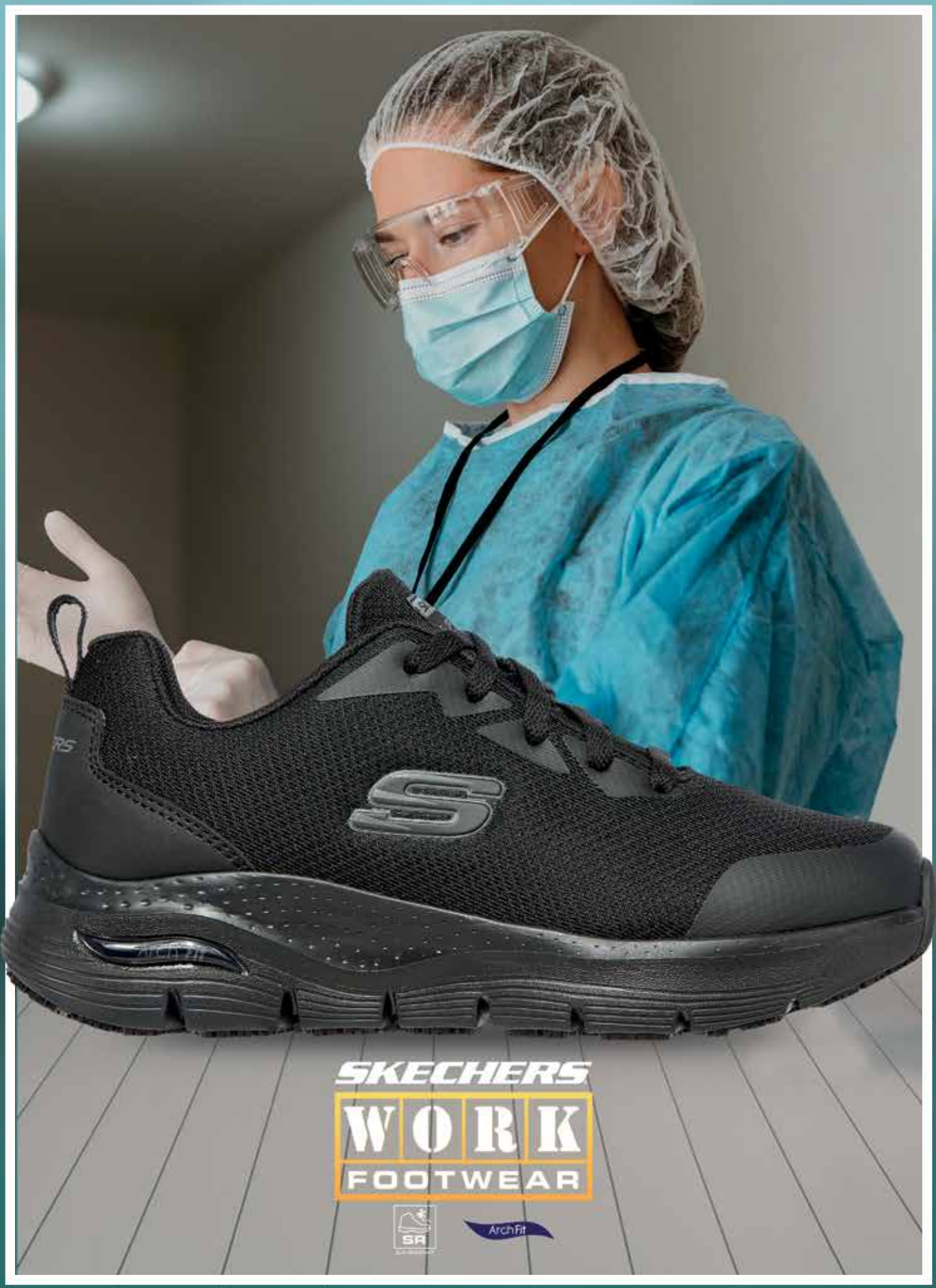
Overcrowding fallout

Nurses and midwives have nothing left to give



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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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For more information log onto www.breastfeeding.ie

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

(ISSN: 2009-4264)
Volume 30 Number 3
April 2022

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

medmedia publications

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

Production & news editor Tara Horan

Sub-editor Max Ryan

Designers Fiona Donohoe, Paula Quigley

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

Publisher Geraldine Meagan

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

INMO
Irish Nurses and Midwives Organisation

Editor-in-chief: Phil Ní Sheaghdha

INMO editorial board:
Karen McGowan
Eilish Fitzgerald, Kathryn Courtney

INMO editors:
Siobhan De Paor (siobhanl.depaor@inmo.ie)
Freda Hughes (freda.hughes@inmo.ie)

INMO photographer: Lisa Moyles

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

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

www.facebook.com/irishnursesandmidwivesorganisation

twitter.com/INMO_IRL

Much to debate at ADC 2022

AS WE approach the 2022 annual delegate conference (ADC), it is very encouraging to see a strong interest in the Executive Council elections. Thank you to all members who came forward to compete in this process. The current Executive has played an essential role in deciding policy at a most challenging time in our Organisation's history and a great depth of gratitude is owed to them. Like all of you, they are working nurses and midwives who gave of their own time to serve on the Executive and proudly uphold the democratic structures as required.

The INMO has joined colleagues in the International Council of Nurses and the European Federation of Nurses and international midwife organisations in condemning the terrible atrocities in Ukraine, This month the Executive Council supported the ICTU request for all working people to give an hour's salary to the Irish Red Cross to support the provision of medical aid and assistance directly to the people in Ukraine. This invasion and the resulting war have indiscriminately targeted and destroyed medical facilities, maternity hospitals and humanitarian services. We encourage INMO members to support this call for all Irish workers to show solidarity with the people of Ukraine in this practical way.

As our colleagues in Palestine remind us, it is through the injustice of occupation that lives are tragically lost, changed and societies altered, while health services are placed in incredibly difficult situations. Therefore, international support and immediate sanctions are necessary to practically assist and emphasise and show a strong intolerance for these breaches of human rights.

This past month has seen a continuation of the now endemic overcrowding in our acute hospitals. The INMO's request for the Oireachtas Health Committee to convene and hear evidence was accepted and we presented to it on March 9 (see **www.inmo.ie** for details). We also met the Minister for Health on this issue on March 10. INMO ED representatives gave a clear picture of their daily experiences. A report on the Oireachtas presentation can be found on *page* 9. The presentation to the minister was a true example of advocacy by nurses on behalf of both the public attending for care and colleagues. It emphasised that the tolerance for overcrowding and substandard care and working conditions has gone beyond any acceptable level. The government cannot plead ignorance of the effects of overcrowding any longer – it has been advised in the clearest of terms and now must act; delays cost lives.

This month the Executive Council joined other public service trade unions and called for immediate commencement of revision of the pay terms of the public service agreement. We highlighted the issues nurses and midwives face as wages are eroded by inflation and the consequences for recruitment of these essential workers, increasing rent, accommodation shortages, and the cost of travel and parking.

The current public service agreement Building Momentum allows for a review if economic circumstances change. It is clear that economic circumstances have changed and immediate engagement on a review is now absolutely necessary.

Furthermore, the INMO Executive Council made it clear that all the outstanding matters must be implemented in full before any successor agreement is considered by our members. The issues still under consideration by the government include: the Report of the Working Hours body recommending a return to the 37.5-hour week for nurses and midwives; the report from the Expert Review Group on Nursing and Midwifery; and the sectoral bargaining process to complete the correction of differential for nurse/midwife managers' pay.

We look forward to seeing delegates at the ADC in May and to having debates on the issues that continue to affect our working lives as nurses and midwives.

Phil Ní Sheaghdha
General Secretary, INMO

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A positive focus with the president

Karen McGowan, INMO president

Recognition at the Áras

I HAD the pleasure of attending Áras an Uachtaráin on St Patrick's day as part of a celebration to recognise nurses, midwives and carers. It was a lovely event and meeting President Michael D Higgins was wonderful. He was very thankful to the professions for their work throughout Covid-19 and the continued efforts during this time. I also attended the National Day of Remembrance and Reflection at the Garden of Remembrance on Parnell Square, Dublin. Nursing and midwifery were represented well, with individuals in attendance from acute care to the Cancer Society nurses who all gave so much during this time. They laid wreaths to remember those who were lost during the pandemic. The day was very poignant with many speakers recounting their experiences of loss due to Covid-19.

Gold standard respiratory care in Mayo

THIS month I spoke with Aoife Folliard who is an advanced nurse practitioner in Mayo University Hospital. Ms Folliard told *WIN* that she is part of a close-knit team which also includes two consultants, two clinical nurse specialists, a physiotherapist and physiologist.

Aoife Folliard, advanced nurse practitioner in respiratory care at Mayo University Hospital

Her passion for respiratory care emerged during her time as a student nurse in Dublin's Adelaide Hospital and it has never diminished. Ms Folliard currently runs two nurse-led clinics every week. While overseeing these clinics she has seen a need to extend their scope into sinus disease management and as a result they now have direct access to ENT consultant care. This is an example of the holistic approach that the nurse-led clinic provides.

There is a significant demand for the respiratory service, which has led to twice-monthly clinics being set up in the community in north Mayo. Ms Folliard emphasised that, when it is done well, asthma management will prevent emergency admissions to hospital.

"It is a reversible disease when it is managed correctly, and the benefits to the patient are massive and life saving," she said.

For patients who are struggling with their symptoms and face difficulties travelling, Ms Folliard has made the clinics accessible by conducting virtual clinics and a telephone triage service for rapid access to the respiratory service.

Ms Folliard told *WIN* of some of the challenges to advanced practice, such as access to certain diagnostics such as CT scanning. However, she maintained that when you conduct the research and show that certain diagnostics are justified it is possible to gain the access required. "This lends itself to streamlining the service being delivered as a gold standard," she added.

Ms Folliard is passionate about improving patient care and is the chairperson of Anáil (Respiratory Nurses Association of Ireland). As she has demonstrated, enhancing an aspect of care can lead to developing the service further. Ms Folliard hopes to develop further clinics and create research projects but this is a challenge within busy services. She is also an adjunct lecturer in Galway Mayo Institute of Technology (GMIT) and enjoys lecturing in her specialist area.

Executive Council update

THE Executive Council met through a hybrid model this month, with some members attending in person and some taking part via Zoom. The increased cost of living was identified as the most urgent issue. Joining other unions, the Executive Council agreed to call for the pay terms and conditions of Building Momentum to be reviewed. These issues formed part of an important debate and no doubt will be the subject of further debate at our ADC.

The recent submission on hospital overcrowding to the Joint Oireachtas Health Committee and matters requiring immediate government attention were also discussed.

The Executive Council also received an update from the INMO director of industrial relations on progress relating to matters that are under discussion with the Department of Health and the HSE, including the pandemic bonus announced by government. Meetings were scheduled as we went to print and members will be notified of the outcomes.

The report on additional hours was issued to the Minister for Public Expenditure and Reform, and the INMO and other public service unions have advised that as this is a central part of the Building Momentum agreement it must be implemented in full. Likewise, the Expert Review Group on Nursing and Midwifery's report has been issued to the Minister for Health and again the INMO has sought its publication as the matters recommended are of significant importance to nurse/midwife manager members.

The Emergency Nurses Section set out clearly the challenges and the needs of staff working in EDs nationally. The ED representatives clearly articulated their concerns. We await further engagement with the Minister for Health and Chief Nurse.

Final preparations for ADC are now underway and the local committee are progressing plans. Our sincere thanks for their commitment and due diligence as they prepare to host ADC 2022.

The next meeting for Executive Council will be April 4 and 5.

If you would like to showcase you nurse-led initiative or role, please get in touch by email to: president@inmo.ie

Get in touch

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

"Minister must declare overcrowding chaos a national emergency"

WITH 600 patients on trolleys in Irish hospitals on March 22, 2022 – the highest number since the beginning of the pandemic – the INMO said it was past time for the Minister for Health to declare a national emergency.

INMO general secretary Phil Ní Sheaghdha said: "We have seen a 15% increase of patients on trolleys in the past 24 hours with 660 patients for whom there are no beds.

"The Minister for Health needs to intervene and declare this trolley chaos for what it is – a national emergency.

"A range of measures must be taken now in the short to medium-term including the curtailment of all non-emergency, elective care and the reintroduction of mask wearing in crowded and indoor settings.

There is a clear link between reduced transmission and mask wearing. Removing the mask requirement in congregated settings particularly with poor ventilation, is clearly having a detrimental impact in our hospitals.

"The INMO urged the government to move with caution on the removal of the mask-wearing requirement as we were concerned about the health system's ability to cope. Our nurses and midwives are burned out and exhausted. We can't expect them to be able to provide safe care in environments that are overcrowded while dealing with a highly transmissible airborne virus."

This call on the Minister followed a previous call on the HSE to declare the current overcrowding situation in acute hospitals as an emergency and impose all necessary assistances and restrictions in order to enable hospitals to cope. The union said that restrictions on elective care should be in place until Easter, at least.

Ms Ní Sheaghdha said: "We have been sounding the alarm on this situation for far too long. We are not in a space in which our health service can cope with such high numbers on trolleys coupled with well over 1,000 inpatients with Covid-19. If our past experience of Covid and high numbers of patients on trolleys has taught us anything, we will be seeing the impacts of this on our health system for many weeks to come.

The general secretary pointed out that in week 9 of 2022 of the total of 129 Covid outbreaks recorded, 116 were in healthcare facilities, including 28 in acute hospitals.

"Air hygiene in hospitals is poor, Covid is an airborne pathogen and despite all the evidence the HSE has attached very little urgency to the very real need for the introduction of hospital-wide air filtration and measurement systems," Ms Ní Sheaghdha said.

"The HSE must now offer a direction to all hospital groups to cancel elective procedures and prioritise emergency care. We have been put in a situation where the health system is constantly playing catch up with itself because of the amount of pressure it is under, but the simple but unfortunate fact of the matter is that the health service is creaking and unable to do everything. The HSE has a duty as an employer and as a service provider to take the necessary steps to scale up capacity. The current state of our health system is extremely concerning."

The INMO set out in detail what is needed now from government to the Oireachtas Health Committee at a special meeting convened at the union's request *(see opposite page)*. The union also met with the Minister for Health last month and ED nurses from units around the country set out in detail the dangers presented for patients in overcrowded hospitals right now.

"There should be no doubt at this stage as to the negative effects of overcrowding. The HSE and political system have a responsibility to the exhausted workforce to ensure their workplaces are safe. There must be no tolerance for hospital overcrowding, especially while a highly transmissible airborne virus is making its way around our hospitals. Improvements to air quality in our hospitals must be a priority.

"The HSE has a duty as an employer and as a service provider to take the necessary steps to scale up capacity. The current state of our health system is extremely concerning. It is now time for the Minister to attend the ED Taskforce and to ask the HSE to put in place realistic short term pressure reliving measures.

Calls for urgent action on increase in Covid cases in Mater Hospital

AHEAD of the St Patrick's Day long weekend, INMO members in the Mater Misericordiae University Hospital, Dublin were reporting extreme overcrowding in the hospital due to the high number of presentations in the emergency department, with 188 patients presenting on Monday, March 14 alone.

The union reports that the high number of presentations is causing extreme delays in the ED and is calling on the hospital to take emergency measures to deal with the situation.

The INMO is specifically requesting that no further beds or new services are opened until the current Covid crisis abates, and that all necessary measures to ensure patient safety are taken immediately by hospital management. This took place against the backdrop of St Patrick's Day and the additional public holiday, with spikes in attendances in ED following bank holiday weekends an inevitable reality, said INMO assistant director of IR Albert Murphy.

Mr Murphy pointed out staff shortages due to Covid were adding to the problem and the ED did not have the required agreed staffing levels. On the day in question there were seven nurses short from the agreed roster. "The hospital needs to ensure that staff and patients are protected during this crisis and that it takes all necessary safety measures."

The Mater Hospital issued its own statement ahead of the bank holiday, calling on the public not to attend due to extreme pressure on the hospital. The union requested an urgent meeting with the hospital CEO to discuss this serious matter.

INMO sets out overcrowding reality to Oireachtas Health Committee

AT A meeting convened at the request of the INMO, the Joint Oireachtas Committee on Health heard how persistent hospital overcrowding is impacting nurses and midwives and patient safety.

INMO president Karen McGowan and INMO general secretary Phil Ní Sheaghdha attended the committee to give an in-depth account of the dangerous overcrowding that is seen in the majority of hospitals across the country. The main points they made were that staff and patients deserve better than the persistent and chronic overcrowding seen on a daily basis.

They stressed that the government must take note of the voices from the frontline. They are sounding the alarm, and are pointing to clinical risk, omissions of care, inhumane environments for care provision, long uncomfortable waiting times to be seen and then a longer time to be admitted.

INMO general secretary Phil Ní Sheaghdha said: "We welcome the fact that the Oireachtas acted so quickly on the INMO's request for the Health Committee to discuss the stark levels of overcrowding in our hospitals."

Members of the Health Committee were the first to hear the results of the latest INMO survey of members in the country's busiest hospitals, which showed that not only have members been placed under enormous pressure owing to a global pandemic, but now, the endemic of consistent overcrowding is significantly impacting the mental and physical health of staff.

- In University Hospital Galway, 96% stated that based on their professional judgment, the current staffing levels and skill mix in their area were not appropriate for meeting clinical and patient work demands. Of these, 66% felt that patient safety was put at risk often, very often or always
- In University Hospital Limerick, 81% stated that they always or often felt worn out by the end of the day, and 61% stated they always or often felt exhausted at the thought of another day at work
- In Midland Regional Hospital Tullamore, 76% stated that their work environment was emotionally exhausting to a high or very high degree
- In Cork University Hospital, 72% stated that they had worked additional unpaid hours over their contracted hours of employment over the past 12 months
- In University Hospital Kerry, 90% stated that based on their professional judgment the current staffing levels and skill mix in their area were not appropriate for meeting clinical and patient work demands. Of these, 80% felt patient safety was put at risk often, very often or always
- In Connolly Hospital, 74% stated they felt pressure to work extra shifts
- In St Vincent's University Hospital, 66% stated that they had considered leaving their current work area due to workplace stress in the past month
- In Letterkenny University Hospital, 87% said that they always or often felt worn out by the end of the day, and 67% that they always or often felt exhausted at the thought of another day at work.

Call for immediate action: *INMO president Karen McGowan and General secretary Phil Ní Sheaghdha address the Joint Oireachtas Committee on the health meeting on ongoing and persistent overcrowding crisis in hospitals*

Key actions identified by INMO for government to take immediately

- All nurse staffing must be underpinned by the Framework for Safe Nurse Staffing and Skill Mix. The Framework must be funded, underpinned by legislation, and expanded across the health service
- Bed occupancy must be reduced to 85% as per the Health Service Capacity Report
- Government must commit to multi-annual funding of Sláintecare
- Zero tolerance for overcrowding in all hospitals
- Statutory agencies must carry out their roles and make recommendations to the Minister for Health when compelled to by those on the frontline
- Health and safety legislation needs to be strengthened to protect nurses and midwives

Members of the committee were extremely engaged with the issues of concern that the INMO highlighted at the meeting, particularly on the issues of assaults against INMO members and their colleagues while on duty, the impact that burnout and stress is having on members, workforce planning and the need to press ahead with Sláintecare.

Members of the committee accepted the view of the INMO that additional amendments are needed to health and safety legislation in order to protect nurses and midwives in their workplaces. In the coming weeks, the INMO will follow up with members of the Health Committee to ensure that the issue of safety remains a cross-party priority.

"We cannot allow our politicians to be desensitised to the soaring trolley numbers. The INMO will continue to use its voice to bring the experience of members to politicians of all parties and none, as often as we can, so we can get meaningful change in the system," said Ms Ní Sheaghdha.

"ED overcrowding was not caused by Covid-19; however, unfortunately, today, it is endemic in our public health system. Winter plans are produced four months after the horse has bolted. Service plans that promise six hour wait times are unacceptable. We need a government-led and overseen implementation of the agreed reform plan. If the government doesn't intend to fully fund and implement the reforms, then our members will take action," Ms Ní Sheaghdha said.

– Síobhan de Paor, INMO

INMO director of industrial relations Tony Fitzpatrick updates members

Implementation of the review of HSE HR investigation processes

THE INMO and health sector unions secured a review of the HSE human resources investigation process, which was conducted by former chair of the Labour Court Kevin Duffy.

This review focused on the operation of the HSE HR Investigation Unit, which was established in 2016 for the purpose of investigating complaints by or against health service staff.

The unions have been engaging with the HSE on the implementation of the report and matters are close to conclusion. Much discussion centred around several issues.

Full time investigator grade

The HSE outlined that there would be a budget for 14 WTE investigators at Grade 7 level. It is intended that the full-time investigator would be employed on a fixed-term contract for three years.

Recruitment process

The HSE outlined that it believed rather than a straightforward interview process there should also be an 'in-tray exercise', ie. a work simulation assessment, or an off-the-shelf process to assist in the selection process.

It was confirmed that the health sector trade unions would be involved in the selection process.

On the assignment of assessors with professional expertise, discussion took place in relation to whether an expert panel would be formed (with agreement). Alternatively it was proposed that the HSE and unions could have an explicit agreement under which individuals, agreed between the parties, could be nominated to be involved in investigations of regulated professionals.

The HSE is drafting up wording on this and is due to revert to the unions.

External adjudicator

Discussion took place on where a dispute arises in relation to the terms of reference or the makeup of the investigation team, an external adjudicator would be retained to deal with it and complete adjudication within a four-week period. This would be like the panel that previously existed within the Dignity at Work process. Work is ongoing on agreeing same.

It is hoped that once all these matters are addressed it will ensure that investigation processes are conducted fairly and expeditiously.

Covid-19 special leave with pay

FOLLOWING the changes introduced by the Department of Public Expenditure and Reform (DPER) to special leave with pay which is now capped at 10 days as of February 7, 2022, the INMO and other health sector unions lodged a claim for a special scheme, similar to the MRSA or blood borne diseases scheme, for individuals who remain off with Covid-19 after 10 days.

Long Covid is well recognised in national and international literature as being a serious matter and therefore, a scheme within the health service is needed where staff had the greatest exposure so that they are not using up their own sick leave entitlement and end up off pay. The HSE replied to the unions outlining the position of DPER and the Department of Health, confirming changes were introduced on February 7 and that the union claim would not be conceded. It has been decided by the Staff Panel that the matter will now be referred to the WRC and will be pursued as an IR matter.

Revision of Dignity at Work policy nearing completion

THERE has been extensive engagement between the unions and the HSE relating to revision of the Dignity at Work policy, which relates to anti bullying, harassment and sexual harassment policy and procedure in the workplace.

Significant amendments put forward by the INMO and other health sector unions have been incorporated into the latest draft.

Through this engagement, the unions have sought several amendments, to ensure that there is proactive early action by management in dealing with complaints of bullying, harassment and sexual harassment. The unions have pressed to ensure that:

- There is appropriate reference to the Safety, Health and Welfare at Work Act 2005, under which the employer is obliged to provide a safe working environment that is free from bullying and harassment
- There is clear reference that the policy applies across the public health service, including HSE and Section 38 agencies
- Mediation is encouraged at all stages of the policy as this is proven to be effective in the resolution of matters for complainants and respondents
- The policy will be reviewed every two years or earlier as required
- The process provides an informal and formal process, as well as the preliminary screening process as previously existed.

A matter of concern for the unions was to ensure that, as well as sharing documentation with the respondent/complainant, the HSE would also provide copies to their representatives, which the HSE had been refusing to do. This has been addressed and is recorded in the policy that copies will be provided to representatives on request.

The revised policy is based on two codes

- The 2020 'Code of Practice for employers and employees on the prevention and resolution of bullying at work', which was developed by the Health and Safety Authority and the WRC
- The Equality Act 1998 (Code of Practice) (Harassment) Order 20912 issued by the Human Rights and Equality Commission in accordance with the Employer Equality Acts 1998-2015.

This Dignity at Work policy is due to be finalised in the coming weeks and members will be updated.

on recent national issues under discussion

INMO pursues errors in application of pre-retirement scheme

A PRE-RETIREMENT initiative was introduced for nurses and midwives under HSE Circular 14/2017, further to the recruitment and retention agreement of 2017. This reintroduced, on a pilot basis, a pre-retirement job-sharing scheme available in the early 2000s.

Under the scheme, those aged 55 years or over can avail of a *maximum* of five years on the scheme until the age of 65.

The INMO has learned that several individual staff members who had less than five years to retirement were advised erroneously that they could not avail of the benefits of the scheme as they had not completed the five-year period.

Further to engagement with the HSE, it became clear that the superannuation departments are incorrectly applying the scheme on interpretations provided to them by the Department of Health.

This issue was raised with HSE HR and pensions departments at several meetings. The INMO has again outlined to the HSE our position with supporting documentation. The HSE has committed to raising these directly with the pensions division of the Department of Health to clarify the matter.

The union has successfully pursued individual grievances, with the outcome that members should have the scheme applied as per the INMO interpretation. However, despite the grievance being successful with HR, the pensions office will not recommend same until it receives clarification from the Department of Health.

If any members have been adversely affected by the current HSE interpretation it is important that they contact the INMO for assistance.

The second matter is that the scheme re-introduced by Circular 14/2017 was for a two-year period and the INMO has been seeking to ensure the scheme will continue to apply considering that the ceiling of 250 applicants per year was not reached, and the initiative is beneficial in retaining experienced staff within the service.

Currently, the HSE is accepting applications but they are not being processed. Members will be updated after our next engagement on this initiative.

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

Nurses/midwives strongly condemn att

MEMBERS, and all right-minded people, will be utterly shocked and distressed at the senseless violence and human misery associated with the war in Ukraine.

The INMO, along with colleagues in the European Federation of Nurses Associations (EFN), the European Forum of National Nursing and Midwifery Associations (EFNNMA) and the International Council of Nurses (ICN), have been reacting and responding to both the war and the humanitarian crisis which accompanies it.

In a joint statement, supported by the INMO, the EFN, EFNNMA and ICN strongly condemned the Russian invasion of Ukraine, the disruption to health services and the attacks on healthcare facilities and innocent civilians. They called for an immediate ceasefire, an end to all hostilities and for the commencement of intensified diplomatic negotiations to secure peace.

Speaking on behalf of 28 million nurses, they observed that nurses and other healthcare workers deliver care and treatment to all patients without fear or favour; they must be allowed to do their work protected from threats and violence, and the healthcare facilities they work in must be shielded from harm.

International regulations and the Geneva Convention protecting health facilities and health workers must be respected and enforced. They continued that the people of Ukraine must be provided with the humanitarian aid they are entitled to under international treaties, and they must have ready access to the vital equipment, medicines and supplies that are required to treat all of their healthcare needs, including injuries or illnesses. Refugees from the conflict must be afforded the right of free passage and provided with healthcare and support on their journeys and when they reach a place of safety.

The world's nurses demanded that the health and wellbeing of the people of Ukraine be safeguarded and that can only be achieved through lasting peace, because peace and health are inseparable.

As hostilities continued it became clear that healthcare facilities and workers were coming under attack. This is direct violation of international humanitarian law and the Geneva Conventions which especially protect healthcare workers and facilities. The ICN, Global Nurses United (GNU), and the INMO have rightly condemned these breaches of international law, and attacks on the most basic elements of human dignity and reason.

The GNU expressed its solidarity with the nurses and other healthcare professionals of Ukraine who are struggling mightily to provide care during this unprovoked invasion. Further, the GNU strongly condemned the ongoing attacks by Russian forces on healthcare personnel and healthcare facilities in Ukraine, pointing to the bombing of a maternity and children's hospital in the Ukrainian city of Mariupol, which left at least three dead, including a child, with many more wounded.

The GNU also referred to Amnesty International which has found that the "Russian invasion of Ukraine has been marked by indiscriminate attacks on civilian areas and strikes on protected objects such as hospitals." The World Health Organization (WHO) now confirms 24 attacks on hospitals, ambulances and other healthcare facilities since the beginning of the invasion, resulting in multiple deaths and injuries among patients and staff.

The GNU stated that the heinous attacks constituted war crimes and must not pass as unfortunate events taking place in the fog of war. They fully supported the WHO's statement that "Attacks on healthcare violate international law and endanger lives. Even in times of conflict, we must protect the sanctity and safety of healthcare, a fundamental human right."

The GNU concluded that: "Nurses and healthcare workers confront trauma and uncertainty when providing care during the best of times, and now our sisters and brothers face targeted military strikes as they treat war casualties and others too sick to flee. In this war of choice, Global Nurses United calls upon the Russian government to choose an immediate ceasefire, ensure the safe passage of those displaced by the fighting, engage in diplomacy in good faith, and withdraw its forces from Ukraine."

Speaking on the attacks on healthcare workers and facilities, ICN president Dr Pamela Cipriano said: "These attacks on healthcare facilities, transport and healthcare professionals are profoundly shocking. It is unacceptable that innocent people, including children and pregnant women, have been targeted in this war. This represents a serious violation of human rights and international humanitarian law. Health professionals and patients must be given special protection and respect.

"We are also aware that crucial healthcare supplies, such as tourniquets and key drugs, are lacking, and that water and electricity cuts are putting patients at great risk. We have heard direct reports from nurses who are living in the basements of hospitals in order to provide 24/7 lifesaving care. It is sickening to learn that their lives are still at risk even in hospitals."

The INMO also reflected specifically on reports of hundreds of Ukrainian staff and patients being held hostage at a hospital in Mariupol, and it joined with the international healthcare community in condemning this attack.

INMO condemns attacks

Having previously condemned the ongoing attacks on medical personnel and healthcare facilities in Ukraine by Russian forces, the INMO issued a statement that our members stand in full solidarity with the nurses, midwives and other medical professionals who are working despite the war raging in Ukraine.

Regarding news that hundreds of staff and patients were being held hostage inside a Ukrainian hospital, INMO general secretary Phil Ní Sheaghdha said:"This is a reprehensible act that is in clear violation of international humanitarian law regarding healthcare professionals. Nurses and healthcare workers around the world have proven in recent times their strength and courage in the most dangerous circumstances, and their commitment to providing

global news affecting nursing and midwifery

acks on hospitals in Ukraine

safe care even when their own safety is at risk. To see these health staff and their patients being targeted in this way will deeply affect the healthcare community around the world."

INMO president Karen McGowan said: "The INMO has joined with the international nursing and midwifery community and Global Nurses United to condemn this attack and all other attacks on civilian areas and healthcare facilities in this conflict. We are once again calling on all parties involved in the conflict to protect the safety of the brave nurses and midwives providing vital care to those who are sick, injured and vulnerable."

The calls for peace and for respect for international law are coming from nursing colleagues across the world. Indeed, the president of the Russian Nurses Association, Valentina Sarkisova shared the following message with the ICN: "Russian Nurses Association with all nurses of the world are extremely concerned for their neighbouring closest colleagues. Politics is far from nursing and armed conflicts are opposite to the main designation of our profession. There are no other professions that cherish life and health as much as nurses. Together with the whole world, we hope for a rapid resolution of all conflicts and a return to a normal and peaceful life. We do believe that no political confrontation can affect the mission of nursing. With all the passion we wish no more lives be lost, and all nurses be back to their peaceful duties in safe and secure environment."

At time of writing, attacks on civilian populations and healthcare workers and facilities are continuing. We are also seeing the largest migration of people seeking asylum in Europe since World War II.

Ireland and our people are responding domestically and in sending aid, with the shocking images emerging from Ukraine and of those fleeing the conflict seeming to have particularly resonated with us.

Of course, this is not the only conflict internationally which is of serious concern, but it certainly is one which brings with it considerable fear and reminder of things we thought had passed on our continent.

As an Organisation we join with others in the world who hope that the peace talks will lead to relief from the war and humanitarian catastrophe. We must also though remember and show solidarity with our fellow human beings and colleagues who are enduring the unimaginable right now.

If you wish to join the efforts of the international nursing community at this time support the ICN **#NursesforPeace** campaign.

Report highlights ICN's critical work to safeguard nurses

THE International Council of Nurses marked the two-year anniversary of the declaration by the World Health Organization of Covid-19 as a pandemic by publishing a report of its work on Covid in 2021.

The report, which tracks the ICN's work month by month from January 2021 to March 2022, highlights several significant ICN publications and statements on the effect of the pandemic on nurses' health, including stress, burnout, traumatisation, as well as infections and deaths. It also highlights the impact on the nursing workforce in terms of education, workload and the global nursing shortage.

ICN president Dr Pamela Cipriano said: "The Covid-19 pandemic has had a significant impact on all of society, but the health workforce has undoubtedly suffered the most. When we look at what nurses have endured, there is no doubt that many will be leaving the profession unless serious measures are enacted to retain the existing workforce and attract young people to take up the profession.

"This report shows the many ways in which the ICN has been publishing the research into the effects of the pandemic on the nursing workforce as well as the recommendations to address the threats to the profession, including the need for investment."

The new report also contains success stories from across the world, which show the ways in which national nursing associations have influenced their governments to improve nurses' salaries and working conditions, education and training, and to appoint a chief nursing officer. It also contains testimonies that highlight the incredible lengths to which nurses will go to care for their patients.

World news

Nurses and midwives in action around the world

Global
- Global Nurses Union says 'heinous' Russian attacks on hospitals amount to war crimes
- Ukraine: Doctors and nurses in the sights of the bombings – GNU calls for a ceasefire

Australia
- NSW union says patient care continues to wane under poor staffing

Brazil
- Nurses' salary floor – a feminist struggle

Canada
- End of Covid-19 restrictions deepens need for paid sick leave, labour federation says
- Nurses union donates $250,000 to colleagues in Ukraine
- Proposed health worker pay roll-backs slammed

Italy
- National day against attacks on health personnel – nursing union in the field

Portugal
- Nurses demand career progression and new competitions

Spain
- Seven out of 10 nurses were attacked during Covid-19
- Union demands a minimum wage increase of 6.5% for nurses and physiotherapists
- Union demands that the government stops blocking the law on nursing ratios

UK
- Student nurses 'expected' to face violence and verbal abuse during placements

US
- Ukraine hospital bombing prompts nurses' union to call for ceasefire

Nurse redeployment at UHL unsafe

UHL's redeployment of nurses threatens Safe Staffing Framework

NURSES working at University Hospital Limerick (UHL) have been alerting the INMO to the fact that redeployment within the hospital is leading to many wards being unsafe, understaffed and is a cause of work-related stress for members.

The use of the additional nursing staff who were recruited to implement the Framework for Safe Nurse Staffing and Skill Mix in UHL, to open unstaffed surge capacity is completely unacceptable to the INMO.

INMO members undertook a national strike in 2019 to secure safer staffing and the resultant additional staffing allocated must not be utilised for other unfunded locations. This could be viewed as a breach of the national agreement.

The matter was raised with management at a meeting on March 7, 2022 where the union also advised of the INMO position that if the redeployment continued, we will consult our members on possible actions to halt a dismantling of the Framework on inpatient wards.

Assurances were provided by the directors of nursing in attendance that this would not continue and the Framework implementation would be left intact.

Aligned to this, the INMO has lodged a claim with management to have dedicated nursing staff and a CNM2 in place in the overflow unit (formerly the surgical short stay unit). This unit opened on a 24/7 basis without consultation or agreement with the INMO on staffing needs. It has capacity for 10 patients therefore the union lodged a claim for a minimum of two nurses on duty at all times. Management agreed to revert to the INMO within two weeks with a staffing proposal.

Mary Fogarty, INMO assistant director of IR: *"The use of additional staff recruited to implement the Safe Staffing Framework is completely unacceptable to the INMO"*

Please contact the INMO if your ward is having ongoing difficulty with the use of additional staff under the Safe Staffing Framework for redeployment. Email: inmo-limerick@inmo.ie or Tel: 061 308999.

– Mary Fogarty, INMO assistant director of IR

Vacancies at UHL dialysis unit

ENGAGEMENT with management at University Hospital Limerick (UHL) is ongoing on a claim to secure the filling of current vacancies at the hospital's dialysis unit, as well as increases in the available nursing staff, based on the unit's activity level which is at maximum capacity.

Management has acknowledged the need for additional nursing staff and committed to submitting a business case for same to the hospital executive team.

Discussion is also ongoing on the provision of the out of hours plasmapheresis service and related outstanding matters on this. The INMO has a further meeting scheduled at the time of going to press.

– Mary Fogarty, INMO assistant director of IR

INMO secures Covid leave for student public health nurses

THE INMO was successful in securing Covid leave for student public health nurses for the academic year 2021/2022. Students had been concerned about completing their course and the effects of having to owe back time if they contracted Covid-19 and subsequently had to isolate as per public health guidelines which would result in missing sections of their course.

Since student PHNs have a higher risk of contracting Covid-19 in the course of their clinical placements and could subsequently need to be absent from their placement, there was an obligation to repay the length of time they were absent.

INMO IRE Karen McCann submitted a claim to the NMBI to seek that flexibility be provided for these student PHNs with regard to the 100% attendance requirement, in the event they contracted Covid-19 in the course of their duties.

The NMBI confirmed that student public health nurses can avail of one week's Covid absence leave (five standard working days) without the need to repay this time to meet requirements for registration.

INMO seeks the return of ED forums in South West

FOLLOWING recent conciliation conference at the Workplace Relations Commission in December 2021, the INMO has sought agreement on the re-establishment of the emergency department (ED) forums across the three major EDs in the South West area.

While a date is awaited for the ED forum to be established in Cork University Hospital, University Hospital Kerry had its first forum meeting on March 1, 2022. This will now provide a platform for INMO members working in the ED at University Hospital Kerry to have their issues addressed.

Challenging circumstances and overcrowding are ongoing issues for all members across the country. In addition, matters that aren't addressed at hospital level will be escalated to the South/South West Group and national level where required.

– Liam Conway, INMO IRO

Think Once-Weekly Ozempic®▼ for People with Type 2 Diabetes who have Atherosclerotic Cardiovascular Disease[1-3]

- Ozempic® provided a **significant 26% risk reduction of MACE**# in people with type 2 diabetes* and cardiovascular disease.[1,2,§]
- This includes a **39% relative risk reduction in non-fatal stroke.**[1,2,‡]
- Ozempic® also has **superior blood glucose and weight-loss efficacy** across all head-to-head clinical trials in the SUSTAIN program.[1-9,†,‡]

* 26% CV risk reduction in patients with type 2 diabetes and high CV risk, compared to placebo, in addition to standard treatment.
# Major Adverse Cardiovascular Events
† Results apply to Ozempic® across SUSTAIN trials, which included placebo, sitagliptin, dulaglutide, canagliflozin, exenatide PR and glargine U100.[1-9]
§ p=0.02 for superiority
‡ p<0.05

Ozempic® is recommended by the ADA/EASD Consensus Report for people with type 2 diabetes who have established atherosclerotic cardiovascular disease[10]

PR = Prolonged Release; ADA = American Diabetes Association; EASD = European Association for the Study of Diabetes.
SUSTAIN = Semaglutide Unabated Sustainability in treatment of Type 2 Diabetes.
*SUSTAIN was the phase 3 clinical trial programme investigating the effects of once weekly semaglutide versus other anti-diabetic agents.

ABBREVIATED PRESCRIBING INFORMATION
Ozempic®▼ semaglutide
Please refer to the Summary of Product Characteristics (SmPC) before prescribing. Ozempic® 0.25 mg solution for injection in pre-filled pen. Ozempic® 0.5 mg solution for injection in pre-filled pen. Ozempic® 1 mg solution for injection in pre-filled pen. One ml of solution contains 1.34 mg of semaglutide (human glucagon-like peptide-1 (GLP-1) analogue). **Indication:** Ozempic® is indicated for 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 • in addition to other medicinal products for the treatment of diabetes. For study results with respect to combinations, effects on glycaemic control and cardiovascular events, and the populations studied, see sections 4.4, 4.5 and 5.1 of the Ozempic® SmPC. **Posology and administration:** Administered once weekly at any time of the day, with or without meals. Injected subcutaneously in the abdomen, thigh or upper arm. Starting dose: 0.25 mg once weekly. After 4 weeks the dose should be increased to 0.5 mg once weekly. After at least 4 weeks with a dose of 0.5 mg once weekly, the dose can be increased to 1 mg once weekly to further improve glycaemic control. When Ozempic® is added to existing metformin and/or thiazolidinedione therapy or to an SGLT2 inhibitor, the current dose of metformin and/or thiazolidinedione or SGLT2 inhibitor can be continued unchanged. When Ozempic® is added to a sulfonylurea or insulin, a reduction in dose of sulfonylurea or insulin should be considered to reduce the risk of hypoglycaemia. Blood glucose self-monitoring is necessary to adjust the dose of sulfonylurea and insulin, particularly when Ozempic® is started and insulin is reduced. A stepwise approach to insulin reduction is recommended. Children: No data available. Elderly: No dose adjustment required, therapeutic experience in patients age ≥75 is limited. Renal impairment: No dose adjustment is required for patients with mild, moderate or severe renal impairment. Experience in patients with severe renal impairment is limited. Not recommended for use in patients with end-stage renal disease. Hepatic impairment: No dose adjustment is required for patients with hepatic impairment. Experience with severe hepatic impairment is limited. Caution should be exercised when treating these patients with semaglutide. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Special warnings and precautions for use:** Should not be used in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis. Not a substitute for insulin. Diabetic ketoacidosis has been reported in insulin-dependent patients whom had rapid discontinuation or dose reduction of insulin. There is no experience in patients with congestive heart failure NYHA class IV and is therefore not recommended in these patients. Use of GLP-1 receptor agonists may be associated with gastrointestinal adverse reactions. This should be considered when treating patients with impaired renal function as nausea, vomiting, and diarrhoea may cause dehydration which could cause a deterioration of renal function. Acute pancreatitis has been observed with the use of GLP-1 receptor agonists. Patients should be informed of the characteristic symptoms of acute pancreatitis. If pancreatitis is suspected, semaglutide should be discontinued; if confirmed, semaglutide should not be restarted. Caution should be exercised in patients with a history of pancreatitis. Use of semaglutide in combination with a sulfonylurea or insulin may have an increased risk of hypoglycaemia, therefore consider reducing the dose of sulfonylurea or insulin when initiating treatment with Ozempic®. In patients with diabetic retinopathy treated with insulin and semaglutide, an increased risk of developing diabetic retinopathy complications has been observed. Caution should be exercised when using semaglutide in patients with diabetic retinopathy treated with insulin. These patients should be monitored closely and treated according to clinical guidelines. Rapid improvement in glucose control has been associated with a temporary worsening of diabetic retinopathy, but other mechanisms cannot be excluded. When semaglutide is used in combination with a sulfonylurea or insulin, patients should be advised to take precautions to avoid hypoglycaemia while driving and using machines. **Fertility, pregnancy and lactation:** Women of childbearing potential are recommended to use contraception when treated with semaglutide. Should not be used during pregnancy or breast-feeding. Discontinue at least 2 months before a planned pregnancy. Effect on fertility unknown. **Undesirable effects:** *Very common (≥1/10):* Hypoglycaemia when used with insulin or sulfonylurea, nausea, diarrhoea. *Common (≥1/100 to <1/10):* Hypoglycaemia when used with other oral antidiabetic medications, decreased appetite, dizziness, diabetic retinopathy complications, vomiting, abdominal pain, abdominal distension, constipation, dyspepsia, gastritis, gastro-oesophageal reflux disease, eructation, flatulence, cholelithiasis, fatigue, increased lipase, increased amylase, weight decreased. *Uncommon (≥1/1,000 to <1/100):* Hypersensitivity, dysgeusia, increased heart rate, acute pancreatitis, injection site reactions. *Rare (≥1/10,000 to <1/1,000):* Anaphylactic reaction. Not known (cannot be estimated from available data): Angioedema. The SmPC should be consulted for a full list of side effects. **MA numbers**: Ozempic® 0.25 mg pre-filled pen EU/1/17/1251/002. Ozempic® 0.5 mg pre-filled pen EU/1/17/1251/003. Ozempic® 1 mg pre-filled pen EU/1/17/1251/005. Each pre-filled pen delivers 4 doses and includes 4 disposable NovoFine® Plus needles. **Legal Category:** POM. For complete prescribing information, please refer to the SmPC which is available on www.medicines.ie or by email from infoireland@novonordisk.com or from the Clinical, Medical and Regulatory Department, Novo Nordisk Limited, 1st Floor, Block A, The Crescent Building, Northwood Business Park, Santry, Dublin 9. **Date last revised:** March 2021.

▼Adverse events should be reported to the Health Products Regulatory Authority. Information about adverse event reporting is available at www.hpra.ie. Adverse events should also be reported to Novo Nordisk on Tel: 1850 665 665 or complaintireland@novonordisk.com

References: 1. Ozempic® Summary of Product Characteristics www.medicines.ie **2.** Marso SP, *et al;* Semaglutide and cardiovascular outcomes in patients with type 2 diabetes. (SUSTAIN 6) *N Engl J Med.* 2 2016;375:1834-1844. **3.** Marso SP, Bain SC, Consoli A, *et al.* Semaglutide and cardiovascular outcomes in patients with type 2 diabetes. *N Engl J Med.* 2016;375(suppl1):S1-S108. **4.** Lingvay I *et al,* Once weekly Semaglutide vs Canagliflozin in type 2 diabetes (SUSTAIN 8) : a double blind phase 3 randomised control trial: *Lancet Diabetes Endocrinol* 2019; 7: 834–44. **5.** Ahmann AJ *et al.* Efficacy and safety of once-weekly semaglutide versus exenatide ER in subjects with type 2 diabetes (SUSTAIN 3): A 56-Week, Open-Label, Randomized Clinical Trial. *Diabetes Care* 2018;41:258-266. **6.** Aroda VR *et al.* Efficacy and safety of once-weekly semaglutide versus once-daily insulin glargine as add-on to metformin (with or without sulfonylureas) in insulin-naive patients with type 2 diabetes (SUSTAIN 4): a randomised, open-label, parallel-group, multicentre, multinational, phase 3a trial. *Lancet Diabetes Endocrinol* 2017;5: 355–66. **7.** Sorli C *et al.* Efficacy and safety of once-weekly semaglutide monotherapy versus placebo in patients with type 2 diabetes (SUSTAIN 1): a double-blind, randomised, placebo-controlled, parallel-group, multinational, multicentre phase 3a trial. *Lancet Diabetes Endocrinol* 2017; 5: 251–60. **8.** Ahrén B *et al.* Efficacy and safety of once-weekly semaglutide versus once-daily sitagliptin as an add-on to metformin, thiazolidinediones, or both, in patients with type 2 diabetes (SUSTAIN 2): a 56-week, double-blind, phase 3a, randomised trial. *Lancet Diabetes Endocrinol* 2017; 5: 341–54. **9.** Pratley RE *et al.* Semaglutide versus dulaglutide once-weekly in patients with type 2 diabetes (SUSTAIN 7): a randomised, open-label, phase 3b trial. *Lancet Diabetes Endocrinol.* 2018;6275-286. **10.**Buse JB *et al.* 2019 update to: Management of hyperglycaemia in type 2 diabetes, 2018. A consensus report by the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). *Diabetes Care* 2020 Feb; 43(2):487-493.

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▼This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information.

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Date of preparation: October 2021. IE21OZM00098

ONCE-WEEKLY OZEMPIC®▼ semaglutide injection

Paid meal break extension refused

The INMO sought to exercise the right within the WRC agreement to discuss a further month of paid meal breaks and overtime arrangements for members in Cork/Kerry acute hospitals due to the continuing challenges of Covid-19/overcrowding. However the South/South West Group rejected the extension citing that as the fourth wave of Covid-19 had ended, it was not warranted.

New reps

Several members across the Kerry area have come forward to act as a link person in their workplace for INMO matters and dissemination of information. In addition the INMO Cork Office will be providing rep training later this year. Anyone interested in becoming a rep or link person, please email: inmocork@inmo.ie

– Liam Conway, INMO IRO

"Incredibly dangerous" overcrowding at LUH

INMO members called for government intervention to resolve the "incredibly dangerous" overcrowding at Letterkenny University Hospital. This came as management informed all staff that the hospital was nearing major incident level capacity.

The Organisation said that overcrowding is having a serious impact on staff wellbeing as well as on the quality of care that they can provide to patients.

INMO IRO Neal Donohue said: "Our members are trying desperately to work safely and keep patients safe in this incredibly dangerous environment, but it's not possible.

"The level of overcrowding in Letterkenny is appalling and the Covid risk is extremely high. It's simply not acceptable to expect or ask people to work in these conditions.

"There's no doubt this is going to have a long-term effect on recruitment and retention in the region, and that's going to impact the entire community. This situation requires immediate attention and government intervention."

Update on implementation of HSE NiRSP app

ENGAGEMENT continues on the National Integrated Staff Records and Pay Program (NiSRP) project with HR in the CHO3 which was planned to go live April 1, 2022. The INMO has raised queries about the recording of public holidays on the app, as well as the mechanism to record public holidays for five over five part-time colleagues. Members should have engagement with their line manager to reconcile their annual leave and public holidays. Access to the app on computer terminals has also been raised for those who don't have a smart phone. A query was also put to HR as to how time off in lieu (TOIL) will be recorded. HR confirmed TOIL will not be recorded on the app.

– Karen Liston, INMO IRE

Haemovigilance officers to vote on WRC settlement proposals

HAEMOVIGILANCE officers from a nursing background who have been on lower pay, worked longer hours and received a lower annual leave entitlement than their medical scientist counterparts carrying out the same role, are set to vote on a new settlement proposal.

Through a number of conciliation conferences at the Workplace Relations Commission (WRC) over the past 12 months, the INMO has fought hard to get the best possible outcome on behalf of haemovigilance officers.

These negotiations with the HSE at national level on behalf of haemovigilance officers culminated in a settlement proposal which will now be put to members.

There is a total of 56 WTE haemovigilance officers across the country, 41 WTE are on a CNM2 grade while 15 WTE are on the senior medical scientist grade.

Proposals

The WRC proposals that we will now be putting to members provide for the following:

- A new pay scale for the role of haemovigilance officer will be created equating to that of senior medical scientist (9-point higher scale)
- CNM2s will move onto the new scale, with effect from January 1, 2021, if the proposals are accepted. Members will move to the nearest point but not below existing salary plus one increment. Members will move up a further increment with effect from January 1, 2022. There is a difference of €9,247 at the top point of the scale
- Hours of work will reduce to 37 hours per week with effect from March 1, 2022 and will remain in line with senior medical scientist hours (set to reduce further)
- Annual leave will increase for all members to 29 days per annum
- Four additional days' annual leave (once off) will be given to members – two in 2022 and two in 2023.

These were difficult protracted negotiations, however, we now have a proposal that addresses the disparity between the grades and will ensure equity and fairness going forward should they be accepted by members.

The INMO is recommending acceptance of these proposals and is currently in the process of organising a ballot of members nationwide.

– Lorraine Monaghan, INMO Information Officer and Liam Conway, INMO IRO

Rosters dispute at Damien House Regional Services nearing resolution

ON BEHALF of members working in Damien House Regional Services and Re Nua Unit, a HSE RNID service in Cashel, an ongoing dispute about rostering issues was referred to a Joint Review Group process under the Public Service Stability Agreement by the INMO and SIPTU late last year.

A Joint Review Group meeting was convened in Kilkenny on February 11, 2022 to hear the dispute, which was presided over by senior national officials from the HSE, the INMO and SIPTU.

At the meeting, management at Damien House Regional Services proposed new rostering arrangements which they said would address the concerns of INMO and SIPTU members working in the services. By that time, INMO members working in Re Nua Unit, Cashel, had successfully engaged locally with their management team and their issues has been resolved.

Management's proposals in respect of Damien House Services were considered by INMO members at a general meeting held on February 22, and a further meeting with management took place on February 23 to clarify several issues regarding the proposals tabled.

INMO members, at a general meeting on March 7, agreed unanimously to accept the revised rosters proposed for Damien House Services, subject to the speedy implementation of all aspects of the proposals negotiated by the INMO on behalf of members.

– Liz Curran, INMO IRO

Settlement reached for member in southern region

THE INMO secured a significant settlement for a member in the south following the maladministration of one of the main investigative policies within the workplace.

The significant sum was important, not only in recognition of the failures of the employer but also to acknowledge the impact of these failures on the member.

This once again highlights the importance of members contacting the INMO to seek advice and representation at the outset if you are contacted for any process, such as a grievance, disciplinary, safe-guarding or a Trust in Care issue. It proved to be crucial in this incidence, that our member had contacted the union on notification from the employer of the initiation of such a policy.

– Liam Conway, INMO IRO

Segregation of HCA/MTA roles

Members at St Camillus Hospital in Limerick are balloting to commence a trial of the proposed roster on one ward for segregated MTA and HCA roles. There are no changes to the nursing roster which will continue to have four nurses on day duty/ two nurses at night. The trial is due to run for three months. The INMO has re-engaged with senior management on the requirement for a domestic supervisor to be appointed as support to the CNM2.

Enhanced practice contract

The Board at Milford Care Centre, a Section 39 service, has agreed to apply the enhanced practice contracts to all nurses who meet the criteria. Verification forms are to be completed with ADONs. Contracts will be issued and the rollout is anticipated to begin in mid June. The INMO is currently in discussion with management on increment dates and migration to the new scale.

– Karen Liston, INMO IRE

12th ICN NP/APN NETWORK CONFERENCE

21–24 August 2022 | Dublin, Ireland

Advanced Practice Nursing Shaping the Future of Healthcare

The INMO is delighted to be collaborating with the IAANMP in hosting the 12th International Council of Nurses, Nurse Practitioner / Advanced Practice Nurses Network Conference in University College Dublin from 21st to 24th August 2022. This year marks 26 years of Advanced Nursing / Midwifery practice in Ireland, and the conference will showcase and celebrate advancements in nursing and midwifery practice from around the world

Who attends?

Who attends? Nurse/ Midwife Practitioners • Advanced Practice Nurses and Midwives • Clinical Nurse and Midwife Specialists • Registered Nurses and Midwives • Those on the pathway to Advanced Practice • Educators • Policy Makers and Managers • Industry Partners • Media

Conference Themes

- Advancing nursing practice to address inequality
- Leading innovation in advanced practice nursing
- Health and Wellbeing
- Global Health and Climate Change
- Building a NP/APN workforce for health
- Evidencing the impact of advanced practice nursing

Call for abstracts now open until 14th March 2022
Visit www.npapndublin2022.com for further details

We Learn. We Innovate. We Advance

When the good gets better

Freda Hughes spoke to clinical facilitators at Cork University Hospital about their 'Mindful March' initiative

LIKE all intensive care units nationwide, Cork University Hospital (CUH) was hit hard during the Covid-19 pandemic. Prior to the initial Covid-19 outbreak, Claire Crowley, an ICU clinical facilitator, had recently returned to work in Ireland after working in ICU in Wellington in New Zealand. There was a big focus on staff wellbeing in the hospital she worked in and this was something she wanted to emulate in CUH.

Acting clinical facilitator Maria Dowling had watched the toll Covid-19 had taken on her colleagues and met with the hospital psychologist Liam Quade and wellness officer Anne Power to see if there was something they could do to build on the incredible teamwork they had established during the pandemic and put the spotlight back on staff wellbeing.

"Covid-19 changed nursing. As part of our undergraduate training we were taught to use our sense of touch and facial expressions as a way of reassuring and communicating with our patients. This wasn't possible in PPE. We had to do palliative care in a whole different way. I don't think any of us have been taught how to comfort a dying patient and hold their hand while wearing protective gloves and without any relatives around to support them.

"The pandemic changed the face of nursing, but it wasn't all negative. It also brought about a great sense of friendship and resilience within the team. We were all working long hours and we came to rely on each other," said Ms Dowling.

She spoke to fellow clinical facilitators Maria Dowling and Lynda O'Leary and they decided that they would try to launch an initiative for ICU staff. Anne Power taught them how to do mindfulness meditations with staff and donated some meditation bells to the project.

They decided the initiative would focus on mindfulness and positivity at work but worried that if they tried to do something every day it might fizzle out after a while so they opted to organise a focus month to begin with, and that's how 'Mindful March' was born.

Mindful March: *Staff pictured in Cork University Hospital were (l-r): Abby Chang, staff nurse; Ann McCarthy, CNM2; Lynda O'Leary, clinical facilitator; Claire Crowley, clinical facilitator; Maria Dowling, clinical facilitator; Elena O'Leary, staff nurse; and Gillian Counihan, staff nurse*

They planned a series of activities throughout the month such as reflective practices with the psychologist, mindful moment exercises and three-minute group meditations daily for the entire multidisciplinary team. Due to the extremely busy environment they work in, they keep the meditations short and efficient, but feel that group meditation helps build on teamwork and team resilience.

The group meditations were timed to suit those working in the unit. Another staff member Laura Heffernan offered 10-minute guided meditations every Monday in March. Two hikes were arranged during the month, one to the Galtee Mountains and another to Gougane Barra. They said these were a great way for nurses coming from overseas to get out and see the countryside and get to know their colleagues. Every Friday they brought in treats and baked goods to share and placed gratitude boxes in each unit. They have also made posters displaying positive affirmations around the unit.

Ms Crowley told *WIN* that they felt this initiative was very much needed as it was important to give back to staff.

"It's for staff but it's also by staff. We are all creating this together. Our first positive affirmation was 'When you focus on the good the good gets better'. It really sums up what we are doing here. Positivity is sparking more positivity around us. We are grateful to staff for taking part, especially at such a busy time. We would love to celebrate Mindful March every year.

"We've had loads of encouragement from the wider hospital team. We'd like to thank the staff of the general ICU because without them engaging and contributing, it wouldn't be as successful as it is. We also want to thank our CNM3 Bridget Doyle and our assistant director of nursing Emer Neau, as well as Anne Power, who have all been very supportive in backing the initiative from the get-go when it was just an idea.

"Staff wellbeing is integral to a productive team. It's very important to give back and acknowledge people's hard work. To find the time and energy to focus on the positive is actually huge in itself. We've had really positive feedback in the unit but it is all of us working together that has made this work," Ms Crowley added.

Fallout from burnout

Niall Conologue discusses the issue of burnout and what we can learn about the caring professions having worked through a pandemic

IT HAS been evident since the pandemic began that there would be an adverse effect on mental health. Service users, healthcare staff and the general public would never have experienced a comparable event and the scale, speed and nature of the change that accompanied it.[1] This article will explore the current wellbeing of patients and nursing staff in hospitals, but first let's consider some of the changes that have take place and the challenges that have arisen.

The fear of contracting an infection associated with healthcare is a concern for patients. Evidence shows links between this worry and patients seeking early discharge and avoidance of hospitals altogether.[2] It can be hypothesised that media coverage of a transmissible virus with high hospital admissions would result in higher levels of anxiety for inpatients, those yet to be admitted and family members.

A notable change implemented was restricting or ceasing of family visits. Healthcare workers know how significantly this affected patients. One study found patients felt that visitors were a great source of psychosocial support during a hospital stay. However, a lack of visits had negative implications for meeting the needs of patients and family members, resulting in lower levels of satisfaction.[3] Moreover, arguably these restrictions fostered feelings of isolation in patients, with negative consequences for their wellbeing.

Nurses working in a general practice setting feel a responsibility and concern for the mental health and wellbeing of their patients.[4,5] Yet there is consensus among practice nurses that they feel ill-equipped and lack confidence in managing these needs. Nonetheless, a desire is present to address these concerns by nurses who adopt a holistic model of care, which considers a patient's physical, spiritual and emotional needs. Critics of this model say that focusing too much on psychological needs leads to time-wasting and emotional exhaustion for nurses,[6] which is a characteristic of staff burnout.

Over the pandemic, significant focus has been given to burnout. This phenomenon presents a burden on a nurse's physical and mental wellbeing. Characterised by factors such as emotional exhaustion, depersonalisation and a decreased sense of personal accomplishment.[7] Nurses and midwives experienced these factors in high levels during the pandemic.[8]

Even in the years preceding the pandemic burnout has been an issue facing nurses, resulting in negative consequences for overall practice brought on by an increased workload.[9] Higher incidence of healthcare-associated infections such as urinary tract infections and surgical site infections have been noted when a nurse's workload increases by even one patient.[10] Additionally, burnout affects our ability to engage with preventive reporting behaviour with regards to errors and near misses – a critical part of addressing safety concerns for any healthcare environment.[11] This is concerning for patient safety outcomes.

Studies have been carried out to explore risk factors for developing burnout with recommendations on preventative measures.[12,13] However, it is important to understand that the consequences of burnout present an emotional challenge to nurses and midwives and can often guide them to leave the profession due to not being able to provide quality care.[14]

It important to consider staff burnout when considering the mental health concerns of our patients. The conclusion that I do not want to reach is that burned-out nurses cannot address the mental health needs of their patients and the past two years are evidence that is not the case. In essence, I find that it is actually the opposite. I think the difficult time experienced by the general public, patients and healthcare workers has revealed the exponential capacity of human resilience. I see it when a business shows how adaptive it can be when accommodating challenging and rotating restrictions.

My colleagues are continuing to work as hard as ever, all while championing professionalism, kindness and empathy. I have also seen empathy in my patients. Often those who are dealt the worst hand, despite the horrors they have been through, will still say "I hope you never have to experience this". It is in those solemn moments where you realise empathy remains one of the most needed qualities in our existence, if we hope to understand each other

While I can't provide solutions to burnout or larger systemic problems from this piece, I believe these struggles we are feeling are all evidence that providing care still matters a great deal to us.

Niall Conologue is a nurse at Beaumont Hospital

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Marie Kilduff and **Margaret Williams** discuss the benefits of developing a mentoring structure for nurses and midwives

Mentorship and you

THE National Clinical Leadership Centre for Nursing and Midwifery (NCLC) supports the clinical leadership development of all grades of nurses and midwives, through its programmes, workshops and development initiatives. The NCLC has recognised the benefit of mentoring for a number of years evidenced by its mentoring implementation programme that supports organisations to develop and sustain a mentoring structure for nurses and midwives.

In 2021, the Office of Nursing and Midwifery Services Director (ONMSD), Chief Nurse's Office (CNO) and the Nursing and Midwifery Board of Ireland (NMBI) proposed that the 2021 nursing and midwifery graduates should be offered mentoring as an additional support, in recognition of the effect of the pandemic over the final two years of their undergraduate programmes. The NCLC was requested to lead on this initiative.

Further to this, the NCLC formed a plan to guide the implementation process. This involved the following steps:

- *Step one:* Meetings with key stakeholder groups of nursing (all disciplines) and midwifery who have new graduates in their service to provide a comprehensive overview of the implementation process and invite them to nominate a mentoring lead for their organisation
- *Step two:* The NCLC mentoring lead meets and supports the nominated mentoring leads to implement the mentoring process in their service using the NCLC Mentorship for Nurses and Midwives – Implementing a Mentorship Programme: A Guiding Framework (2018)
- *Step three:* The NCLC provides a virtual two-hour mentoring training programme for all those who wish to become mentors. The NCLC Mentoring a Guide for Mentors and Mentees (2020) is sent to the local mentoring leads for circulation to mentors and mentees
- *Step four:* The 2021 graduates who wish to engage in the mentoring process are provided with a list of mentors in their service, by the local mentoring lead. The mentee chooses their mentor and following a 'chemistry meeting', the mentor and mentee engage in four mentoring sessions over a 12-month period
- *Step five:* At the end of the mentoring process, the mentee completes an evaluation to seek feedback of their experience of the mentoring process.

Since the initiative began in September 2021, over 300 nurses and midwives have volunteered to become mentors within their services. The initiative has been successfully embedded in a number of nursing (various disciplines) and midwifery services nationally. The feedback has been extremely positive and a number of services have officially launched their mentoring programmes (*see Box above*) in recognition of the value that is being placed on this initiative in their organisations.

The NCLC would like to thank all those who have engaged in this initiative. For further information please contact Marie Kilduff, NCLC director at email: marie.kilduff@hse.ie or Margaret Williams, NCLC mentoring lead, at email: Margaret.williams1@hse.ie

Nurse mentorship in Cork University Hospital

CORK University Hospital (CUH) nursing services recently launched its exciting new nurse mentorship initiative to support new graduate nurses at the outset of their nursing careers in collaboration with the National Clinical Leadership Centre for Nursing & Midwifery. Béibhinn O'Sullivan, allocations liaison officer, Mary Davey, ANP acute medicine, and Andrea Moriarty, practice development officer, are leading the CUH nurse mentorship programme for graduate nurses. Work began over six months ago with the leads in CUH linking with the NCLC and undertaking the mentorship training provided by Margaret Williams, NCLC national lead. Promotion of the initiative began in earnest in December 2021. The CUH leads set up a mentorship stand in the hospital for a week at the beginning of that month and were delighted with the enthusiasm of the nursing staff signing up to become mentors.

"We were overwhelmed with the uptake from senior nursing staff of all levels. We were conscious that they are already over-stretched in their busy clinical areas but there is an understanding among them that to retain nursing staff, we need to provide more support," said Andrea Moriarty, CUH lead on nurse mentorship.

CUH officially launched nurse mentorship for graduate nurses on March 1 this year with a large attendance of mentors, mentees and nursing management present. Bridie O' Sullivan, chief director of nursing for the South/South West Hospital Group, opened the launch followed by Dr Aoife Lane, leadership advisor with the NCLC, who spoke about the importance of supporting newly qualified nurses. Siobhan Scanlon, acting director of nursing at CUH, praised the uptake in mentorship in CUH with over 70 mentors signed up to date. Ann Marie Galvin, nurse practice development co-ordinator at CUH, said that in the long-term she would like to see every nurse in CUH having the opportunity to have a mentor.

There is great enthusiasm for the initiative at CUH with many staff nurses saying they would have relished the opportunity to avail of a mentorship programme if something similar had been in place when they were graduates. Louise Murphy, ANP in rheumatology, who signed up as a mentor said: "It's great to have a mentorship programme for our nursing graduates and I would have loved this myself when I was starting out."

The initiative is going well, according to Ms Moriarty: "The mentees were quick off the mark and studied the database of potential mentors to decide who would be a good fit for them on their career pathway. Mentorship relationships were established in a timely manner. We look forward to evaluating this initiative at the end of the first year and expanding it to other nursing staff. We are so lucky to be able to launch the nurse mentorship programme in CUH. At the moment our thoughts and solidarity are with our nursing and midwifery colleagues who are working in such incredibly difficult circumstances in Ukraine."

– Béibhinn O'Sullivan and Mary Davey

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Refer to Summary of Product Characteristics before prescribing. **PRESENTATION** KEYTRUDA 25 mg/mL: One vial of 4 mL of concentrate contains 100 mg of pembrolizumab. **INDICATIONS** KEYTRUDA as monotherapy is indicated for the treatment of advanced (unresectable or metastatic) melanoma in adults. KEYTRUDA as monotherapy is indicated for the adjuvant treatment of adults with Stage III melanoma and lymph node involvement who have undergone complete resection. KEYTRUDA as monotherapy is indicated for the first-line treatment of metastatic non-small cell lung carcinoma (NSCLC) in adults whose tumours express PD-L1 with a ≥50% tumour proportion score (TPS) with no EGFR or ALK positive tumour mutations. KEYTRUDA, in combination with pemetrexed and platinum chemotherapy, is indicated for the first-line treatment of metastatic non-squamous NSCLC in adults whose tumours have no EGFR or ALK positive mutations. KEYTRUDA, in combination with carboplatin and either paclitaxel or nab-paclitaxel, is indicated for the first-line treatment of metastatic squamous NSCLC in adults. KEYTRUDA as monotherapy is indicated for the treatment of locally advanced or metastatic NSCLC in adults whose tumours express PD-L1 with a ≥1% TPS and who have received at least one prior chemotherapy regimen. Patients with EGFR or ALK positive tumour mutations should also have received targeted therapy before receiving KEYTRUDA. KEYTRUDA as monotherapy is indicated for the treatment of adult and paediatric patients aged 3 years and older with relapsed or refractory classical Hodgkin lymphoma (cHL) who have failed autologous stem cell transplant (ASCT) or following at least two prior therapies when ASCT is not a treatment option. KEYTRUDA as monotherapy is indicated for the treatment of locally advanced or metastatic urothelial carcinoma in adults who have received prior platinum-containing chemotherapy. KEYTRUDA as monotherapy is indicated for the treatment of locally advanced or metastatic urothelial carcinoma in adults who are not eligible for cisplatin-containing chemotherapy and whose tumours express PD L1 with a combined positive score (CPS) ≥ 10. KEYTRUDA as monotherapy or in combination with platinum and 5-fluorouracil (5-FU) chemotherapy, is indicated for the first-line treatment of metastatic or unresectable recurrent head and neck squamous cell carcinoma (HNSCC) in adults whose tumours express PD-L1 with a CPS ≥ 1. KEYTRUDA as monotherapy is indicated for the treatment of recurrent or metastatic HNSCC in adults whose tumours express PD-L1 with a ≥ 50% TPS and progressing on or after platinum-containing chemotherapy. KEYTRUDA, in combination with axitinib, is indicated for the first-line treatment of advanced renal cell carcinoma (RCC) in adults. KEYTRUDA, in combination with lenvatinib, is indicated for the first line treatment of advanced renal cell carcinoma in adults. KEYTRUDA as monotherapy is indicated for the first line treatment of metastatic microsatellite instability high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer in adults. KEYTRUDA, in combination with platinum and fluoropyrimidine based chemotherapy, is indicated for the first-line treatment of locally advanced unresectable or metastatic carcinoma of the oesophagus or HER-2 negative gastroesophageal junction adenocarcinoma in adults whose tumours express PD-L1 with a CPS ≥ 10. KEYTRUDA, in combination with chemotherapy, is indicated for the treatment of locally recurrent unresectable or metastatic triple negative breast cancer in adults whose tumours express PD L1 with a CPS ≥ 10 and who have not received prior chemotherapy for metastatic disease. KEYTRUDA, in combination with lenvatinib, is indicated for the treatment of advanced or recurrent endometrial carcinoma in adults who have disease progression on or following prior treatment with a platinum containing therapy in any setting and who are not candidates for curative surgery or radiation. **DOSAGE AND ADMINISTRATION** See SmPC for full details. Therapy must be initiated and supervised by specialist physicians experienced in the treatment of cancer. The recommended dose of KEYTRUDA in adults is either 200 mg every 3 weeks or 400 mg every 6 weeks administered as an intravenous infusion over 30 minutes. The recommended dose of KEYTRUDA as monotherapy in paediatric patients aged 3 years and older with cHL is 2 mg/kg bodyweight (up to a maximum of 200 mg), every 3 weeks administered as an intravenous infusion over 30 minutes. For use in combination, see the Summary of Product Characteristics (SmPC) for the concomitant therapies. KEYTRUDA must not be administered as an intravenous push or bolus injection. When administering KEYTRUDA as part of a combination with intravenous chemotherapy, KEYTRUDA should be administered first. Treat patients until disease progression or unacceptable toxicity (and up to maximum duration of therapy if specified for an indication). For the adjuvant treatment of melanoma, KEYTRUDA should be administered until disease recurrence, unacceptable toxicity, or for a duration of up to one year. KEYTRUDA, as monotherapy or as combination therapy, should be permanently discontinued (a) For Grade 4 toxicity except for: endocrinopathies that are controlled with replacement hormones; or haematological toxicity, only in patients with cHL in which KEYTRUDA should be withheld until adverse reactions recover to Grade 0-1; (b) If corticosteroid dosing cannot be reduced to ≤10 mg prednisone or equivalent per day within 12 weeks; (c) If a treatment-related toxicity does not resolve to Grade 0 1 within 12 weeks after last dose of KEYTRUDA; (d) If any event occurs a second time at Grade ≥ 3 severity. Patients must be given the Patient Alert Card and be informed about the risks of KEYTRUDA. *Special populations Elderly:* No dose adjustment necessary. *Renal impairment:* No dose adjustment needed for mild or moderate renal impairment. No studies in severe renal impairment. *Hepatic impairment:* No dose adjustment needed for mild hepatic impairment. No studies in moderate or severe hepatic impairment. *Paediatric population:* Safety and efficacy in children below 18 years of age not established except in paediatric patients with cHL. **CONTRAINDICATIONS** Hypersensitivity to the active substance or to any excipients. **PRECAUTIONS AND WARNINGS** *Assessment of PD-L1 status* When assessing the PD-L1 status of the tumour, it is important that a well-validated and robust methodology is chosen to minimise false negative or false positive determinations. *Immune-related adverse reactions* Immune-related adverse reactions, including severe and fatal cases, have occurred in patients receiving pembrolizumab. Most immune related adverse reactions occurring during treatment with pembrolizumab were reversible and managed with interruptions of pembrolizumab, administration of corticosteroids and/or supportive care. Immune related adverse reactions have also occurred after the last dose of pembrolizumab. Immune-related adverse reactions affecting more than one body system can occur simultaneously. Immune-related adverse reactions are immune-related pneumonitis, immune-related colitis, immune-related hepatitis, immune-related nephritis, immune-related endocrinopathies (including adrenal insufficiency, hypophysitis, type 1 diabetes mellitus, diabetic ketoacidosis, hypothyroidism, and hyperthyroidism), Immune-related skin adverse reactions (also including Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN)), Refer to SmPC for more information and management of immune-related adverse reactions. *Complications of allogeneic Haematopoietic Stem Cell Transplant (HSCT):* Cases of graft-versus-host-disease (GVHD) and hepatic veno-occlusive disease (VOD) have been observed in patients with classical Hodgkin lymphoma undergoing allogeneic HSCT after previous exposure to pembrolizumab. *Infusion-related reactions:* Grades 1, 2, 3 or 4 infusion reactions including hypersensitivity and anaphylaxis, could be seen with pembrolizumab treatment. Refer to SmPC for more information and management of infusion-related reactions. *Overdose:* There is no information on overdose with pembrolizumab. In case of overdose, monitor closely for signs or symptoms of adverse reactions and treat appropriately. **INTERACTIONS** No formal pharmacokinetic drug interaction studies have been conducted with pembrolizumab. No metabolic drug drug interactions are expected. The use of systemic corticosteroids or immunosuppressants before starting pembrolizumab should be avoided because of their potential interference with the pharmacodynamic activity and efficacy of pembrolizumab. Corticosteroids can be used as premedication, when pembrolizumab is used in combination with chemotherapy, as antiemetic prophylaxis and/or to alleviate chemotherapy-related adverse reactions. **FERTILITY, PREGNANCY AND LACTATION** *Women of childbearing potential* Women of childbearing potential should use effective contraception during treatment with pembrolizumab and for at least 4 months after the last dose of pembrolizumab. *Pregnancy* No data on use in pregnant women. Do not use during pregnancy unless the clinical condition of the woman requires treatment with pembrolizumab. *Breast-feeding* It is unknown whether pembrolizumab is secreted in human milk. A risk to newborns/ infants cannot be excluded. *Fertility* No clinical data available. **SIDE EFFECTS** Refer to SmPC for complete information on side effects. Pembrolizumab is most commonly associated with immune-related adverse reactions. Most of these reactions resolved with appropriate medical treatment or withdrawal of pembrolizumab. The most serious adverse reactions were immune-and infusion-related adverse reactions. When pembrolizumab is administered in combination with axitinib or lenvatinib, refer to the SmPC for axitinib or lenvatinib prior to initiation of treatment. For additional lenvatinib safety information related to advanced RCC see the SmPC for Kisplyx and for advanced EC see the SmPC for Lenvima. **Monotherapy:** *Very Common:* anaemia, hypothyroidism, decreased appetite, headache, dyspnea, cough, abdominal pain, nausea, vomiting, constipation, musculoskeletal pain, arthralgia, asthenia, oedema, pyrexia, diarrhoea, rash, pruritus, fatigue. *Common:* pneumonia, thrombocytopenia, neutropenia, lymphopenia, hyponatraemia, hypokalaemia, hypocalcaemia, insomnia, neuropathy peripheral, lethargy, dry eye, cardiac arrhythmia (including atrial fibrillation), hypertension, hyperthyroidism, thyroiditis, insomnia, dizziness, dysgeusia, pneumonitis, colitis, dry mouth, severe skin reactions, vitiligo, dry skin, alopecia, eczema, dermatitis acneiform, erythema, dermatitis, myositis, pain in extremity, arthritis, influenza like illness, chills, AST and ALT increases, hypercalcaemia, increase in blood alkaline phosphatase, blood bilirubin increased, blood creatinine increased, infusion related reaction. **In combination with chemotherapy:** *Very Common:* pneumonia, neutropenia, anaemia, thrombocytopenia, leukopenia, hypothyroidism, hypokalaemia, decreased appetite, insomnia, neuropathy peripheral, headache, dizziness, dyspnoea, cough, nausea, vomiting, diarrhoea, abdominal pain, constipation, alopecia, rash, pruritus, musculoskeletal pain, arthralgia, pyrexia, fatigue, asthenia, oedema, ALT increase, AST increased, blood creatinine increased. *Common:* febrile neutropenia, lymphopenia, infusion related reaction, hyperthyroidism, hyponatraemia, hypocalcaemia, lethargy, dysgeusia, dry eye, cardiac arrhythmia (including atrial fibrillation), hypertension, pneumonitis, colitis, dry mouth, gastritis, hepatitis, severe skin reactions, erythema, dermatitis, dry skin, myositis, pain in extremity, arthritis, acute kidney injury, influenza-like illness, chills, hypercalcaemia, blood alkaline phosphatase increased, blood bilirubin increased. **In combination with axitinib or lenvatinib:** *Very Common:* urinary tract infection, anaemia, hypothyroidism, decreased appetite, headache, dysgeusia, hypertension, dyspnoea, cough, diarrhoea, abdominal pain, nausea, vomiting, constipation, rash, pruritus, arthralgia, musculoskeletal pain, myositis, pain in extremity, fatigue, asthenia, oedema, pyrexia, lipase increased, alanine aminotransferase increased, aspartate aminotransferase increased, blood creatinine increased. *Common:* pneumonia, neutropenia, thrombocytopenia, lymphopenia, leukopenia, infusion-related reaction, adrenal insufficiency, hyperthyroidism, thyroiditis, hyponatraemia, hypokalaemia, hypocalcaemia, insomnia, dizziness, neuropathy peripheral, lethargy, dry eye, cardiac arrhythmia (including atrial fibrillation), pneumonitis, colitis, pancreatitis, gastritis, dry mouth, hepatitis, severe skin reactions, dermatitis, dry skin, erythema, dermatitis acneiform, alopecia, arthritis, nephritis, influenza like illness, chills, amylase increased, blood bilirubin increased, blood alkaline phosphatase increased, hypercalcaemia. **PACKAGE QUANTITIES** KEYTRUDA 25 mg/mL: 4 mL of concentrate in a 10 mL Type I clear glass vial. **Legal Category:** POM. **Marketing Authorisation numbers** EU/1/15/1024/002 **Marketing Authorisation holder** Merck Sharp & Dohme B.V., Waarderweg 39, 2031 BN Haarlem, The Netherlands. **Date of revision:** November 2021. Further information is available on request from: MSD, Red Oak North, South County Business Park, Leopardstown, Dublin D18 X5K7 or from www.medicines.ie. II0104_105

Adverse events should be reported. Reporting forms and information can be found at www.hpra.ie. Adverse events should also be reported to MSD (Tel: 01-2998700)

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R/M = recurrent or metastatic, CPS = combined positive score, ESMO = European Society for Medical Oncology, ChT = chemotherapy, HNSCC = head and neck squamous cell carcinoma.

MSD
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IE-KEY-00476 Date of Preparation: January 2022

Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Annual leave for enhanced staff midwives

Q. I have 16 years' experience and work as an enhanced staff midwife. I only work 24 hours per week (normally Mondays, Tuesdays and Wednesdays). How much annual leave am I entitled to?

Staff midwives who work part time are entitled to annual leave on a pro rata basis. As you have over 10 years' experience and are an enhanced staff midwife, this would mean that the calculation would be to take 27 days, divide it by 39 hours, and multiply it by the number of reduced hours per week you work, ie. 24 hours. This will give you your annual leave entitlement in days, and if you multiply this number by 7.8 it will give you the answer in hours – so you would have approximately 16.62 days or 129.64 hours of annual leave per annum.

Sick leave

Q. I am currently on sick leave and have taken 74 days of sick leave so far. My employer has informed me that I will be moving on to half pay in less than three weeks. Is this correct?

Yes, this is correct. The Public Service Sick Leave Scheme provides for 92 days (three months) on full pay in a rolling 12-month period, followed by 91 days (three months) on half pay, subject to an overall maximum limit of 183 days of paid sick leave in a rolling four-year period.

Salary scales

Q. I recently qualified as a staff nurse and was put on point 1 of the salary scale. However, I was a sponsored student and worked as a healthcare assistant for five years before I started the course. Should I not be on a higher point of the salary scale?

You are correct. As per HSE HR Circular 011/2008, employees who were sponsored to undergo the nursing degree programme, on appointment as a staff nurse, should be assimilated on the nearest monetary point of the staff nurse salary scale based on their existing salary. Additionally, this provision also applies to employees who self fund the nursing degree programme as per HSE HR Circular 030/2017. I advise you to contact your payroll/salaries department regarding the appropriate point of the salary scale. If you encounter any issues your INMO official will support you.

Working after retirement

Q. I am due to retire in two months and am on a PRSI class D stamp. Can I continue to work a few shifts each month following my retirement?

Before undertaking employment in the public sector, retired nurses and midwives should take into account the impact such employment may have on their pension. If you are in receipt of a public sector occupational pension and following retirement, you return to work in the public sector, you may not earn more, by way of 're-employed' salary and pension, than the uprated salary for the post from which you retired. Where your new salary and pension exceed your previous uprated salary, your employer will deduct the excess from your pension. This is known as 'pension abatement'. Abatement is determined by the specified period of re-employment and with reference to the work in that period. The extent of the 'specified period' may have the impact of permitting you to earn up to 50% of the uprated salary of your former post, before your pension is reduced. You should contact your superannuation department if you have any queries/concerns before retiring and commencing part-time work following retirement.

Special leave with pay changes

Q. Can you advise in relation to special leave with pay? I contracted Covid-19 at work and I am on day 10 of special leave with pay. As I am still testing positive for Covid I am unable to go back to work. My employer advised that I am no longer entitled to be paid special leave with pay and that on day 11 I will be placed on sick leave. Is this correct?

The application of special leave with pay has changed from February 7, 2022. The special leave with pay scheme for Covid-19 will be applicable for a maximum of 10 consecutive calendar days for all new cases. This arrangement applies to all nurses/midwives advised to self-isolate because they are displaying symptoms of Covid-19 and/or have received a positive PCR test result for Covid-19. If an employee is unable to return to work after 10 consecutive calendar days they now move to ordinary sick leave arrangements.

Know your rights and entitlements

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

Contact Information Officers Catherine Hopkins and Catherine O'Connor at
Tel: 01 664 0610/19
Email: catherine.hopkins@inmo.ie, catherine.oconnor@inmo.ie
Mon to Thur 8.30am-5pm; Fri 8.30am-4.30pm

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

Playing her part

A chance encounter with a renowned film director inspired nurse Helen Behan to pursue a career on the big screen. **Freda Hughes** spoke to the BAFTA-nominated actress about her nursing background, leaving the profession and returning to the health service during the pandemic

AFTER more than 20 years of nursing, a chance encounter in a seaside pub changed nurse Helen Behan's life forever.

Although she always enjoyed acting in school, Ms Behan had never had the opportunity to pursue it as a career, until one night while out with friends in a pub in the seaside village of Bettystown, she noticed film director Shane Meadows there. Mr Meadows was renowned for directing cult classics *This is England*, *Dead Man's Shoes* and *A Room For Romeo Brass*. She decided to take a chance and introduce herself.

They hit it off and by the end of the night Ms Behan decided to ask him if there was any chance of her landing a part in one of his productions. She wrote her number on a till receipt and didn't expect to hear from him again. Within a month she got a call and was asked to audition for a role in the *This is England* spin-off series *This is England '88*.

"I was younger and braver then but he was very generous and open to it. It was kind of a serendipitous moment where I asked at the right time and he was willing to extend his generosity and his expertise," Ms Behan said.

Her first acting role had involved playing a nurse. She said she was petrified but knew how to be a nurse, which helped her ease into the role. She said it was difficult getting used to the terminology and the ever-present cameras but that she relished her new opportunity.

Nursing background

Ms Behan trained as a nurse in Beaumont Hospital before moving to Australia, where she worked in ENT and vascular surgical nursing. On her return to Ireland she began working as a practice nurse, a role she stayed in until her acting career took over. She also worked on the school vaccination programmes during her time as a practice nurse.

In the early days of her acting career she was working three jobs while also raising children. When the offers of roles became more frequent, it was important to make a decision about which career path she was going to follow and about five years ago she decided to focus on acting full time.

Directed by Mr Meadows, the TV series *The Virtues* was coming out around then and Ms Behan was nominated for a BAFTA for her role. This was a major turning point and offers of work started to flood in. She made the difficult decision to leave nursing and focus on her acting career.

"It was a huge risk but so far it's working out. I always loved acting but I became

a nurse and that was my life. When this opportunity presented itself, I put both my hands out and have managed to hold on to it so far.

"Shane is a great filmmaker. He portrays characters who wouldn't get much of an empathetic portrayal elsewhere. He makes films about what he knows so there's a real authenticity to them. His characters have depth and he has a knack for nurturing and cultivating talent.

"To have empathy as a human being is going to lend itself to telling those stories. At the root of most stories there's a person with real struggles and real pain and real drama in their lives. Everybody has drama in their lives at some point or other, and I think being a nurse has helped me to tune into compassion and empathy. And I've used that to fuel my characters. It adds depth to the character and nursing has a lot to do with that for me," she told *WIN*.

Covid-19

When the pandemic hit, the fear of her colleagues and the hospitals becoming overwhelmed prompted Ms Behan to find a way of using her nursing skills to help out. When accommodation centres were being set up for Covid-positive patients to take the pressure off the hospitals, she made herself available and almost immediately started working in the centre, known as a hub, in Co Louth.

"We looked like something from the NASA space station but as nurses we have an innate sense of warmth and welcoming. God love the patients trying to communicate with us in full PPE. The hubs were so well run and I started to feel safe despite working with Covid-positive patients. It was great to be able to offer comfort to those patients at such a scary time," she said.

After that Ms Behan took on a swabbing role in a Covid-19 test centre in the area and then worked in the vaccination centres until recently. She was joined by nurses and midwives from all walks of life, many of whom had retired and returned to help out.

"It was all hands on deck. We were working like the hounds of hell vaccinating. It was very rewarding to be able to help but it was scary at the beginning. I was worried I would bring it home to my family or get sick myself. It was the great unknown. I had a skill set and help was needed – it was as simple as that.

> *"Being a nurse has helped me to tune into my compassion and empathy – I've used that to fuel my characters"*

"It's this thing we have built into us as nurses – we have to help if we can. I was doing my job. I didn't do anything extraordinary. To me it was my societal duty. In living memory I don't remember when nurses were needed so much as during this pandemic. It's been an exhausting two years, but once a nurse, always a nurse. We're a special breed of people," she said.

Employment options

Although she loves nursing, Ms Behan is glad to have other employment options due to the tough conditions and oppressive workloads faced by those in the professions.

On returning to nursing, she noticed that little had changed in terms of working conditions and financial remuneration for nurses and midwives. She feels that the professions are undervalued while nurses and midwives are still being expected to work long hours in difficult conditions despite this.

"Nurses and midwives are the boots on the ground. They took the responsibility of getting us through the Covid-19 pandemic, but sadly I fear our input won't be recognised.

"Nurses don't have a seat at the table or a say in policy development, despite our in-depth frontline knowledge. It's the boots on the ground that put themselves at risk but sadly we are a trod-upon division, often forgotten.

"All the clapping in the world won't pay the bills or rest our weary bodies after a long shift. The work is so emotionally draining and we've yet to see the full effects of the pandemic on the mental health of nurses and midwives who are now being pushed to the back of the queue. That's the most disheartening thing," she said.

Ms Behan recently finished filming the TV series *Holding*, which is based on Graham Norton's book of the same name. She also has a number of other projects in the works, but none that she can reveal to us just yet, a case of 'watch this space'...

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

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Section focus

INMO Professional

Jean Carroll, Section Development Officer

Strike settlement terms discussed at CRGN Section webinar

INMO SENIOR management hosted an information webinar for the CRGN Section recently, as a follow-on from the regional meetings that took place in each CHO area throughout January and February.

The points raised at the webinar included the financial gains for CRGNs under the 2019 strike settlement, which include the new enhanced practice salary scale. The highlights of this scale include:

- Reaching the maximum point of the salary scale four years earlier
- Access to senior staff nurse/midwife scale is now available after 17 years, which previously took 20 years
- A 20% increase to existing location/specialist qualification allowances where applicable.

This equates to higher lifetime earnings overall and therefore higher pension on retirement. Also discussed was the caseload allowance of €3,943 where applicable.

Mileage and subsistence allowances are relevant issues at the moment. The rates applied across the public sector are negotiated by the civil service trade unions. The INMO and other non-civil service unions are not party to negotiations on mileage and subsistence rates. However, the INMO has raised the issue. A review has been sought by civil service unions with the Department of Public Expenditure and Reform.

Other issues discussed at the meeting included running regional workshops on the application of the enhanced practice scale and caseload allowance, increased representation and input regarding the metrics project and applicability to CRGNs.

Sinead Lawlor, HSE national practice development co-ordinator with the HSE, was a guest speaker at the meeting and following this event a member of the CRGN Section has joined the national metrics project committee.

Deputy chief nursing officer Georgina Bassett also attended, updating members on relevant issues within the Department of Health. The INMO is seeking representation regarding the future of the CRGN grade, to include representation from the section.

In conjunction with Section officer, INMO Professional will be developing a CRGN conference to include expert input and discussion regarding the future of the role.

The INMO has developed template letters to assist with the application for a community caseload allowance or for the application for a specialist qualification allowance. Contact jean.carroll@inmo.ie if you would like to be sent a copy by email.

CPC Section elects new officers at meeting

THE Clinical Placement Co-ordinators (CPC) Section recently elected new section officers to continue to steer its ongoing work.

CPC Rachael Phelan, from Waterford, was elected chairperson, while Eileen Fallon, from Beaumont Hospital, Dublin, was elected secretary.

Rachael Dolan and Catriona McCahey, both from Our Lady of Lourdes, Drogheda, will take over as joint education officers of the section.

Outgoing chair Angela Lally was thanked for her service over the past two years, while it was announced that Anne-Marie Murray, education officer for the past four years, would be moving to a post in practice development in Our Lady of Lourdes Hospital, Drogheda.

Aiden Butler was also thanked for his term as the section's national secretary.

Speaking to *WIN*, Ms Lally said: "We are very conscious that things remain uncertain in clinical areas but we are delighted to see the new committee established. The role of the CPC is multifaceted and it is wonderful to see new CPCs joining the section. I look forward to working and supporting the new committee in the months ahead.

"A sincere thank you for your commitment to quality patient care, student and preceptor support. I look forward to working with you all at section level to enhance the clinical learning environment in our workplaces and support nurses as they take up CPC positions."

The next meeting of the CPC Section will take place via Microsoft Teams on April 27.

The annual CPC Section seminar will take place in late October/early November 2022. It is hoped that this will be an in-person event.

In brief...

Third Level Student Health Nurses meeting

MEMBERS of the Third Level Student Health Nurses Section are looking forward to returning to face-to-face meetings and have organised one for Friday, June 10 – their first one since the pandemic began. The meeting will take place at the Richmond Education and Event Centre from 10am. The educational component will comprise a talk on the transmission, diagnosis and treatment of hepatitis C, which will be delivered by Gail Hawthorne, CNS. All members of the INMO Third Level Student Health Nurses Section are invited to attend.

Sections to discuss ADC motions

THE INMO ADC is taking place from May 6-8 in the Radisson Blu Hotel, Sligo. At this stage, all the motions for debate have been submitted, ratified by the standing orders committee and are now ready for your section to review and decide how your nominated section delegates are going to vote on the day. It is important to attend the meeting that is scheduled for your section in April so that you can have your say. Meetings will take place via Zoom or Microsoft Teams.

Get in touch

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

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

Webinars & Conferences for Nurses and Midwives

Webinars and Conferences 2022

ONLINE AND IN-PERSON EVENTS

All conferences and webinars are Category 1 approved by NMBI

Thursday 9 JUNE — Emergency Department Nurses Section Webinar

Tuesday 20 SEPTEMBER — Care of the Older Person Section Webinar

Wednesday 28 SEPTEMBER — Telephone Triage Nurses Nurses Section Webinar

Thursday 17 NOVEMBER — All Ireland Midwifery Conference

Date to be Confirmed — Operating Department Nurses Section Webinar

Date to be Confirmed — Occupational Health Nurses Section Webinar

Date to be Confirmed — RNID Section Webinar

Date to be Confirmed — Director & Asst. Directors Section Webinar

Date to be Confirmed — Public Health Nurses Section Webinar

Date to be Confirmed — International Nurses Section Culture Fest

For more Information:

Jean Carroll, Section Development Officer
jean.carroll@inmo.ie, www.inmoprofessional.ie/conference

INMO Professional

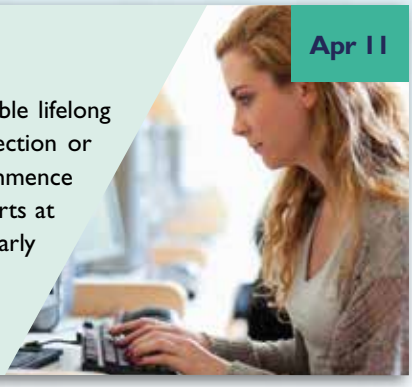
Continuing professional development for nurses and midwives

INMO EDUCATION PROGRAMMES

In the pull-out this month…

Introduction to Effective Library Search Skills

Apr 11

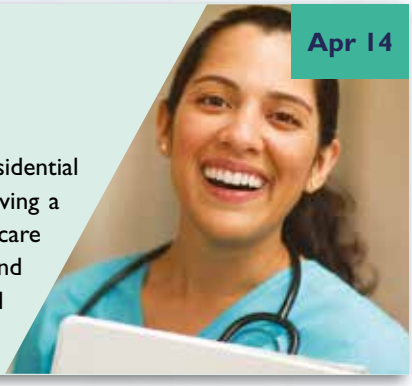


This short online course is aimed at nurses and midwives who would like to develop valuable lifelong information seeking skills to get the most up-to-date information for clinical practice, reflection or policy development. This course will assist participants who are undertaking or about to commence post-registration academic programmes. Training is provided by our librarians who are experts at demonstrating some top tips that will enhance your searching skills. Places are limited so early booking is advisable.

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

Clinical Governance for Senior Management for Nurses and Midwives

Apr 14



This short online programme is most relevant to senior nurse managers within the acute or residential healthcare settings to help them understand and be confident in building their skills and having a keen knowledge of clinical governance. Clinical governance is the system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish. €30 INMO members; €65 non-members

International Yoga Day

Jun 21

10.00-11.00am, Richmond Education and Event Centre, Dublin

Inviting all nurses and midwives to come together and celebrate International Day of Yoga with INMO on the theme 'Yoga for Nurse's Health and Wellbeing'. While helping our patients, let's begin our healing through the practice of yoga asanas. United Nations recognised yoga's universal appeal on December 11, 2014. The United Nations proclaimed June 21 as the International Day of Yoga by resolution 69/131. This day is celebrated all across the globe to raise awareness about yoga and its holistic approach to health. June 21 is also the summer solstice. On this day it is a tradition in yoga to revere the sun and draw its energy. Free for INMO members.

Steve Pitman
Head of Education and Professional Development

THE increasing number of Covid-19 cases in March is a clear indication that the pandemic is not over. The health service remains overstretched and working beyond capacity, with the March trolley watch figures providing a stark reminder of the level of pressure on Irish hospitals.

This situation makes it difficult to deliver a responsive, safe and quality service to patients and services users. The unrelenting high pressure continues to place unacceptable demands on nurses and midwives. The evidence is clear that nurses are experiencing high levels of work-related stress, which leads to physical and mental exhaustion.

Nurses and midwives regularly find it difficult to take lunch and coffee breaks while at work. A high percentage of nurses continue to report that they have considered leaving their current work area and the professions as a direct consequence of workplace stress. Nurses report being worn out at the end of the working day and exhausted in the morning at the thought of another day at work.

The current situation can only be alleviated by action from the health service to reduce the demands by increasing capacity and cancelling elective procedures and prioritising emergency care. At a government level the issue of mask wearing needs to be reconsidered in indoor and crowded settings during a period where there has been an increase in Covid cases and patients with Covid in hospitals.

ICN NP/APN Network Conference 2022

The call for abstracts and registration is now open for the 12th ICN NP/APN Network Conference in Dublin. The conference will be an in-person event that will take place between August 21-24, 2022 in UCD. This will be one of the largest nursing conferences held in Ireland.

The conference is hosted by the INMO and the Irish Association of Advanced Nurse and Midwife Practitioners and is open to nurse/midwife practitioners, advanced practice nurses/midwives, clinical nurse/midwife specialists and registered nurses and midwives. The theme for the conference is 'Advanced Practice Nursing, Shaping the Future of Healthcare'. Further information can be found on the conference website at **www.npapndublin2022.com**

CJ Coleman Award 2022

The CJ Coleman Research and Innovation Award 2022 submissions close on April 7, 2022. CJ Coleman has been generously sponsoring the INMO members research award for more than a decade. A bursary of €1,000 will be awarded for a completed research/change project, promoting and improving the quality of patient care and/or staff working conditions in an innovative way. A link to the award application form is available at **www.inmo.ie** where further details can be found.

All-Ireland Midwifery Conference

The planning has started for the 2022 INMO/RCM All-Ireland Midwifery Conference. The conference this year will be an in-person event and will take place in Cavan on November 17. A call for abstracts and further information about the conference will appear in *WIN* over the coming months.

Menopause in the workplace

The INMO is supporting a study on nurses' and midwives' lived experience of menopause in the workplace. The study is being conducted by Arleen Neville, a student at the Irish College of Humanities and Applied Sciences.

The results from this study will complement the findings of the recent INMO Menopause in the Workplace Survey. If you are interested in participating, contact Ms Neville at 20204381@ichs.ie Further information is available on the INMO website (**www.inmo.ie**) and social media.

On-site Education

INMO Professional offers an extensive range of on-site programmes facilitated by expert practitioners. If you are interested in booking one, email marian.godley@inmo.ie or call 01 6640642.

Delivering courses and writing for *WIN*

INMO Professional is eager to offer members the opportunity to work with us in delivering education courses. If you are an advanced nurse or midwife practitioner, a clinical nurse/midwife specialist or a nurse/midwife with expertise in clinical or management practice, we would like to hear from you by email: education@inmo.ie or Tel: 01 6640642.

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

INMO Professional

Online Education Programmes

Tel: 01 6640641/18
Email: education@inmo.ie

All of the following programmes are category 1 approved by the NMBI and allocated continuous education units
Fee: €30 members; €65 non-members
Time: 10am-1pm

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

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

Apr 7 **Diabetes CBT and General Wellbeing**

The self-management of diabetes is associated with high incidence rates of depression and anxiety. The use of different strategies, cognitive behaviour therapy (CBT) and clinical trials look at the area of wellbeing and theories and models to help clients and healthcare providers to formulate plans to look at these issues. This programme explores techniques to help clients to manage their diabetes.

Apr 11 **Introduction to Effective Library Search Skills**

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.

Apr 12 **Introduction to Chemotherapy**

Chemotherapy simplified: this introductory session will equip you with the main principles of chemotherapy, its side effects and how to feel safe and confident handling these drugs. In return you will feel empowered to deliver improved care to your patients. This session will cover pharmacology of chemotherapy; chemotherapy side-effects and chemotherapy regimes and safe handling of cytotoxics. As good communication skills with patients and families are crucial in chemotherapy, this programme will keep your skills up to date.

Apr 13 **Introduction to Wound Management for Nurses and Midwives**

Topics covered in this programme will include wound healing, wound bed preparation, treatment options and dressing selections. Participants will learn about the anatomy and physiology of wound management, the factors influencing wound healing, the differences between acute and chronic wounds, implementation of a holistic assessment wounds and different types of dressing and their application.

Apr 14 **Clinical Governance for Senior Nurse Managers (Acute/Residential Healthcare Settings)**

This short online programme is aimed at the most relevant to senior nurse managers within the acute or residential healthcare settings to help them understand and be confident in building their skills and having a keen knowledge of clinical governance. Clinical Governance is the system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish.

Apr 14 **Competency-based Interview Preparation for Nurses and Midwives**

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

Apr 20 **PEG Feeding – Caring for Adults and Paediatrics who have a PEG Tube**

This short introductory programme is aimed at all nurses working within the hospital and community setting caring for adults and paediatrics who have a percutaneous endoscopic gastrostomy (PEG) tube. It will address the clinical indications and requirements for PEG feeding in the home and hospital setting. It will provide guidance on medication administration and nutrition with a focus on hospital policies and government guidance. It will also discuss the complications of PEG feeding that can occur and how these can be clinically managed.

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

Apr 21 **Infection Control Regulation 27: Guide to Thematic/Focused Inspections in your Facility**

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

Apr 26 **Restrictive Practices in Residential Care Settings for Older People**

This online course encourages participants to reflect on interventions that could be seen as restraining residents if viewed from a resident's perspective. Many interventions in healthcare environments can restrict movement of older people. They are unintentional and are in the best interest or for the protection of residents, for example, a nursing home locked at night to protect residents and staff from intruders.

Apr 27 **Introduction to Leg Ulcer Management**

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

Apr 27 **Improve Your Academic Writing and Research Skills**

This short course is designed for nurses and midwives in third-level education. It will assist participants in completing their written assignments. The objective of the course is to help prepare the student for academic study, which requires efficient literature searching, research critique and accurate referencing skills. On the day there will also be a question and answer session to help you with any of your queries.

Apr 28 **Chronic Obstructive Pulmonary Disease (COPD) – Getting the Basics Right**

This course is for nurses working in clinical practice who require basic knowledge and skills to care for people with COPD. It will help participants to understand the clinical evidence underpinning the diagnosis and ongoing care of patients with COPD.

Apr 28 **Recognition and Management of Sepsis**

This online session will focus on early recognition and management of sepsis. Case studies will be included to create an interactive learning platform to engage participants throughout the session. Outcomes: discuss and provide background for development of sepsis; identify the early recognition of signs of sepsis; discuss implementations of sepsis guidelines through fluid and antimicrobial stewardship; apply and integrate evidence based guidelines into patient care planning.

May 5 **Adult Asthma – Getting the Basics Right**

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

May 10 **Risk Management and Incident Reporting**

This course outlines the principles of best practice in managing risk, enabling participants to understand terms related to risk management in healthcare, outline the stages of the risk management process based on the international standard and framework for risk management, outline the five steps of risk assessment, understand the purpose of a risk register and complete accurate records of incidents.

May 10 **Understanding and Developing Care Plans for Nurses and Midwives**

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

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

May 11 **Introduction to Treating and Preventing Pressure Ulcers**

This short online course will advise participants on pressure ulcer prevention. Topics covered on the day include; causes of pressure ulcers, risk assessment, and prevention of pressure ulcers. Learning outcomes: discuss the causes of pressure ulcers; identify the factors that place a person at risk of developing pressure ulcers; have an understanding of the key principles of preventing ulcers and be able to take action to prevent pressure ulcers in the clinical environment; have an understanding of pressure ulcer classifications and grading; have an understanding of the key principles of the SSKIN Bundle and how to implement it in the clinical environment.

May 12 **Telephone Assessment and Advice Skills**

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

May 12 **Best practice for Clinical Audit for Nurses and Midwives**

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

May 18 **End of Life Care in Residential Care Settings for Older Persons**

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

May 24 **Introduction to Management and Leadership Skills for Nurses and Midwives**

The aim of this programme is to identify managerial and leadership competencies for frontline managers and to explore how these are applied in practice. The course will include management theory, effective leadership and teamwork, as well as delegation and clinical supervision.

May 25 **Introduction to Wound Management for Nurses and Midwives**

Topics covered in this course will include wound healing, wound bed preparation, treatment options and dressing selections. Participants will learn about the anatomy and physiology of wound management, the factors influencing wound healing, the differences between acute and chronic wounds, implementation of a holistic assessment of individuals with wounds and different types of dressing and their application.

Jun 9 **Tracheostomy Care Study Day**

This programme introduces a holistic and interdisciplinary approach to the management of the adult patient with a tracheostomy. Participants will be given the necessary knowledge, skills and confidence to assess, manage and evaluate the nursing care of a patient with tracheostomy. The programme will cover the anatomy, the different types of tracheostomy tubes, complications communication and swallowing in a patient with a tracheostomy, how to manage emergencies safely, the purpose of humidification, managing safe suctioning of a patient and how to be aware of nursing care of a tracheostomy.

Jun 12 **Medication Management Best Practice – Guidance for Nurses and Midwives**

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

Jun 16 **Retirement Planning Webinar**

This webinar is to help support you in planning your retirement and will briefly cover the following: superannuation and your entitlements, options for drawing down your AVC at retirement, considering lump sums and AVCs before retirement, protecting your lump sum against inflation, key steps to long term investing, top tax tips for retirement and a Covid-19 Q&A session.

Jun 21 **Overview of Nursing Assessment and Management of Stroke**

This course will give participants an overview of nursing assessment and management of stroke during the Covid-19 pandemic. At the end of the training participants will be able to: identify and discuss the two types of strokes; identify and ascertain the various treatment options; understand best practice for the nursing care of people who have suffered an acute stroke, including secondary prevention; be aware of aetiology of stroke and rationale for specific diagnostic tests.

Jun 21 **International Yoga Day**

Inviting all nurses and midwives to come together and celebrate International Day of Yoga with INMO on the theme 'Yoga for Nurse's Health and Wellbeing'. While helping our patients, let's begin our healing through the practice of yoga asanas. United Nations recognised yoga's universal appeal on December 11, 2014. The United Nations proclaimed June 21 as the International Day of Yoga by resolution 69/131. This day is celebrated all across the globe to raise awareness about yoga and its holistic approach to health. June 21 is also the summer solstice. On this day It is a tradition in yoga to revere the sun and draw its energy.

Jul 7 **Tools for Safe Practice**

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

INMO Professional

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Irish Nurses and Midwives Organisation
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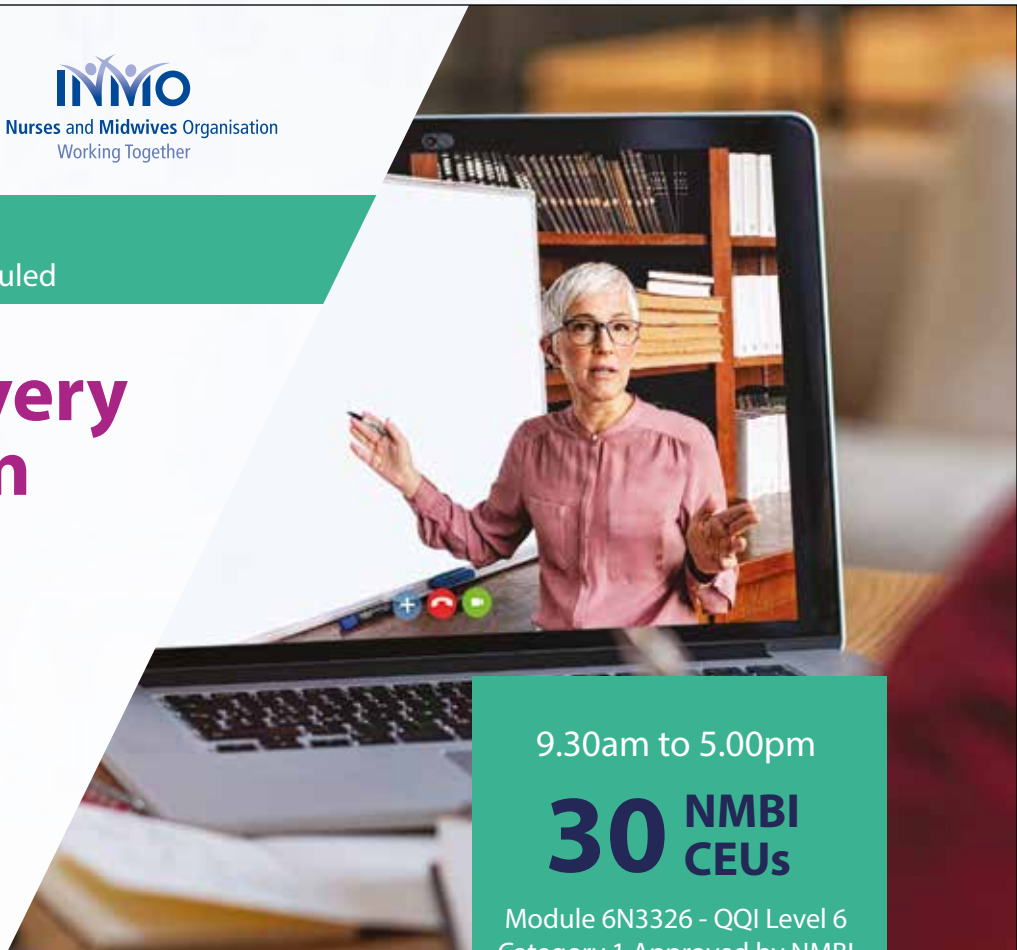
NEW 2022 DATES
March/April dates have been rescheduled

Training, Delivery and Evaluation

September and October 2022

5 Day PROGRAMME

Day 1 **Tues 20 - Sept**
Day 2 **Wed 21 Sept**
Day 3 **Thurs 22 Sept**
Day 4 **Tues 4 Oct**
Day 5 **Wed 5 Oct**



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30 NMBI CEUs

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- Key steps to long term investing.
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- Covid-19 Q & A:
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- **Documentation**
- **Fitness to Practise Complaints**

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deborah.winters@inmo.ie or 01 6640618

A look at the journals

This month the staff in the library highlight some recently published Irish and international research from the journals

Older people

- Donnelly S, Ó Coimín D, O'Donnell D, Ní Shé É, Davies C, Christophers L et al. Assisted decision-making and interprofessional collaboration in the care of older people: a qualitative study exploring perceptions of barriers and facilitators in the acute hospital setting. Journal of Interprofessional Care 2021 Nov ;35(6):852–62
- Mallett J, Redican E, Doherty AS, Shevlin M, Adamson G, Mallett PJ et al. Depression trajectories among older community dwelling adults: Results from the Irish Longitudinal Study on Ageing (TILDA). Journal of Affective Disorders. 2022 Feb ;298:345–54
- Hughes JE, Russo V, Walsh C, Menditto E, Bennett K, Cahir C. Prevalence and Factors Associated with Potential Drug-Drug Interactions in Older Community-Dwelling Adults: A Prospective Cohort Study. Drugs and Aging. 2021 Nov ;38(11):1025–37
- Naughton C, Simon R, White TJ, de Foubert M, Cummins H, Dahly D. Mealtime and patient factors associated with meal completion in hospitalised older patients: An exploratory observation study. Journal of Clinical Nursing. 2021;30(19/20):2935–47

Intellectual disability

- Ryan J, McCallion P, McCarron M, Luus R, Burke EA. Overweight/obesity and chronic health conditions in older people with intellectual disability in Ireland. Journal of Intellectual Disability Research. 2021 Dec ;65(12):1097–109
- McCausland D, Guerin S, Tyrrell J, Donohoe C, O'Donoghue I, Dodd P. A qualitative study of the needs of older adults with intellectual disabilities. Journal of Applied Research in Intellectual Disabilities. 2021 Nov ;34(6):1560–8
- Scanlon G, Doyle A. Transition stories: Voices of school leavers with intellectual disabilities. British Journal of Learning Disabilities. 2021 Dec ;49(4):456–66

General practice

- Madden C, Lydon S, Murphy AW, O'Connor P. Patients' perception of safety climate in Irish general practice: a cross-sectional study. BMC Family Practice. 2021 Dec 27 ;22(1):1–11

Covid-19

- Smith V, Panda S, O'Malley D, Vallejo N, Barry P. Covid-19 and clinical outcomes of pregnancy: a comparative study. British Journal of Midwifery. 2021 ;29(11):642–7
- Hyland P, Vallières F, Daly M, Butter S, Bentall RP, Fox R, et al. Trajectories of change in internalizing symptoms during the COVID-19 pandemic: A longitudinal population-based study. Journal of Affective Disorders. 2021 Dec ;295:1024–31
- Frisina Doetter L, Preuß B, Rothgang H. Taking stock of Covid-19 policy measures to protect Europe's elderly living in long-term care facilities. Global Social Policy. 2021 Dec ;21(3):529–49
- Khurshid Z, McAuliffe E, De Brún A. Exploring healthcare staff narratives to understand the role of quality improvement methods in innovative practices during Covid-19. BMC Health Services Research. 2021 Nov 25 ;21(1):1–11
- Hartigan I, Kelleher A, McCarthy J, Cornally N. Visitor restrictions during the Covid-19 pandemic: An ethical case study. Nursing Ethics. 2021 Nov; 28(7/8):1111–23
- Doyle L. 'All in this together?' A commentary on the impact of Covid-19 on disability day services in Ireland. Disability & Society. 2021 Oct ;36(9):1538–42.
- Allen N, Riain UN, Conlon N, Ferenczi A, Carrion Martin AI, Domegan L, et al. Prevalence of antibodies to SARS-CoV-2 in Irish hospital healthcare workers. Epidemiology & Infection. 2021 Oct ;149:1–11
- McCausland D, Luus R, McCallion P, Murphy E, McCarron M. The impact of Covid-19 on the social inclusion of older adults with an intellectual disability during the first wave of the pandemic in Ireland. Journal of Intellectual Disability Research. 2021 Oct; 65(10): 879–89
- Stafford O, Berry A, Taylor LK, Wearen S, Prendergast C, Murphy E et al. Comorbidity and Covid-19: investigating the relationship between medical and psychological well-being. Irish Journal of Psychological Medicine. 2021;38(4):272–7

Nursing

- McMenamin R, Faherty K, Larkin M, Loftus L. An investigation of public awareness and knowledge of aphasia in the West of Ireland. Aphasiology. 2021 Nov ;35(11):1415–31
- Kelly D, Casey M, Beattie McKenna F, McCarthy M, Kiely P, Twomey F et al. Identifying the gaps in Irish cancer care: Patient, public and providers' perspectives. Health Policy. 2021 Nov;125(11): 1482–8
- Clarke C, Cannon M, Skokauskas N, Twomey P. The debate about physician assisted suicide and euthanasia in Ireland - Implications for psychiatry. International Journal of Law & Psychiatry 2021
- Madden C et al. What are the predictors of hand hygiene compliance in the intensive care unit? A cross-sectional observational study. Journal of Infection Prevention. 2021 Nov; 22(6):252–8

Library services

The library has a number of services to support your practice and educational requirements, including literature searching, document supply, reference desk assistance and searching consultations. To find out more, call 016640614 or email: library@inmo.ie

Online – Introduction to Effective Library Search Skills

Next course date: Monday, April 11, 2022

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

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

INMO Professional

RCM i-learn

THE ROYAL COLLEGE OF MIDWIVES

Epilepsy in pregnancy

Epilepsy is a serious, potentially life-threatening neurological condition. A new module from RCM i-learn module looks at its presentation in pregnancy and the midwife's role in its management

EPILEPSY is the most common serious, potentially life-threatening neurological condition to encounter in pregnancy and up to a year postnatally. Increasing midwifery knowledge about epilepsy can help to reduce morbidity and mortality rates through recognition of risks and a deteriorating medical condition.

This updated i-learn module on epilepsy aims to develop knowledge and understanding of epilepsy and its treatment and management, as well as to improve midwives' confidence in supporting pregnant women and their relatives more effectively as part of a wider multidisciplinary team.

Why this topic is important

For women with epilepsy the risk of dying during or in the year following pregnancy is ten times higher than women without epilepsy. In the majority of maternity cases where a woman with epilepsy has died, improvement in multiprofessional care may have prevented their death.

Role of the midwife

It is important for the midwife to understand when taking the patient's history that some types of epilepsy that appear resolved in childhood can recur in adulthood and that pregnancy may be an independent risk factor for this recurrence risk.

For the majority of women with epilepsy, seizure control will remain the same or improve during pregnancy. However, midwives need to be aware that a minority of women will experience an increase in seizures, either during pregnancy or in the postnatal period, particularly the early weeks. Also, the presentation of the epilepsy can change and this may involve the woman experiencing tonic-clonic seizures for the first time during pregnancy or in the postnatal period.

Midwives can discuss the benefits and risks of breastfeeding to women with epilepsy. For most women taking anti-epileptic medicines, breastfeeding is generally safe; however each mother needs to be supported in the choice of feeding method that bests suits her and her family.[1]

Learning outcomes

Having completed this module you will:

- Understand the impact of epilepsy in pregnancy and how to ensure women receive proactive, patient-centred, flexible, multidisciplinary support
- Understand epilepsy terminology, pregnancy facts and risks
- Understand the principles of anti-epileptic drug (AED) treatment and the role of the midwife in supporting drug adherence
- Be aware of the dilemmas women with epilepsy face in balancing the potential risks of AED exposure in pregnancy versus risk of harm from seizures
- Signpost women with epilepsy and other healthcare professionals to local and national epilepsy pathways and support.

Reference

1. HSE National Clinical Programme for Epilepsy (2018) Practice Guide for the Management of Women with Epilepsy. www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/practice-guide-for-mgt-of-women-with-epilepsy.pdf

RCM i-learn access for INMO midwife members

Free access is available to all midwife members of the INMO. If you are interested in learning more about the modules outlined or in completing a learning module, visit **www.inmoprofessional.ie/RCMAccess** or email the INMO library at library@inmo.ie for further information

Spotlight on Leadership

Authentic leadership in a healthcare setting

IN THE latest in a series of articles exploring the topic of leadership, this month's column focuses on authentic leadership. What follows is an overview of authentic leadership, definitions, key concepts and how they apply in a healthcare setting.

Although authenticity as a quality has been researched in several forms over decades of academic writing, only since the 1990s has it become associated with academic literature in leadership and management. Born of a strong desire to develop leaders with values such as honesty and integrity, following several high-profile ethical breaches within a corporate setting,[1] authentic leadership emerged as a more responsive type of leadership with core moral values. Leadership theory soon developed, with several authors writing on the topic.

There are a number of definitions for what authentic leadership is and, as a theory, it has been further developed since its first inception. Luthans and Avolio[2] define authentic leadership as "a process that draws from both positive psychological, organisational context, which results in both greater self-awareness and self-regulated positive behaviours on the part of leaders and associates, fostering positive self-development".

The authentic leader has been described as a transparent and ethical leader who encourages openness in sharing information and values input from followers.[3] This leadership approach has also been described as multilevel in its focus, drawing not only on the leader but also on the follower and organisation or context.

Although several definitions exist, there are common behaviours in academic writing *(see box)*.

Avolio and Gardner[4] consider authentic leadership to be a "root construct" or a basic necessity for the development of any positive leadership style. An important component of authentic leadership is the positive psychological capacities of the leader.[2] These psychological capacities are made up of four attributes: hope, confidence (efficacy), resilience and optimism.[5] These attributes act both individually and synergistically to enhance authentic leadership. •

The key benefits of authentic leadership are associated with building trust and maintaining relationships. It allows employees to feel included in their teams and workplaces and encourages collaboration within teams and the setting of standards ingrained in morals.

However, as with other leadership approaches, it is not without its critics.[6] Northouse[7] argues that authentic leadership research is still in an early stage of development. The inclusion of the moral perspective and the rationale for including the positive psychological capacities have not been clearly explained. Further work is required to demonstrate how authentic leadership leads to positive organisational outcomes.

Much of the literature has focused on how authentic leadership works in a healthcare setting. Many healthcare organisations worldwide have come under public scrutiny due to poor care and patient safety concerns. Therefore, authentic leadership is seen as a potential approach to improving patient outcomes and delivering high-quality care.[8]

A moral and ethical code underpins the nursing and midwifery professions, and many of their values, practices and characteristics align with the behaviours associated with authentic leadership. Nurses and midwives are reflective in their approach. As part of a multidisciplinary team, they work objectively towards a shared goal, keeping the patient/client central to decision-making.

Authentic leadership has been identified as an approach that can improve work environments for nurses. A systematic review[9] analysing relational leadership approaches, including authentic leadership in the healthcare setting, found improved outcomes for nurses, such as improvements in teamwork, health and wellbeing and the working environment.

While authentic leadership is still developing, there are several positive outcomes associated with the approach in general and within a healthcare setting. Therefore it warrants consideration for nurses and leaders wishing to develop their leadership skills.

Characteristics of the authentic leader

- **Balanced processing** requires a leader to objectively analyse all relevant information or data as part of the decision making process. The authentic leader truly listens to all information, even if it is at odds with their personal opinion
- A leader with **relational transparency** appropriately openly shares information and feelings as needed within a particular context and with followers
- **Internalised moral perspective** refers to a type of internal moral code that guides the authentic leader in their behaviour at all times. Thus allowing the leader to act in a moral or ethical way
- **Self-awareness:** finally, the authentic leader is self-aware of their strengths and weaknesses. It is important for authentic leaders to understand how they influence others. They practice self-reflection and gather feedback from others to achieve self-awareness

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

Launched in 2021, the Nursing Now Challenge brings forward the Nightingale Challenge mandate, which focuses on developing leadership opportunities for nurses and midwives globally. Visit ***www.nursingnowireland.ie***

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

References available on request by emailing nursing@medmedia.ie (Quote Adams N & Pitman S. WIN 30 (3): 38)

Understanding your pay slip

Róisín O'Connell explains everything you need to know about pay slips

IN RECENT weeks I have received many queries from internship students about pay, increments and pay slips. There are so many different terms about pay that can be incredibly difficult to understand, but it is important to try to fully understand your pay slip so that you can ensure you are being paid the correct amount.

Pay slips

Under the Payment of Wages Act 1991, all employees have the right to a pay slip. A pay slip is a written statement outlining your gross wages and detailing the deductions made by your employer. Pay slips in the private and public sectors tend to follow a similar format and are typically sent to you electronically. The main differences between public and private sector pay slips are the pension contributions.

Pay slips state your employer details, your employee number and your position, eg. staff nurse/midwife. It will also have a section outlining the period for which you are being paid, eg. week of the year if paid weekly/fortnightly or a number outlining the month if paid monthly.

Your pay slip will also contain your PPS number. This is unique to you and is used as a reference number for tax purposes. It also allows you access to social welfare benefits and public services in Ireland.

Payments

Your pay slip is divided into two columns. On the left-hand side is the payments column, where you will find your gross pay. This is the total amount paid to you before any deductions are made for that pay period. Net pay is the total amount paid once all deductions are made for that period. Basic pay is the standard amount paid before any additional premiums or allowances are added.

It is important to monitor your basic pay to ensure that it increases in line with your increments. To calculate your salary point from your hourly rate you must multiply your hourly rate by 39 to give you your weekly rate. Then multiply your weekly rate by 52.18 to give an estimate of what your yearly salary is. Those who graduated in 2021 need to remember that after working 16 weeks following the end of their internship, they will skip point two of the salary scale and proceed directly to point three. It is also important for 2020 graduates to remember that as they progress to point four of the salary scale they are eligible to apply for the enhanced practice contract and avail of the higher rate of pay.

Premium pay includes Saturday, Sunday, night duty, bank holidays and time plus one-sixth. These are all itemised separately from your basic pay. Some nurses and midwives will also be eligible to receive allowances such as the specialist qualification allowance (€3,561 per annum) or the location allowance (€2,371 per annum). See also: **www.inmo.ie/salary_information**

Deductions

On the right-hand side you will see the deductions column. This includes tax, universal social charge (USC) and pay-related social insurance (PRSI). Pay as you earn (PAYE) is a form of income tax that is deducted by your employer on behalf of the government and is calculated as a percentage of your gross income. We are all eligible to apply for tax credits. Registering for the correct tax credits reduces the amount of tax you need to pay during the year. Tax credits are specific to your personal circumstances. To learn more about tax and tax credits, see: **www.revenue.ie**

It is important to remember that your employer applies PAYE based on the information they receive from Revenue. It is also important to update Revenue of any relevant changes that may affect your tax credits, eg. having dependants or changing marital status. The USC is another form of tax deducted from your wages. The current rates of USC are shown in the *Table*. These rates may change yearly, depending on the current budget. Your PRSI will also be stated on your pay slip and specifies the mandatory PRSI contributions you are paying. These contributions determine future eligibility to access social insurance payments (provided you meet the eligibility criteria). PRSI contributions are calculated as 4% of your total earnings.

Current rates of USC

Rate of USC	Year 2022
0.5%	First €12,012
2%	From €12,012.01 to €21,295
4.5%	From €21,295.01 to €70,044
8%	From €70,044.01

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 and regulations of this scheme are outlined in the Public Service Pensions (Single Scheme and Other Provisions) Act 2012. For more about the Single Scheme, see: **https://bit.ly/363FY3v**

Union membership

INMO membership is free for undergraduate students, but once you graduate there is a fee (see: **www.inmo.ie/membership**). If you choose to pay your membership by deduction at source, it will come directly from your salary and will be listed as a deduction on your payslip.

If you have a query, please get in touch. If your queries relate to your pay, contact your salaries or payroll department first.

Róisín O'Connell is the INMO's student and new graduate officer

Medication management

Nurses and midwives must be clear about their responsibilities in the medication management process to ensure they stay within their scope of professional practice, writes **Steve Pitman**

THE role of nurses and midwives in the training, delegation and supervision of unregulated healthcare workers (HCWs) in the administration of medicines presents a continuing concern within the professions.

The INMO believes that all patients should have the right to be assisted in their medication management by regulated HCWs who operate within a professional and legal framework of responsibility and accountability that ensures safety.

The States Claims Agency[1] reported in 2018 that more than a third of reported medication errors occurred during the administration process – second only to prescription errors. Globally, the WHO *Medication Without Harm Report*[2] states that "errors occur most frequently during administration". Medication errors are the result of human factors and weak medication systems.[2] This highlights the importance of medication practice delivered by competent, registered professionals.

Nurse and midwives, as regulated healthcare professionals, are responsible and accountable for their decisions and actions, including inactions and omissions, in their practice.[3] Providing safe and competent practice supported by evidence and best practice standards underpins nursing/midwifery practice. This ensures that safe, high-quality care is delivered to patients.

Medication management requires knowledge, skills and competencies that nurses and midwives develop during the four-year pre-registration degree programme. Competence is further developed by the nurse/midwife through continuing professional development (CPD). In comparison, the training of unregulated HCWs in the safe administration of medicines, as part of a one- or two-day course, raises questions about the level of knowledge and competency achieved. There is no evidence on the safety and effectiveness of short medication-management courses and their potential risk to patients and service users. An evaluation of these courses is required to examine the impact on patient/service user outcomes. This is fundamental to ensuring medication administered by unregulated HCWs is safe and meets medication management standards.

It is the position of the INMO that the administration of medication is not a mechanistic task and is one that should be approached holistically. In particular, the administration of medication requires skills that enable the practitioner to understand the type of medication to be administered, when it is to be administered, to whom it is to be administered and the method by which it is to be administered. It also requires an understanding of the patient's care needs, different presentations that might militate against the administration of medication prescribed and an ability to assess the impact of a medication. This enables care to be observed and changed, as well as additional measures to be adopted, to ensure that a medication regime does not harm the patient.

The INMO's view is that there are serious questions to be asked regarding the standard of care or assistance that any person should expect.

The Scope of Professional Practice[4] emphasises the role of nurses/midwives in working with members of the multidisciplinary team, which includes the delegation, supervision and education of unregulated HCWs. Delegation occurs when "the nurse or midwife (the delegator) who has the authority for the delivery of healthcare, transfers to another person the responsibility of a particular role or activity that is normally within the scope of practice of the delegator". The nurse/midwife delegating must provide an appropriate level of supervision. Supervision is a structured approach that includes direction, guidance, support and evaluation. Tasks and responsibilities should not be delegated beyond the competence of the individual.

The 2007 and 2020 Guidance on Medication Management[5,6] does not outline any requirements for nurses/midwives to take responsibility for the training, education or supervision of unregulated HCWs in administering medicines. Delegation is only mentioned in the context of supporting student nurses and midwives.

Organisations that allow unregulated HCWs to administer medicines must ensure that explicit policies and procedures are in place to support this practice. These must be comprehensive, appropriate, robust and up to date.[7] It is important to recognise that this role has been designated to the non-regulated HCW by the organisation, and the issue of the nurse/midwife delegating medication administration or management should not arise.

Nurses/midwives should be cautious about participating in the training of non-regulated HCWs in administering medicines. Those participating in the training of non-regulated HCWs will be held professionally accountable for doing so.

Nurses/midwives must be clear about their responsibilities in the medication management process to ensure they stay within their scope of professional practice.

Steve Pitman is head of education and professional development with the INMO

References available on request by email to nursing@medmedia.ie (Quote Pitman S 2022: 30 (3): 40)

A column by Maureen Flynn

Quality & Safety

Reflections on leading quality safety care

THIS month we focus on the essence of clinical leadership. In the early stages of the pandemic it was evident that nurses and midwives of all grades were demonstrating significant clinical leadership in very challenging times. Here we provide information on a series of conversations with nurses and midwives that reveal the unique role played by our professions in delivering quality safe care in extraordinary circumstances.

National Clinical Leadership Centre

The HSE National Clinical Leadership Centre for Nursing and Midwifery (NCLC), supports clinical leadership development for all nurses and midwives through their programmes, workshops and development initiatives. As the pandemic evolved the NCLC saw the opportunity to develop a webinar series that would provide ways for nurses and midwives to present their clinical leadership experiences and share the learning across disciplines and services.

In August 2020, the NCLC Director collaborated with the Chief Nursing Office (CNO) and the RCSI Institute of Leadership to plan a webinar series called 'Sharing the Learning'. The series has nine webinars delivered live between September 2020 to February 2021. These were recorded and are now available to watch and listen back to at any time.

To create the series, submissions were sought from midwifery services and from each discipline of nursing nationally. There was immense interest and a panel designed the focus and theme for each session. The series includes speakers from a wide range of services, the CNO office and the Office of the Nursing and Midwifery Services Director. The prerecorded webinars were circulated using email, social media and the NCLC, CNO and RCSI websites.

In each episode, the speakers discuss the effect of Covid 19 on people within their area, patients, themselves, colleagues, the provision of care and how they and their colleagues led during this time.

Nursing and Midwifery Clinical Leadership during Covid-19 webinars

Episode	Speaker	Theme
1	Dr Geraldine Shaw and Rachel Kenna	Learning from our senior leaders
2	Deirdre Lang, Brian Magennis and Claire Noonan	Learning from older person services
3	Fiona Hanrahan, Claire Fitzpatrick, Yvonne Connolly and Carmel Connelly	Learning from midwifery services
4	Neil Dunne, Katherine O'Sullivan, Niamh Martin and Sharon Boyle	Learning from public health services
5	Aine Lynch, Kate Brennan, Sinead Horgan and Rynagh Gilligan	Learning from acute services
6	Joy John, Ella Townsend, Jenny Sinnott and Adrienne Adams	Learning from mental health services
7	Grainne Bourke, Evelyn Reilly, Majella Meehan, Niamh Walsh	Learning from intellectual disability services
8	Tracy Wall, Yvonne O'Connor, Doris O'Toole and Ashling Keogh	Learning from children's nursing services
9	Rachel Kenna and Dr Geraldine Shaw	Sharing the learning past, present and future

The exemplary responsiveness to the evolving crisis is palpable. Feedback from listeners demonstrated that they benefited immensely from hearing the contributors share their stories and the lessons learned, with one commenting: "This series has really made me so proud of our profession, it really highlights the care, professionalism and high quality leadership that was demonstrated during such a challenging time".

Get involved

The webinars are listed in the box above and each is available to view on YouTube on the HSE's channel: **www.youtube.com/user/HSEIreland** by searching the webinar series title. You might like to listen back to some of the webinars and share your insights from this at an upcoming team, clinic, ward or journal club gathering.

Further information

For information relating to programmes offered by NCLC contact: Niamh Mann at Tel: 061 483 301 or email: nmleadership@hse.ie

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

Acknowledgements: Thank you to my colleague Marie Kilduff, NCLC director, for assistance in writing this column and the NCLC team for their work on this initiative. The NCLC would like to thank the CNO and RCSI for their support and collaboration. Sincere gratitude to colleagues who participated in the panels for each webinar. A special thank you to the speakers who took the time to present and join the conversation. It was an honour to listen to your reflections on leading quality safe care

Time is brain

Lisa Donaghy gives an overview of stroke assessment and management for nurses and midwives, emphasising that time lost is brain lost

ACCORDING to the World Health Organization, 15 million people are diagnosed with a stroke annually.[1] One-third of stroke survivors recover fully, one-third die and one-third suffer long-term disability.[2] While more people are surviving stroke, it remains the leading cause of disability in adults. Disability disrupts the activities of daily living, which can lead to a withdrawal from social participation.[3] Stroke prevalence will rise as the average age of the population increases, signifying the importance of trained and skilled staff.

Two million brain cells die every minute when stroke symptoms occur, emphasising that every minute counts.[4] Stroke is a medical emergency requiring trained and experienced staff to assess and treat promptly and accurately. The emergency assessment and management of acute stroke symptoms – also referred to as 'FAST positive' – must be treated with the same team dynamic as a cardiac arrest, where adequate team members are available and individual roles are assigned to assess and treat rapidly.

Infarction refers to irreversible dead tissue caused by inadequate blood supply to the affected area of the brain. Penumbra refers to the tissue surrounding the infarct that is salvageable but at risk. Rapid transfer to a hospital with a stroke service will allow for protection of penumbra through emergency interventions and medical management, reducing the size of the infarct, increasing the chances of recovery.

Stroke can occur at any age and affect any person. No matter what area of nursing or midwifery, the skills of assessment and management of stroke are relevant. The prevalence is on the increase both nationally and internationally. Almost 25%

Types of stroke

A stroke occurs when a blood vessel, which is carrying oxygen and nutrients to the brain, suddenly bursts or is blocked by a clot. This causes an interruption of the blood supply to part of the brain and results in the sudden death of brain cells. **– Irish Heart Foundation, 2010**

Haemorrhagic | Ischaemic | Atherosclerosis

of all stroke cases affect people under the age of 65 years.

Classification of stroke

- Ischaemic (clot) – 85% of cases
- Haemorrhagic (bleed) – 15% of cases

Risk factors

Cardiovascular risk factors encompass hypertension, atrial fibrillation, ischaemic heart disease, hyperlipidaemia and diabetes. Family history of stroke, obstructive sleep apnoea, patent foramen ovale, carotid stenosis and migraine with aura are also well documented as risk factors, along with modifiable behavioural lifestyle elements such as low physical activity, obesity, poor diet, smoking, excess alcohol intake and stress.

Up to 80% of all strokes can be prevented. The HSE programme for health professionals entitled 'Making every contact count' assists with the knowledge to encourage patients to make healthier lifestyle choices to help prevent and manage chronic diseases such as stroke.[5]

Treatment

In the emergency phase for an ischaemic stroke, thrombolysis can be administered if not contraindicated and if symptom onset is less than four and a half hours. This highlights the importance of obtaining the specific time of onset of symptoms if witnessed or when the patient was last seen well if unwitnessed. Mechanical thrombectomy is indicated for selected patients with acute ischaemic stroke due to a large vessel occlusion detected on imaging and in conjunction with a high NIHSS (stroke scale). Suitable patients are referred to one of the two centres in Ireland (Beaumont or Cork), where stent retrievers are used to remove large clots from a blocked artery in the brain, resulting in lesser disability and improved patient outcomes.

The acute phase comprises pharmacology interventions such as DAPT (dual anti-platelet therapy) or anticoagulation if indicated and high-dose statin for ischaemic strokes. Education on medications and advice on the importance of medication compliance is vital for secondary prevention.

Treatment opportunities are more limited for haemorrhagic stroke. Monitoring neurological status is key, by regularly recording neurological observations. As per the NICE guidelines, the minimum frequency of neurological observations is two hourly or less if indicated. The rationale for strict adherence to neurological observations monitors progress, promotes early detection of deterioration, allowing rapid intervention to advocate for optimum patient outcomes.

The development of a severe headache, vomiting or new or evolving neurological signs, such as pupil inequality, poses great concern and must be escalated to a medical professional immediately. In conjunction with frequently observing neurological status, controlling blood pressure (with a target of < 140/90mmHg in most cases), reversing anticoagulation agents if appropriate and referral to a neurosurgical centre are other treatment options to be considered for a haemorrhagic stroke.

Acute stroke work up to determine aetiology of the stroke event

- CTB +/ CTA +/ CT perfusion
- MRI brain
- 12 lead ECG
- Echo +/- bubble study
- TOE if bubble study is positive or clinically indicated
- Carotid dopplers
- Fasting risks – lipids and HBA1C
- Telemetry or 72 Holter monitor +/- referral for loop recorder
- Thrombophilia and vasculitis screen
- CT TAP if malignancy is suspected.

Stroke unit care and rehabilitation

Stroke units provide immediate acute care, close monitoring and appropriate intervention in the evolving stroke. Cohorting patients in such units allows the patient to progress seamlessly from the acute event through early rehabilitation with the aid of a structured programme and back to the community with early supported discharge.

It is widely documented that stroke unit care reduces death and disability through the provision of specialist multidisciplinary care for diagnosis, emergency treatments, normalisation of homeostasis, prevention of complications, rehabilitation and secondary prevention.

All stroke survivors can benefit from provision of high-quality medical and nursing care. A standard patient pathway should include assessment of neurological impairment, vascular risk factors, swallowing, fluid balance and nutrition, cognitive function, communication, mood disorders, continence, activities of daily living and rehabilitation goals.[6]

Communication and shared decision making with patients and their families are integral to high-quality stroke care and recovery. Patients with mild or moderate disability, who are medically stable, can continue rehabilitation in their home environment with the assistance of early supported discharge teams rather than needing a prolonged stay in hospital.

The first few days following the stroke event, patients are at risk of a further stroke and complications. Complications include: urinary incontinence/retention/UTI, constipation, respiratory tract infection, DVT/PE, pain, falls, low mood, delirium, pressure sores and seizures. Nursing care in a designated stroke unit aims to optimise recovery and prevent complications.

Conclusion

Time is of the essence when stroke symptoms occur. The death rate and level of disability resulting from a stroke can be dramatically reduced by immediate and appropriate medical and nursing care. It is important that warning signs are not ignored.

Lisa Donaghy is a registered advanced nurse practitioner in stroke at Connolly Hospital in Dublin

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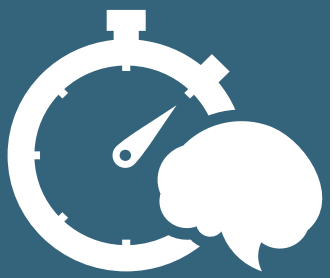

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palbociclib

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Real-world experience[2]
Patient-reported outcomes[3]
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One scheduled monitoring provision[1]
One tablet, Once daily[1]

NOW AVAILABLE IN TABLETS

Indications:
IBRANCE® is indicated for the treatment of HR+/HER2- locally advanced or mBC:[1]
- In combination with an **AI**
- In combination with **fulvestrant in women who have received prior ET**
- In **pre- or peri-menopausal women**, the ET should be combined with an LHRH agonist

For more information visit www.pfizerpro.ie/product/ibrance

IBRANCE® (PALBOCICLIB) PRESCRIBING INFORMATION:

Please refer to the Summary of Product Characteristics (SmPC) before prescribing IBRANCE 75 mg, 100 mg or 125 mg. **Presentation:** Hard capsules or film-coated tablets containing 75 mg, 100 mg or 125 mg palbociclib. **Indications:** Treatment of hormone receptor (HR) positive, human epidermal growth factor receptor 2 (HER2) negative locally advanced or metastatic breast cancer: in combination with an aromatase inhibitor; or in combination with fulvestrant in women who have received prior endocrine therapy. In pre- or perimenopausal women, the endocrine therapy should be combined with a luteinizing hormone releasing hormone (LHRH) agonist. **Dosage:** Therapy should be initiated and supervised by a physician experienced in the administration of anti-cancer medicinal products. The recommended dose is 125 mg of palbociclib once daily for 21 consecutive days followed by 7 days off treatment (Schedule 3/1) to comprise a complete cycle of 28 days. When coadministered with palbociclib, the aromatase inhibitor should be administered according to the dose schedule reported in the SmPC. Treatment of pre/perimenopausal women with the combination of palbociclib plus endocrine therapy should always be combined with an LHRH agonist (see SmPC section 4.4). Capsules and tablets should be swallowed whole (should not be chewed, crushed, split or opened prior to swallowing). Capsules should be taken with food, preferably a meal to ensure consistent palbociclib exposure (see SmPC section 5.2). Tablets may be taken with or without food. Palbociclib should not be taken with grapefruit or grapefruit juice (see SmPC section 4.5). Dose modification of IBRANCE is recommended based on individual safety and tolerability. Management of some adverse reactions may require temporary dose interruptions/delays, and/or dose reductions, or permanent discontinuation. For dose reduction guidelines for management of adverse reactions, haematologic and non-haematologic toxicities, refer to SmPC section 4.2. IBRANCE should be permanently discontinued in patients with severe interstitial lung disease (ILD)/pneumonitis. For patients who experience a maximum of Grade 1 or 2 neutropenia in the first 6 cycles, complete blood counts for subsequent cycles should be monitored every 3 months, prior to the beginning of a cycle and as clinically indicated. No dose adjustments of IBRANCE are required for patients with mild or moderate hepatic impairment (Child-Pugh classes A and B). For patients with severe hepatic impairment (Child-Pugh class C), the recommended dose of IBRANCE is 75 mg once daily on Schedule 3/1 (see SmPC section 5.2). No dose adjustments of IBRANCE are required for patients with mild, moderate or severe renal impairment (creatinine clearance [CrCl] ≥15 mL/min) (see SmPC section 5.2). No dose adjustment of IBRANCE is necessary in patients ≥65 years of age (see section 5.2). **Contraindications:** Hypersensitivity to the active substance or to any of the excipients (see SmPC section 6.1), use of preparations containing St. John's Wort (see SmPC section 4.5). **Warnings and Precautions:** Ovarian ablation or suppression with an LHRH agonist is mandatory when pre/perimenopausal women are administered IBRANCE in combination with an aromatase inhibitor, due to the mechanism of action of aromatase inhibitors. Palbociclib in combination with fulvestrant in pre/perimenopausal women has only been studied in combination with an LHRH agonist. Dose interruption, dose reduction, or delay in starting treatment cycles is recommended for patients who develop Grade 3 or 4 neutropenia. Appropriate monitoring should be performed (see SmPC sections 4.2 and 4.8). Severe, life-threatening, or fatal ILD and/or pneumonitis can occur in patients treated with cyclin dependent kinase 4/6 (CDK4/6) inhibitors, including IBRANCE when taken in combination with endocrine therapy. Across clinical studies (PALOMA-1, PALOMA-2, PALOMA-3), 1.4% of IBRANCE-treated patients had ILD/pneumonitis of any grade, 0.1% had Grade 3, and no Grade 4 or fatal cases were reported. Additional cases of ILD/pneumonitis have been observed in the post-marketing setting, with fatalities reported. Patients should be monitored for pulmonary symptoms and IBRANCE treatment should be immediately interrupted in patients suspected to have developed ILD/pneumonitis, see SmPC section 4.2, 4.4 and 4.8. Since IBRANCE has myelosuppressive properties, it may predispose patients to infections. Infections have been reported at a higher rate in patients treated with IBRANCE in randomised clinical studies compared to patients treated in the respective comparator arm. Grade 3 and Grade 4 infections occurred respectively in 5.6% and 0.9% of patients treated with IBRANCE in any combination (see SmPC section 4.8). Patients should be monitored for signs and symptoms of infection and treated as medically appropriate (see SmPC section 4.2). Physicians should inform patients to promptly report any episodes of fever. Strong inhibitors of CYP3A4 may lead to increased toxicity (see SmPC section 4.5). Avoid concomitant use of strong CYP3A inhibitors during treatment with palbociclib. Coadministration should only be considered after careful evaluation of the potential benefits and risks. If coadministration with a strong CYP3A inhibitor is unavoidable, reduce the IBRANCE dose to 75 mg once daily. When the strong inhibitor is discontinued, the dose of IBRANCE should be increased (after 3–5 half-lives of the inhibitor) to the dose used prior to the initiation of the strong CYP3A inhibitor (see SmPC section 4.5). Coadministration of CYP3A inducers may lead to decreased palbociclib exposure and consequently a risk for lack of efficacy. Therefore, concomitant use of palbociclib with strong CYP3A4 inducers should be avoided. No dose adjustments are required for coadministration of palbociclib with moderate CYP3A inducers (see SmPC section 4.5). Women of childbearing potential or their male partners must use a highly effective method of contraception while taking IBRANCE (see SmPC section 4.6). IBRANCE capsules contain lactose. Patients with rare hereditary problems of galactose intolerance, the Lapp lactase deficiency, or glucose-galactose malabsorption should not take this medicinal product. Palbociclib tablets do not contain lactose. **Drug Interactions:** The concomitant use of strong CYP3A inhibitors including, but not limited to: clarithromycin, indinavir, itraconazole, ketoconazole, lopinavir/ritonavir, nefazodone, nelfinavir, posaconazole, saquinavir, telaprevir, telithromycin, voriconazole, and grapefruit or grapefruit juice, should be avoided (see sections 4.2 and 4.4). No dose adjustments are needed for mild and moderate CYP3A inhibitors. The concomitant use of strong CYP3A inducers including, but not limited to: carbamazepine, enzalutamide, phenytoin, rifampin, and St. John's Wort should be avoided (see SmPC sections 4.3 and 4.4). No dose adjustments are required for moderate CYP3A inducers. The dose of sensitive CYP3A substrates with a narrow therapeutic index (e.g., alfentanil, cyclosporine, dihydroergotamine, ergotamine, everolimus, fentanyl, pimozide, quinidine, sirolimus, and tacrolimus) may need to be reduced when coadministered with IBRANCE as IBRANCE may increase their exposure. Based on in vitro data, palbociclib is predicted to inhibit intestinal P-glycoprotein (P-gp) and breast cancer resistance protein (BCRP) mediated transport. Therefore, administration of palbociclib with medicinal products that are substrates of P-gp (e.g., digoxin, dabigatran, colchicine, pravastatin) or BCRP (e.g., rosuvastatin, sulfasalazine) may increase their therapeutic effect and adverse reactions. Based on in vitro data, palbociclib may inhibit the uptake transporter organic cationic transporter OCT1 and then may increase the exposure of medical product substrates of this transporter (e.g., metformin). **Pregnancy & Lactation:** Females of childbearing potential who are receiving this medicinal product, or their male partners should use adequate contraceptive methods (e.g., double-barrier contraception) during therapy and for at least 3 weeks or 14 weeks after completing therapy for females and males, respectively (see SmPC section 4.5). There are no or limited amount of data from the use of palbociclib in pregnant women. Studies in animals have shown reproductive toxicity (see SmPC section 5.3). IBRANCE is not recommended during pregnancy and in women of childbearing potential not using contraception. Based on male reproductive organ findings (seminiferous tubule degeneration in testis, epididymal hypospermia, lower sperm motility and density, and decreased prostate secretion) in nonclinical safety studies, male fertility may be compromised by treatment with palbociclib (see SmPC section 5.3). Thus, men may consider sperm preservation prior to beginning therapy with IBRANCE. **Driving and operating machinery:** IBRANCE may cause fatigue and patients should exercise caution when driving or using machines. **Side Effects:** The most common (≥20%) adverse reactions of any grade reported in patients receiving palbociclib in randomised clinical studies were neutropenia, infections, leukopenia, fatigue, nausea, stomatitis, anaemia, diarrhoea, alopecia, and thrombocytopenia. The most common (≥2%) Grade ≥3 adverse reactions of palbociclib were neutropenia, leukopenia, anaemia, fatigue, infections, alanine aminotransferase (ALT) increased and aspartate aminotransferase (AST) increased. Dose reductions or dose modifications due to any adverse reaction occurred in 38.4% of patients receiving IBRANCE in randomised clinical studies regardless of the combination. Very common adverse events (≥1/10) are neutropenia, infections, leukopenia, fatigue, anaemia, asthenia, pyrexia, nausea, stomatitis, alopecia, diarrhoea, thrombocytopenia, vomiting, rash, decreased appetite, dry skin, AST increased and ALT increased. Commonly reported adverse events (≥1/100 to <1/10), are dysgeusia, epistaxis, ILD/pneumonitis, lacrimation increased, vision blurred, dry eye, febrile neutropenia. Refer to section 4.8 of the SmPC for further information on side effects, including description of selected adverse reactions. **Legal Category:** S1A. **Marketing Authorisation Numbers:** EU/1/16/1147/001 – 75 mg (21 capsules); EU/1/16/1147/003 – 100 mg (21 capsules); EU/1/16/1147/005 – 125 mg (21 capsules), EU/1/16/1147/010 – 75 mg (21 tablets), EU/1/16/1147/012 – 100 mg (21 tablets) and EU/1/16/1147/014 – 125 mg (21 tablets). **Marketing Authorisation Holder:** Pfizer Europe MA EEIG, Boulevard de la Plaine 17, 1050 Bruxelles, Belgium. For further information on this medicine please contact: Pfizer Medical Information on 1800 633 363 or at medical.information@pfizer.com. For queries regarding product availability please contact: Pfizer Healthcare Ireland, Pfizer Building 9, Riverwalk, National Digital Park, Citywest Business Campus, Dublin 24 + 353 1 467 6500.

Last revised: 01/2022.

Ref: 10_0.

Pfizer Oncology

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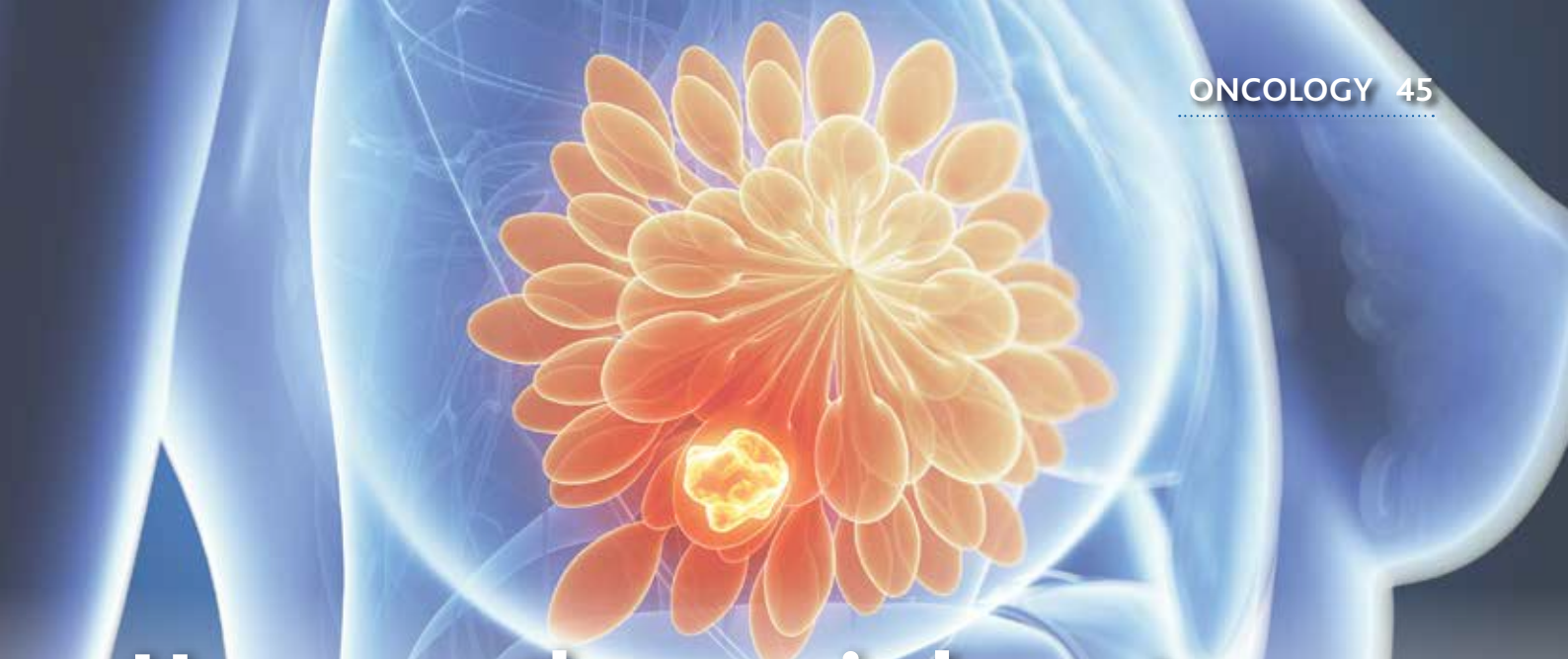
AI = aromatase inhibitor; **ET** = endocrine therapy; **HR+/HER2-** = hormone receptor-positive, human epidermal growth factor receptor 2-negative; **LHRH** = luteinising hormone releasing hormone; **mBC** = metastatic breast cancer; **SmPC** = summary of product characteristics.

PP-IBR-IRL-0505
Date of preparation: March 2022



Hormone therapy in breast cancer

Specialist cancer nurse **Alex Stanley** discusses the use of adjuvant endocrine therapy in patients with hormone sensitive breast cancer

A 35-YEAR-OLD woman was referred to the rapid access breast clinic by her GP with a lump in her left breast. Her medical history included endometriosis but there was no cancer family history. She was a smoker and a social drinker. A mother to one son, she presented to primary care with a hard lump she found in her left breast and was referred to the rapid access breast clinic.

A biopsy performed showed multifocal breast cancer, oestrogen positive, progesterone positive and HER2 negative disease. She had a left mastectomy and axillary clearance. The patient elected to undergo immediate breast reconstruction and a latissimus dorsi flap and implant surgery was performed. Post-operatively she developed some wound complications and lost some native skin tissue due to necrosis. This was successfully managed conservatively and did not require further surgical intervention at this time. Post-operative histology confirmed multifocal breast cancer, with eight of 15 nodes involved, T2N2M0.

This woman was discussed at a multidisciplinary team meeting and a decision for aggressive adjuvant chemotherapy was recommended. She consented to participate in the NSABP-38 study.[1]

The NSABP-38 study randomised breast cancer patients to one of three chemotherapy regimens:

- Group One received doxorubicin 50mg/m^2, cyclophosphamide 500mg/m^2, docetaxel 75mg/m^2 every three weeks for six cycles followed by hormonal therapy
- Group Two received doxorubicin 60mg/m^2, cyclophosphamide 600mg/m^2 every two weeks for four cycles, followed by paclitaxel 175mg/m^2 every two weeks for four cycles, ending with hormonal therapy
- Group Three received doxorubicin 60mg/m^2, cyclophosphamide 600mg/m^2 every two weeks for four cycles, followed by paclitaxel 175mg/m^2 and gemcitabine 200mg/m^2 every two weeks for four cycles, ending with hormonal therapy.

The patient in this case study was randomised to group two. She completed the regimen with relatively minimal complications. She had one episode of neutropenia but did not require hospitalisation for same and remained well throughout. She commenced adjuvant hormonal therapy, tamoxifen, and started radiotherapy. She completed three field 25 fractions of 50Gy radiotherapy to the left mastectomy site. She was stable on hormonal therapy following surgery, adjuvant chemotherapy and radiotherapy.

Two years after commencing tamoxifen she experienced prolonged per vaginum (PV) bleeding and was referred to a gynaecologist. She had a hysteroscopy and the histology was benign, hence she continued on tamoxifen. A few months later, she presented again with PV bleeding and elected to have a hysterectomy and bilateral oophorectomy. Histology confirmed endometriosis and her endocrine therapy changed to letrozole.

The patient's disease remained stable on adjuvant letrozole for 10 years in total. The consultant medical oncologist and patient made the informed decision to stop treatment as per evidence-based guidelines at the time and she was discharged to GP care.

Six months later the patient presented to her GP with left breast discomfort with associated axilla pain and a new 1cm solid cystic lump at the inner area of her left breast at the chest wall.

The GP once again referred the patient to the rapid access breast clinic. A core biopsy of the nodule was performed and cytology confirmed malignant breast cancer cells. CT TAP revealed a small pleural effusion with bone and liver lesions. Histology showed oestrogen and progesterone positive and HER2 negative breast cancer

Firstline treatment for metastatic breast cancer of fulvestrant, palbociclib and denosumab was commenced. Two years into her treatment for metastatic breast cancer she developed progressive disease in liver lesions. The patient was enrolled in the EMERALD Clinical Trial in March 2020.[2] However, due to onset of the Covid-19 pandemic this clinical trial was ceased and she was commenced on oral capecitabine and denosumab monthly.

The patient maintained stable disease on capecitabine for six months. At this stage she self-reported new onset of dysphagia with persistent reflux. Despite maximum proton pump inhibitor cover and soft diet only, the patient was unable to tolerate her oral anticancer medication, capecitabine. However, CT TAP showed stable disease and the patient was commenced on eribulin chemotherapy.

Re-occurrence of hormone positive breast cancer

Breast cancer is the most common cancer diagnosed in women.[3] Approximately 80% of breast cancer diagnosed is

hormone sensitive – oestrogen or progesterone.[4] Effective screening, advancement and access to treatments have improved the five-year and 10-year breast cancer survivorship statistics.[4]

The COSMO study in Italy[5] was recently completed. The intent of this study was to determine overall survival in metastatic breast cancer patients. It determined that a number of prognostic factors impact overall survival, including sites of metastases, age at diagnosis and the disease free interval. The findings also correlate with the National Cancer Registry Ireland findings that hormone sensitive breast cancer patient's overall survival had improved.[4] This was attributed to access to new treatments among other factors.[5]

For this patient, the metastatic sites of bone and liver metastases would indicate a need for a more guarded prognosis. However, bone metastases alone, in metastatic breast cancers has an improved overall survival[5] in comparison to liver or central nervous system metastases. It is acknowledged that further research is required to develop a greater understanding of the above mentioned prognostic factors to improve survival in metastatic breast cancer.

Hormone therapy in hormone sensitive breast cancer patients

As presented in the above case study, this patient completed 10 years of adjuvant endocrine therapy. Awan and Esfahani identified endocrine therapy in the treatment of hormone sensitive breast cancer in the adjuvant and metastatic setting as an ever-evolving field.[6]

The use of tamoxifen with an ovarian suppression agent in high-risk women (aged ≤ 35 years at diagnosis) is regarded as standard of care.[6] In a systematic review Emons et al concluded that there was a greater risk of developing endometrial and uterine cancers after two years on tamoxifen.[7]

As per the NICE guidelines, extending adjuvant endocrine therapy can be recommended to women for management of hormone sensitive breast cancer.[8] The NCCP published findings recommending continuation of adjuvant hormonal or endocrine therapy for a minimum of 10 years, as statistics showed this decreased the disease re-occurrence and mortality.[9]

This patient tolerated 10 years of adjuvant endocrine therapy, completed treatment and unfortunately progressed within a six-month period of completion. Discussions surrounding duration of hormonal therapy in this patient group are continuing and there is a large body of literature available on this issue.

Alex Stanley is an oncology clinical nurse specialist at St James's Hospital, Dublin

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When treating adult patients with *gBRCA-mutated* HR+/HER2- or triple-negative locally advanced or metastatic breast cancer[1]

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TALZENNA significantly prolonged median PFS vs chemotherapy: 8.6 months vs 5.6 months (HR=0.54 [95% CI: 0.41-0.71]; P<0.0001)[1]

DOUBLED OBJECTIVE RESPONSE RATE (ORR)
ORR for TALZENNA was 62.6% (95% CI: 55.8-69.0) vs 27.2% (95% CI: 19.3-36.3) with chemotherapy (OR=4.99 [95% CI: 2.93-8.83]; P<0.0001)†‡

CONVENIENT DOSING
TALZENNA provides convenient, once-daily oral dosing, with or without food[1]

Indication: TALZENNA is indicated as monotherapy for the treatment of adult patients with germline *BRCA1/2*-mutations, who have HER2-negative locally advanced or metastatic breast cancer. Patients should have been previously treated with an anthracycline and/or taxane in the (neo)adjuvant, locally advanced or metastatic setting unless patients were not suitable for these treatments (see section 5.1 of full SmPC). Patients with hormone receptor (HR)-positive breast cancer should have been treated with a prior endocrine-based therapy, or be considered unsuitable for endocrine-based therapy.

CI=confidence interval; gBRCA=germline breast cancer susceptibility gene;
HER2-=human epidermal growth factor receptor 2 negative;
HR=hazard ratio; **HR+**=hormone receptor-positive;
OR=odds ratio;
RECIST=Response Evaluation Criteria in Solid Tumors.

* Capecitabine, eribulin, gemcitabine, or vinorelbine.
† Conducted in the intent-to-treat population with measurable disease at baseline. Per RECIST v1.1, confirmation of response was not required.1
‡ ORR is the proportion of patients who have a partial or complete response to treatment.

Reference: 1. TALZENNA Summary of Product Characteristics.

PRESCRIBING INFORMATION

▼This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions. Refer to section 4.8 of the SPC for how to report adverse reactions.

Talzenna® ▼ 0.25 mg and 1 mg hard capsules IE Prescribing Information:

Before prescribing Talzenna (talazoparib) please refer to the full Summary of Product Characteristics (SmPC). **Presentation:** Each 0.25 mg hard capsule contains talazoparib tosylate equivalent to 0.25 mg talazoparib. Each 1 mg hard capsule contains talazoparib tosylate equivalent to 1 mg talazoparib. **Indications**: Talzenna is indicated as monotherapy for the treatment of adult patients with germline BRCA1/2 mutations, who have HER2-negative locally advanced or metastatic breast cancer. Patients should have been previously treated with an anthracycline and/or a taxane in the (neo)adjuvant, locally advanced or metastatic setting unless patients were not suitable for these treatments. Patients with hormone receptor (HR)-positive breast cancer should have been treated with a prior endocrine-based therapy, or be considered unsuitable for endocrine-based therapy. **Dosage and Administration:** Treatment should be initiated and supervised by a physician experienced in the use of anticancer medicinal products. Patients should be selected for the treatment of breast cancer with Talzenna based on the presence of deleterious or suspected deleterious germline BRCA mutations determined by an experienced laboratory using a validated test method. Genetic counselling for patients with BRCA mutations should be performed according to local regulations, as applicable. The recommended dose is 1 mg talazoparib once daily. Patients should be treated until disease progression or unacceptable toxicity occurs. Complete blood count should be obtained prior to starting Talzenna therapy and monitored monthly and as clinically indicated. To manage adverse drug reactions, interruption of treatment or dose reduction based on severity and clinical presentation should be considered (see SmPC section 4.2). Special populations: Hepatic impairment: See SmPC section 4.2. No dose adjustment is required for patients with mild, moderate or severe hepatic impairment. Renal impairment: See SmPC section 4.2. No dose adjustment is required for patients with mild renal impairment. For patients with moderate renal impairment, the recommended starting dose of Talzenna is 0.75 mg once daily. For patients with severe renal impairment, the recommended starting dose of Talzenna is 0.5 mg once daily. Talzenna has not been studied in patients with CrCL < 15 mL/min or patients requiring haemodialysis. Elderly: No dose adjustment is necessary in elderly (≥ 65 years of age) patients. Paediatric population: The safety and efficacy of Talzenna in children and adolescents < 18 years of age have not been established. **Method of administration**: Talzenna is for oral use. To avoid contact with the capsule content, the capsules should be swallowed whole, and must not be opened or dissolved. They can be taken with or without food (See SmPC section 5.2). **Contra-indications:** Hypersensitivity to the active substance or to any of the excipients. Breast-feeding. **Special Warnings and Precautions:** Myelosuppression: Myelosuppression consisting of anaemia, leucopenia/neutropenia, and/or thrombocytopenia, have been reported in patients treated with talazoparib (see section 4.8). Talazoparib should not be started until patients have recovered from haematological toxicity caused by previous therapy (≤ Grade 1). Precautions should be taken to routinely monitor haematology parameters and signs and symptoms associated with anaemia, leucopenia/neutropenia, and/or thrombocytopenia in patients receiving talazoparib. If such events occur, dose modifications (reduction or interruption) are recommended. Supportive care with or without blood and/or platelet transfusions and/or administration of colony stimulating factors may be used as appropriate. Myelodysplastic syndrome/Acute myeloid leukaemia: Myelodysplastic syndrome/Acute Myeloid Leukaemia (MDS/AML) have been reported in patients who received poly (adenosine diphosphate-ribose) polymerase (PARP) inhibitors, including talazoparib. Overall, MDS/AML has been reported in < 1% of solid tumour patients treated with talazoparib in clinical studies. Potential contributing factors for the development of MDS/AML include previous platinum-containing chemotherapy, other DNA damaging agents or radiotherapy. Complete blood counts should be obtained at baseline and monitored monthly for signs of haematologic toxicity during treatment. If MDS/AML is confirmed, talazoparib should be discontinued. Contraception in women of childbearing potential: Talazoparib was clastogenic in an in vitro chromosomal aberration assay in human peripheral blood lymphocytes and in an in vivo bone marrow micronucleus assay in rats but not mutagenic in Ames assay (see section 5.3), and may cause foetal harm when administered to a pregnant woman. Pregnant women should be advised of the potential risk to the foetus (see section 4.6). Women of childbearing potential should not become pregnant while receiving Talzenna and should not be pregnant at the beginning of treatment. A pregnancy test should be performed on all women of childbearing potential prior to treatment. A highly effective method of contraception is required for female patients during treatment with Talzenna, and for at least 7 months after completing therapy. Since the use of hormonal contraception is not recommended in patients with breast cancer, two non-hormonal and complementary contraception methods should be used. Male patients with female partners of reproductive potential or pregnant partners should be advised to use effective contraception (even after vasectomy), during treatment with Talzenna and for at least 4 months after the final dose. **Interactions:** Talazoparib is a substrate for drug transporters P-gp and Breast Cancer Resistance Protein (BCRP) and it is mainly eliminated by renal clearance as unchanged compound. Concomitant treatment with inhibitors of P-glycoprotein (P gp): Strong inhibitors of P gp may lead to increased talazoparib exposure. Concomitant use of strong P gp inhibitors (including but not limited to amiodarone, carvedilol, clarithromycin, cobicistat, darunavir, dronedarone, erythromycin, indinavir, itraconazole, ketoconazole, lapatinib, lopinavir, propafenone, quinidine, ranolazine, ritonavir, saquinavir, telaprevir, tipranavir, and verapamil) during treatment with talazoparib should be avoided. Co-administration should only be considered after careful evaluation of the potential benefits and risks. If co-administration with a strong P gp inhibitor is unavoidable, the Talzenna dose should be reduced to 0.75 mg once daily. When the strong P-gp inhibitor is discontinued, the Talzenna dose should be increased (after 3 5 half lives of the P-gp inhibitor) to the dose used prior to the initiation of the strong P gp inhibitor. No talazoparib dose adjustments are required when co administered with rifampin. However, the effect of other P-gp inducers on talazoparib exposure has not been studied. Other P-gp inducers (including but not limited to carbamazepine, phenytoin, and St. John's wort) may decrease talazoparib exposure. BCRP inhibitors: The effect of BCRP inhibitors on PK of talazoparib has not been studied in vivo. Co-administration of talazoparib with BCRP inhibitors may increase talazoparib exposure. Concomitant use of strong BCRP inhibitors (including but not limited to curcumin and cyclosporine) should be avoided. If co administration of strong BCRP inhibitors cannot be avoided, patient should be monitored for potential increased adverse reactions. Effect of acid-reducing agents: Population PK analysis indicates that co-administration of acid-reducing agents including proton pump inhibitors and histamine receptor 2 antagonists (H2RA), or other acid reducing agents had no significant impact on the absorption of talazoparib. Systemic hormonal contraception: Drug-drug interaction studies between talazoparib and oral contraceptives have not been conducted. **Fertility, pregnancy and lactation:** Fertility: There is no information on fertility in patients. Based on non-clinical findings in testes (partially reversible) and ovary (reversible), Talzenna may impair fertility in males of reproductive potential. Women of childbearing potential should not become pregnant while receiving Talzenna and should not be pregnant at the beginning of treatment. A pregnancy test should be performed on all women of childbearing potential prior to treatment. Women of childbearing potential must use highly effective forms of contraception prior to starting treatment with talazoparib, during treatment, and for 7 months after stopping treatment with talazoparib. Since the use of hormonal contraception is not recommended in patients with breast cancer, two non-hormonal and complementary contraception methods should be used. Male patients with female partners of reproductive potential or pregnant partners should be advised to use effective contraception (even after vasectomy) during treatment with Talzenna, and for at least 4 months after the final. Pregnancy: There are no data from the use of Talzenna in pregnant women. Studies in animals have shown embryo foetal toxicity. Talzenna may cause foetal harm when administered to a pregnant woman. Talzenna is not recommended during pregnancy or for women of childbearing potential not using contraception. Breast-feeding: It is unknown whether talazoparib is excreted in human breast milk. A risk to breast-fed children cannot be excluded and therefore breast-feeding is not recommended during treatment with Talzenna and for at least 1 month after the final dose. **Undesirable Effects:** The overall safety profile of Talzenna is based on pooled data from 494 patients who received talazoparib at 1 mg daily in clinical studies for solid tumours, including 286 patients from a randomised Phase 3 study with germline BRCA-mutated (gBRCAm), HER2-negative locally advanced or metastatic breast cancer and 83 patients from a non-randomised Phase 2 study in patients with germline BRCA-mutated locally advanced or metastatic breast cancer. The most common (≥ 25%) adverse reactions in patients receiving talazoparib in these clinical studies were fatigue (57.1%), anaemia (49.6%), nausea (44.3%), neutropenia (30.2%), thrombocytopenia (29.6%), and headache (26.5%). The most common (≥ 10%) Grade ≥ 3 adverse reactions of talazoparib were anaemia (35.2%), neutropenia (17.4%), and thrombocytopenia (16.8%). Dose modifications (dose reductions or dose interruptions) due to any adverse reaction occurred in 62.3% of patients receiving Talzenna. The most common adverse reactions leading to dose modifications were anaemia (33.0%), neutropenia (15.8%), and thrombocytopenia (13.4%). Permanent discontinuation due to an adverse reaction occurred in 3.6% of patients receiving Talzenna. The median duration of exposure was 5.4 months (range 0.03-61.1). Very common adverse reactions (>1/10) are Thrombocytopenia, Anaemia, Neutropenia, Leucopenia, Decreased appetite, Dizziness, Headache, Vomiting, Diarrhoea, Nausea, Abdominal pain, Alopecia and Fatigue. Commonly reported adverse reactions (>1/100 to <1/10), are Lymphopenia, Dysgeusia, Stomatitis and Dyspepsia. Refer to SmPC section 4.8 for further information on side effects. **Legal Category:** Product subject to prescription which may not be renewed (A): S1A. **Marketing Authorisation Number:** Talzenna 0.25 mg hard capsules – EU/1/19/1377/001-004; Talzenna 1 mg hard capsules – EU/1/19/1377/005-006. **Marketing Authorisation Holder:** Pfizer Europe MA EEIG, Boulevard de la Plaine 17, 1050 Bruxelles, Belgium.

For further information on this medicine please contact: Pfizer Medical Information on 1800 633 363 or at medical.information@pfizer.com. **For queries regarding product availability please contact:** Pfizer Healthcare Ireland, Pfizer Building 9, Riverwalk, National Digital Park, Citywest Business Campus, Dublin 24 + 353 1 4676500.

Date of Preparation: 11/2021.

Ref: TE 3_0.

PP-TAL-IRL-0045
Date of Preparation January 2022

▼This medicine is subject to additional monitoring. This will allow quick identification of new safety information. You can help by reporting any side effects you may get to HPRA Pharmcoviglance, Earlsfort Terrace, Dublin 2, IRL. Tel: +353 1 676 4971, Fax: +353 1 676 2517, Website: www.hpra.ie, E-mail: medsafety@hpra.ie

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Psoriasis: OTEZLA is indicated for the treatment of moderate to severe chronic plaque psoriasis in adult patients who failed to respond to or who have a contraindication to, or are intolerant to other systemic therapy including ciclosporine, methotrexate or psoralen and ultraviolet-A light (PUVA). **Dosage and administration:** Treatment with OTEZLA should be initiated by specialists experienced in the diagnosis and treatment of psoriasis or psoriatic arthritis. The recommended dose of OTEZLA is 30mg twice daily taken orally in the AM and PM, approximately 12 hours apart, with no food restrictions. The film-coated tablets should be swallowed whole. An initial dose titration is required per the following schedule: Day 1: 10mg in the AM; Day 2: 10mg in the AM and 10 mg in the PM; Day 3: 10mg in the AM and 20mg in the PM; Day 4: 20mg in the AM and 20mg in the PM; Day 5: 20mg in the AM and 30mg in the PM; Day 6 and thereafter: 30mg twice daily in the AM and PM. No re-titration is required after initial titration. If patients miss a dose, the next dose should be taken as soon as possible. If it is close to the time for their next dose, the missed dose should not be taken and the next dose should be taken at the regular time. Patients with severe renal impairment: The dose of OTEZLA should be reduced to 30mg once daily in patients with severe renal impairment (creatinine clearance of less than 30mL per minute estimated by the Cockcroft-Gault equation). For initial dose titration in this group, it is recommended that OTEZLA is titrated using only the AM doses and the PM doses be skipped. Paediatric population: The safety and efficacy of OTEZLA in children aged 0 to 17 years have not been established. No data is available. **Contraindications:** Hypersensitivity to the active substance(s) or to any of the excipients. OTEZLA is contraindicated in pregnancy. Pregnancy should be excluded before treatment can be initiated. **Special warnings and precautions:** Diarrhoea, nausea and vomiting: Severe diarrhoea, nausea, and vomiting associated with the use of OTEZLA have been reported. Most events occurred within the first few weeks of treatment. In some cases, patients were hospitalized. Patients 65 years of age or older may be at a higher risk of complications. Discontinuation of treatment may be necessary. Psychiatric disorders: OTEZLA is associated with an increased risk of psychiatric disorders such as insomnia and depression. Instances of suicidal ideation and behaviour, including suicide, have been observed in patients with or without history of depression. The risks and benefits of starting or continuing treatment with OTEZLA should be carefully assessed if patients report previous or existing psychiatric symptoms or if concomitant treatment with other medicinal products likely to cause psychiatric events is intended. Patients and caregivers should be instructed to notify the prescriber of any changes in behaviour or mood and of any suicidal ideation. If patients suffered from new or worsening psychiatric symptoms, or suicidal ideation or suicidal attempt is identified, it is recommended to discontinue treatment with OTEZLA. Severe renal impairment: See dosage and administration section. Underweight patients: OTEZLA may cause weight loss. Patients who are underweight at the start of treatment should have their body weight monitored regularly. In the event of unexplained and clinically significant weight loss, these patients should be evaluated by a medical practitioner and discontinuation of treatment should be considered. Lactose content: Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicinal product. **Interactions:** Co-administration of strong cytochrome P450 3A4 (CYP3A4) enzyme inducer, rifampicin, resulted in a reduction of systemic exposure of OTEZLA, which may result in a loss of efficacy of OTEZLA. Therefore, the use of strong CYP3A4 enzyme inducers (e.g. rifampicin, phenobarbital, carbamazepine, phenytoin and St. John's Wort) with OTEZLA is not recommended. In clinical studies, OTEZLA has been administered concomitantly with topical therapy (including corticosteroids, coal tar shampoo and salicylic acid scalp preparations) and UVB phototherapy. OTEZLA can be co-administered with a potent CYP3A4 inhibitor such as ketoconazole, as well as with methotrexate in psoriatic arthritis patients and with oral contraceptives. **Pregnancy, lactation and fertility:** Women of childbearing potential should use an effective method of contraception to prevent pregnancy during treatment. OTEZLA should not be used during breast-feeding. No fertility data is available in humans. **Undesirable effects:** Psychiatric disorders: In clinical studies and post-marketing experience, uncommon cases of suicidal ideation and behaviour, were reported, while completed suicide was reported post-marketing. The most commonly reported adverse reactions with OTEZLA in these indications are gastrointestinal (GI) disorders including diarrhoea (15.7%) and nausea (13.9%). These GI adverse reactions generally occurred within the first 2 weeks of treatment and usually resolved within 4 weeks. Adverse reactions reported in the psoriatic arthritis and/or psoriasis clinical trial programme and post marketing experience include: very common (≥ 1/10) diarrhoea*, nausea*; common (≥1/100 to <1/10) bronchitis, upper respiratory tract infection, nasopharyngitis*, decreased appetite*, insomnia, depression, migraine*, tension headache*, headache*, cough, vomiting*, dyspepsia, frequent bowel movements, upper abdominal pain*, gastroesophageal reflux disease, back pain*, fatigue; uncommon (≥1/1,000 to <1/100) hypersensitivity, suicidal ideation and behaviour, gastrointestinal haemorrhage, rash, urticaria, weight loss; not known (cannot be estimated from the available data) angioedema. *At least one of these adverse reactions was reported as serious. Please consult the SPC for a full description of undesirable events. **Pharmaceutical Precautions:** Do not store above 30°C. **Legal category:** POM. **Presentation and Marketing Authorisation Numbers:** Initiation pack containing 27 film coated tablets (4 x 10mg, 4 x 20mg, 19 x 30mg) - EU/1/14/981/001; 30mg film coated tablets in a pack size of 56 tablets - EU/1/14/981/002. **Marketing Authorisation Holder:** Amgen Europe B.V. Minervum 7061, 4817 ZK Breda, The Netherlands. Further information is available from Amgen Ireland Limited, 21 Northwood Court, Santry, Dublin D09 TX31. OTEZLA is a trademark owned or licensed by Amgen Inc., its subsidiaries, or affiliates. **Date of preparation:** April 2020 (Ref: IE-OTZ-2000019).

Adverse reactions/events should be reported to the Health Products Regulatory Authority (HPRA) using the available methods via www.hpra.ie. Adverse events should also be reported to Amgen Limited on +44 (0)1223 436441.

† Otezla met the primary endpoint of the pivotal trials in psoriasis: PASI-75 response vs placebo at 16 weeks. **ESTEEM 1:** 33.1% (N=562) vs 5.3% (N=282); **ESTEEM 2:** 28.8% (N=274) vs 5.8% (N=137), P<0.0001. OTEZLA met the primary endpoint of the pivotal trials in Psoriatic Arthritis: ACR 20 response vs placebo at 16 weeks. **PALACE 1:** 38% (N=168) vs 19% (N=168), P≤0.001. **PALACE 2:** 32% (N=162) vs 19% (N=159) P≤0.01; **PALACE 3:** 41% (N=167) vs 18% (N=169) P≤0.001.[2]

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Amgen Ireland Ltd., 21 Northwood Court, Santry, Dublin 9

IE-OTZ-0820-00002 | Date of preparation: September 2020

AMGEN®

The skin we wear:

Psychological effects of skin disease

Eadaoin Redmond discusses the profound psychological distress that having a skin disease can cause in patients, as well as the emergence of psychodermatology as a subspecialty

OUR skin is the largest organ of our bodies, it is the most visible and acts as our interface with the world. As such the skin has a major impact on personal perceptions and psychological wellbeing.[1] Having a chronic skin condition can have a profound effect on a person's life, both physically and mentally.

Up to 85% of dermatology patients report that the psychological aspect of their skin disease is a major component of their illness,[1] and suicidal ideation has been reported to be higher among those living with a skin disease.[2]

Dealing with a skin disease

Many dermatology patients find dealing with their skin condition challenging as it is accompanied with significant changes in a person's physical appearance. The visibility of a skin disease hinders the patient from dealing with their disease privately.

Firstly, the visibility of a skin disease can attract attention in social situations or work situations. Patients are often subjected to questions about their condition or others view them as contagious or unclean. Many patients avoid activities such as swimming, gyms, going to the hairdressers or nail technicians as they find others react negatively towards them.

Secondly, most dermatology conditions require a daily time commitment to a regime of bathing, and application of greasy steroids and emollients to successfully manage their condition. Often patients must deal with greasy sheets and clothes, and flaking of skin on household surfaces and clothes. People find this embarrassing and it negatively affects their confidence.

A 2019 UK study examined the psychological impact of living with a skin condition, patients have reported that their skin condition affects their daily activities and their emotional state.[3] Most reported low or bad mood and increased stress levels, worry/anxiety and feelings of embarrassment and self-consciousness and social isolation. Some patients even reported that they felt their life was not worth living.

Patients felt that their skin disease negatively affected their work, sleep and affected existing relationships and the ability to form new relationships. What makes matters worse is negative emotions caused by a skin condition can in turn exacerbate a skin disease, creating a vicious cycle of positive feedback.[4] The burden of psychological distress is underestimated by dermatologists in Europe and providing psychological support as well as effective treatment improves the outcomes for patients with skin conditions.[5]

Psychodermatology

Psychodermatology is a new and emerging subspecialty of dermatology where dermatologists, dermatology nurses, psychologists and psychiatrists work together to manage the physical manifestations on the skin and the profound impact this has on the patient's psyche. This collaboration of healthcare professionals not only

ensures the best outcome for the patients in a timely manner, but evidence is emerging that it is more cost effective.

In this evolving specialty, patients can present with a primary dermatological disorder with secondary psychosocial comorbidities (acne with body dysmorphic disorder), or a primary psychiatric condition which presents to a dermatologist (dermatitis artefacta). There are patients who require psychosocial support with their skin disease (eczema and low self-esteem), those who may develop psychiatric disease following initiation of medication for a dermatological disease (isotretinoin may be associated with suicidal ideation) and those that have developed a skin disease after taking psychotropic medication (lithium may be associated with psoriasis).[3]

Patients with a primary psychiatric disorder may not have insight and therefore will not engage with mental health specialties without the engagement of a dermatologist and engaging with patients that have psychocutaneous disease is crucial.

Psychological interventions that most dermatological patients can benefit from include psychoeducation, self-help treatments, relaxation, mindfulness, meditation and social skills training. More complex patients could be referred for cognitive behavioural therapy (CBT) or habit reversal therapy. Despite the recognition for these services many dermatological departments around the country do not have a psychodermatology clinic and have little access to psychology services.

What we can do

We need to speak to hospital managers and business partners; it may be mistakenly perceived as a costly investment but there is often a hidden layer of resources used prior to them being successfully treated in psychodermatology clinics.[6] We need to reach out to our colleagues in psychiatry and psychology as they may also be struggling to manage these patients in practice and be keen to improve pathways of referral or even consider a collaboration of services.

Training is required for the dermatology team to help us identify and best support these patients. Consultation times for new patients need to be increased. On average a new patient consultation time is 20 minutes, this time is very limited when taking a history and performing a skin exam for the dermatological condition. Increasing the time to 40 minutes would help to gain rapport with the patient, actively listen to their concerns and discuss the effect the skin condition is having on their psychosocial wellbeing.

It is vital the patient feels heard and supported to build an effective clinical relationship and time-limited consultations can make this difficult and frustrating for both the consultant and patient. We can use tools prior to the appointment to collect information such as Dermatology Life and Quality Index and Becks Depression Inventory; this can ensure more time can be spent listening to the patient and ensuring the patient feels validated.

We can also try to help alleviate the stress on patients attending dermatology departments, which can be quite stressful, eg. time off work to attend, childminding, parking and lengthy waits in departments. By using consultation tools open to us in the Covid era, we can maximise our ability to reach our patients. If a patient had a face-to-face consultation prior, we could possibly consider follow up by video/telephone to assess the effectiveness of treatment, thus reducing the stress and anxiety of the patient. Following up stable patients requiring only a repeat prescription by phone sets aside more time for first consultations and assessing psychological impact.

When we have identified patients in need of support, it is important that we link them in with appropriate support. If psychological support pathways are not available in the department we can refer the patient to psychology. Contacting their GP can also be valuable as there is often psychological support available in the community.

Self-help groups can provide emotional support and practical tips for managing skin disease, the shared experience helps to reduce feelings of isolation and embarrassment. As clinicians we can point patients to effective internet sites that provide quality information and support, such as 'Skin Support' which is produced by the British Association of Dermatologists.[7] We can educate our patients on the effect that stress can have on their condition and advise in relation to stress management activities such as mindfulness and meditation.

Conclusion

Dermatology healthcare professionals recognise the need to not only assess but manage the psychological impact of skin conditions to maximise the outcomes for their patients. The range of support available is often limited, with restrictions on time, finance and facilities in addition to long waiting lists, but despite this psychodermatology is emerging as an exciting new field within dermatology.

It is recognised that there is a need for training and support to be put in place to establish a psychodermatology service, however there are also several practical ways we can support our patients in the current environment.

Eadaoin Redmond is a CNM2 in dermatology at St Vincent's University Hospital in Dublin

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WILD-TYPE

ESTIMATTR-CM

wtATTR-CM: A DISEASE THAT OFTEN GOES UNDETECTED[1]

Introducing the **wtATTR-CM estimATTR**—an online tool that was developed based on an artificial intelligence/machine learning (AI/ML) algorithm to learn how combinations of clinical conditions are associated with this underrecognised disease.[2-4]

Wild-type transthyretin amyloid cardiomyopathy (wtATTR-CM) is an underrecognised, progressive, infiltrative disease that can often be overlooked as a cause of heart failure.[1,3,4] Once diagnosed, untreated patients with wtATTR-CM have a median survival of ~3.5 years.[5-7]

The wtATTR-CM estimATTR is an easy-to-use educational tool that was built leveraging AI/ML and can estimate the probability of wtATTR-CM in hypothetical heart failure scenarios. The tool allows you to test various combinations of clinical conditions in a hypothetical patient, see what combinations are associated with wtATTR-CM, and help distinguish from heart failure due to other causes.[2] This tool is for educational purposes only, and it is not to be used in a clinical setting for the suspicion or diagnosis of wtATTR-CM in individual patients.

www.estimattr.ie

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PP-RDP-IRL-0154 October 2021

Pfizer Rare Disease

Urgent need for adequate resourcing of public genetic testing service

Rare Diseases Ireland calls for the strategic development of genetic services to be prioritised, as its recent report outlines the delays involved in accessing public genetic testing and receiving a diagnosis

DELAYS in receiving a diagnosis of a rare disease and in genetic testing have been highlighted in a recent survey on the healthcare experiences of people living with a rare condition.

In some cases people had to wait up to 10 years for a diagnosis of their condition and many had been investigated for multiple diseases by varied specialists before a definite diagnosis was eventually given. It is estimated that some 300,000 people in Ireland have a rare disease. Around 70% of these are genetic and most of these start to develop in childhood, with about 30% showing up later in life.

The results of the survey are included in a report published by Rare Disease Ireland (RDI), 'Rare reality: Living with a rare disease in Ireland – healthcare experiences'. The data came from an online questionnaire of 111 patients and their families taken in late 2021.

One in five patients had waited two year for a final diagnosis; 14% had waited five to 10 years and 23% had waited over 10 years. Nearly half of the patients surveyed reported seeing between three and five specialists along the way to diagnosis, and 25% saw six or more specialists.

Genetic testing

The importance of genetic testing was highlighted in the RDI report. Nearly two-thirds of respondents had experience of genetic testing and in these cases, 77% had a definitive diagnosis through genetic testing. One in five people said they waited more than two years for genetic test results through the public system. The waiting time was less than two years via the private system.

The report identified issues with the communication of potentially life-changing test results to patients. Around a quarter of patients received their genetic results by phone and around the same number received their results by letter or email. Only a little over half of genetic test results were given to the individual in person.

Only half the respondents said that they had received treatment to slow down or stop deterioration of their rare condition. The majority of patients were given treatments to relieve symptoms. One in five people reported that treatment was not available in Ireland due to waiting lists. Lack of reimbursement and HSE processes were also identified as impediments to receiving treatment.

One in three respondents reported regularly attending four or more different types of specialist hospital clinics to manage their condition. One in four attend just one. Typically, a quarter of respondents engage with hospital/GP services one to three times per year, while a slightly higher number of respondents (30%) engage with those services more than 10 times annually. When it comes to other healthcare professionals and services in the community, 44% of respondents engage with them one to three times per year, and almost one in four (23%) engage with them more than 10 times annually.

Many respondents felt that their condition deteriorated during the Covid-19 pandemic, in terms of physical, mental and emotional health.

Importance of timely diagnosis

"Rare conditions are complex", commented Vicky McGrath, CEO of Rare Diseases Ireland. "Getting a timely and accurate diagnosis is far from easy and must be prioritised for action. People are waiting too long for a diagnosis. Delays mean that not only does the person not get the care they need, they may also be provided with unnecessary and potentially harmful treatment."

She added that care can be fragmented with patients or their guardians having to link up services and specialties themselves. RDI has called for the strategic development of genetic services to be made a priority. The organisation has pointed out that more resources are needed to appoint key specialist staff in the genetics area.

"Equally, where expertise in a particular condition is not available in Ireland, patients should be given the opportunity to avail of expert care abroad", said Ms McGrath. She welcomed the development of the European Reference Networks (ERNs), a body set up to provide access to expertise, research and education for rare conditions.

Meanwhile, Health Minister Stephen Donnelly welcomed a recent communication from the European Commission that applications from five Irish academic hospitals to join ERNs have been approved.

This will enable Irish researchers to engage with peers across the EU on best practice in the treatment of rare diseases. It should lead to improvements in the diagnosis and multidisciplinary treatment of rare diseases including kidney and neuromuscular conditions, paediatric and adult cancers and immunodeficiency, autoinflammatory and autoimmune disease.

Ireland has a Model of Care for Rare Disease which was produced in 2019. Recommendations from this are in the process of being implemented through the HSE, Health Research Board and the National Rare Diseases Office.

Gastroenterology focus

WIN takes a look at some new findings in gastrointestinal disease research published in the journals

Scientists use digital oesophagus to monitor Barrett's disease

A RESEARCH team in the US has developed a digital tool to better monitor a condition known as Barrett's oesophagus. Barrett's occurs when the mucosal lining of the lower oesophagus deteriorates, altering its cellular structure, and is most common in those with chronic acid reflux.

Barrett's is considered a premalignant condition to oesophageal cancer – of which Ireland has one of the highest incidences in Europe – so monitoring patients is critical. The current model for tracking the progress of the disease, known as the Seattle protocol, is invasive, expensive and potentially ineffective.

The protocol involves an invasive procedure every few months that only captures a small percentage of the affected tissue.

The research team, which included researchers from Oak Ridge National Laboratory (ORNL), Columbia University's Irving Medical Center, Mount Sinai's Icahn School of Medicine and Massachusetts General Hospital's Institute for Technology Assessment, published their results in the journal *Simulation*.

They set out to test the effectiveness of the Seattle protocol by constructing a computational model to represent the human oesophagus, using real-world data across a large population of tissues.

"The ultimate goal was to strike a balance between physically poking a patient and how often you find something that may be concerning," said Jim Nutaro, leader for computational systems engineering at ORNL and a researcher on the project.

He explained that the new digital tool reproduces historical data and the cancers that surface in the simulations are analogous to the real world.

"These are virtual patients, and we can poke them as much as we want," he added.

The team's end goal is to minimise the invasiveness of tracking the condition and, by extension, reduce deaths from oesophageal cancer by providing a testbed for potential future monitoring regimes.

To examine their digital patients, the researchers first needed to construct a digital oesophagus via a computational model. The team drew input data for Barrett's onset and death ages from an actual 1960s cohort and validated the resulting model with real-world data, such as detection rates and population statistics.

The model is in the public domain, available to those who can apply it to the physical treatment of Barrett's patients.

In the near term the researchers are looking to apply it to studying variations in the detection of Barrett's across different timescales and tissue areas. Ultimately, they would like to find partners in the medical community that could use their findings to develop a new protocol and, by extension, improve the lives and life expectancies of patients with Barrett's oesophagus.

– DOI: 10.1177/00375497211040074

Unique underpinnings of stomach's acid pump revealed

Researchers at Nagoya University in Japan have improved understanding of the molecular mechanisms of a key protein that makes the stomach acidic. Published in the journal *Nature Communications*, their findings could lead to better drugs for stomach ulcers and shed light on the functions of similar proteins across the human body.

"This gastric protein pumps in acidic ions to fortify our stomach, which is important for digestion but can sometimes lead to ulcers. Our results improve our understanding of how these types of proteins work, and we expect them to have further applications in drug development," said Dr Kazuhiro Abe, a protein crystallographer at Nagoya University who led the research.

The H+/K+ ATPase protein is an enzyme that pumps hydrogen ions (H+) into the stomach to help digestion and kill any bugs we might swallow with our food and drink. However, excessive stomach acidification can lead to ulcers. Drugs that block the enzyme's activity could therefore reduce acidification and ease ulcer symptoms.

To design more effective drugs, scientists need to know how the protein works. In this study, the researchers demonstrated it has an unusual feature. To pump the hydrogen ions into the stomach, the protein first needs to bind to a potassium ion (K+). Similar proteins typically bind two such potassium ions to trigger the pump mechanism. But H+/K+ ATPase needs only one.

To investigate, the researchers fabricated novel versions of the protein. By adding five amino acids at specific locations, and then studying the new structure with a cryo-electron microscope, they fabricated a mutant form of H+/K+ ATPase that bound to two potassium ions. The findings will help scientists understand why these important pump proteins bind to different numbers of ions. They can use that information to unpick the molecular mechanisms of similar proteins elsewhere.

"We have many cation (ion with a positive charge) pumps in our body. Sodium pumps keep cells alive and drive signalling in the nervous system. Calcium pumps are vital for muscle contraction. Our strategy would be useful to investigate the cation selectivity for each cation pump, which is a central question for scientists working on the cation transport proteins," said Dr Abe.

– DOI: 10.1038/s41467-021-26024-1

Must-read dementia books

A COLLECTION of 'top 25 dementia books', compiled by Ireland's librarians, has been launched. The development of the specially curated selection offers a range of perspectives on life with the disease and follows on a need identified by people with dementia and their loved ones for greater information and support. It has been created in partnership with colleagues from the Dementia Services Information and Development Centre, Dublin (DSIDC).

Each year more than 11,000 people develop dementia across the country – that's around 30 people every day. Approximately 64,000 people are living with dementia in Ireland today and this number is expected to more than double to over 150,000 by 2045. The most common forms of dementia are Alzheimer's disease, vascular dementia, mixed Alzheimer's disease/vascular dementia, frontotemporal dementia and Lewy body disease.

Through an initiative of the Healthy Ireland at Your Library programme, and supported by the Dementia: Understand Together campaign, led by the HSE, the top 25 dementia books are now available in or through 330 libraries nationwide.

The collection features an eclectic mix of titles on the subject of dementia, from slowing the onset of the disease to ways to improve our brain health, from first-hand accounts of people living with dementia to ways to improve life through nutrition, music, the arts and more.

The introduction of the collection has been supported by the delivery of dementia awareness training to library staff. Delivered by the DSIDC, the training provided information on the different types of dementia and their symptoms. It also gave information and advice on creating a supportive environment and how best to assist and communicate with the person with dementia when visiting the library.

The top three books on the list are:

- *100 Days to a Younger Brain* by Dr Sabina Brennan, which features details of 100 programmes aimed at improving brain health, including information needed to empower you to make informed choices every day about your sleeping, eating and lifestyle habits
- *A Pocket Guide to Understanding Alzheimer's Disease and Other Dementias* by Dr James Warner and Dr Nori Graham, a book which helps to demystify these conditions and gives practical advice on how those with dementia and those supporting them can be better placed to cope
- *Adaptive Interaction and Dementia* by Dr Maggie Ellis and Prof Arlene Astell, on how non-verbal techniques can help the person with dementia to remain in touch with the 'social world'.

The full top 25 dementia books can be found at **www.understandtogether.ie** under the 'news' section (item dated February 24, 2022). The Libraries Development Committee will continue to review and add to this listing as appropriate, as new books arrive.

Library staff are on hand to share their insights on the different books and to point readers in the right direction of the most suitable titles depending on the particular interest they might have.

– Tara Horan

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Take a break with CROSSWORD Competition

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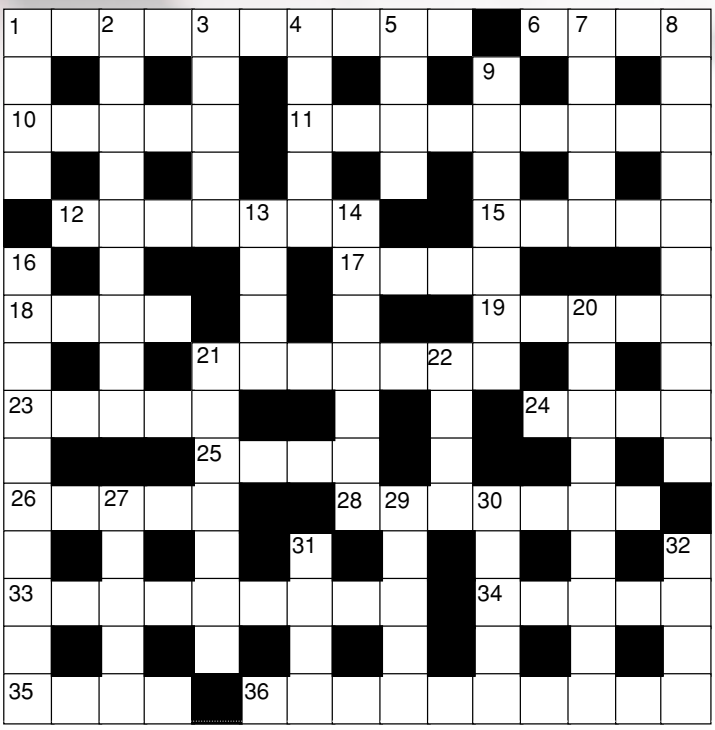
Across

1 Early science fiction writer involved in June revels (5,5)
6 Shelled out (4)
10 French singer Ms Piaf (5)
11 Concerning the bit about a surgical procedure (9)
12 breathe out and a tisane will appear (4,3)
15 Relating to a bone in the forearm (5)
17 Iconic mountain of Japan (4)
18 Performs a role in a play or film (4)
19 Itinerary (5)
21 Paul, French impressionist artist (7)
23 Veranda (5)
24 Ms O'Brien, Irish novelist (4)
25 Precious stone with no friend? (4)
26 Horrify (5)
28 Oriental (7)
33 Another way to show me a sprint? How tasty is that! (9)
34 This river is joined by the Saone in Lyon (5)
35 Appends (4)
36 Coffee-making appliance (10)

Down

1 Mock, taunt (4)
2 City in the English Midlands (9)
3 Indian term of respect from colonial times (5)
4 Spooky (5)
5 It is worked on in rhinoplasty (4)
7 From the largest continent (5)
8 Ken robbed a fast food concoction (5,5)
9 Get – some singers, by the sound of it! (7)
13 Ripped (4)
14 Pleasant, charming (7)
16 The world's largest body of inland water (7,3)
20 The first layer of paint (9)
21 Disturbance in a chorale is fatally infectious (7)
22 Town in Kildare (4)
27 Implore (5)
29 Native of ancient Mexico (5)
30 Scenic part of Austria (5)
31 First aid acronym found in a paddy field? (1,1,1,1)
32 Dread (4)



Name:

Address:

You can email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included putting 'crossword competition' in the subject line. Closing date: **Friday, April 22, 2022.** If preferred you can post your entry to: WIN Crossword, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Dublin, A96E096

March crossword solution

Across: 1. Archbishop 6 Owed 10 Pilau 11 Anthology 12 Problem 15 Salsa 17 Aunt 18 AIDS 19 Edict 21 Mermaid 23 Liege 24 Pain 25 Skit 26 Nails 28 Hammock 33&34 Operating table 35 Ease 36 Assessment

Down: 1 Alps 2 Coleridge 3 Blurb 4&31 Spare ribs 5 Oats 7 Whorl 8 Dry martini 9 Jousted 13 Lure 14 Mammoth 16 Fall in love 20 Irascible 21 Messiah 22 Item 27 Ideas 29 Angle 30 Maths 32 Newt

The winner of the March crossword is: Katie Lawlor, Bagenalstown, Co Carlow

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Please recruit your friend/colleague and ask them to complete an INMO new member Application Form (*please contact any INMO office for a supply of Application Forms*). Insert **your** name and INMO membership number on the 'Recruited By' portion of the application form at the end of Section 1.

*For every new member or re-joining member recruited, you receive a €20 One4all Gift Card.

Survey aims to measure impact of Covid on infection control practices

A TEAM of researchers at the School of Nursing, Psychotherapy and Community Health at Dublin City University (DCU) is asking nurses in general hospitals in Ireland to respond to a survey investigating the impact of Covid-19 on infection prevention and control (IPC), and whether the increased workload has led to IPC practices being delayed or missed in their workplaces.

Every day, nurses and midwives must balance competing priorities to deliver high-quality patient care, and can therefore provide important insights to enhance our understanding of the factors that impact the provision of IPC care in hospitals.

The team at DCU, led by Dr Marcia Kirwan and Prof Anne Matthews, is asking staff nurses and clinical nurse managers on general medical units, surgical units, critical care units or in emergency departments of any public or private general hospitals in Ireland to participate, along with IPC nurses in those hospitals.

The study is intended to support nurses and midwives through the identification of factors in their workplaces that may prevent them from providing adequate IPC care to patients.

The research will provide new evidence to support practice development, education and policy-making to improve IPC practices and patient outcomes.

The survey is anonymous and takes around 10 minutes to complete. No personal, ward or hospital details are requested as part of this research.

Nurses are widely acknowledged as key players in keeping patients safe in hospitals and other settings, where due to their proximity to the patient, they are often seen as the last line of defence in the chain of care delivery.

However, when nurses and midwives have more vital patient care to provide than time or resources will allow, it is inevitable that some care will be omitted or delayed.

In recent years this phenomenon has been described by some researchers as 'missed nursing care', 'nursing care left undone' or 'implicitly rationed care'. While these concepts vary slightly, they all seek to describe the increasingly common situation for nurses and midwives where important patient care is delayed or omitted due to insufficient resources or levels of support.

These delays or omissions leave patients vulnerable to reduced quality of overall care and at greater risk of adverse outcomes, and leave nurses vulnerable to adverse personal outcomes.

To access the survey, please visit **https://bit.ly/3tvoVjY**

Contact Marcia.kirwan@dcu.ie or elizabeth.egan22@mail.dcu.ie for further information.

CHI teams up with Coventry University and Nursing Now to improve digital literacy skills of early-career nurses

COVENTRY University, in collaboration with Children's Health Ireland (CHI) and other partners, is set to play a key part in training the next generation of nursing and midwifery leaders in Uganda, the US and Ireland through its Nursing Now Challenge programme and the innovative use of digital technology.

In partnership with Nursing Now Challenge members Cincinnati Children's Hospital and MILCOT Uganda, as well as CHI, Coventry University will create and implement a new virtual simulated nursing placement (VSP) to improve the digital literacy skills of early-career nurses and midwives.

The placement has been made possible thanks to a grant from the Burdett Trust for Nursing of almost £100,000.

VSPs are virtual environments created to simulate healthcare scenarios, recreating life-like challenging situations.

The placement will help to develop leadership skills among nurses, with a specific focus on digital leadership for early-career nurses.

The placement will allow participants to make independent and autonomous decisions in a safe, virtual environment and provide the opportunity to learn from role models. Those taking part will receive immediate performance feedback and enhance their digital literacy skills.

One advantage of a VSP over a traditional nursing placement is that everyone will experience the same clinical scenarios, making it equal for all those taking part.

Nursing Now Challenge participants from Children's Health Ireland, Cincinnati Children's Hospital and MILCOT Uganda will be the first to pilot the placement, with the hope of one day offering exchange opportunities to nurses having completed the VSP. It will be created by nurses, with early-career nurses being heavily involved during the development phase.

Prof Lisa Bayliss-Pratt, programme director, Nursing Now Challenge said: "We are delighted to add this VSP to the vast ecosystem of support that we offer to our members. We hope this project will facilitate and improve global partnerships and placement opportunities for early-career nurses and midwives around the world."

Coventry University assistant professor of health simulation Abbie Green, who is leading this project, said: "We are excited to be collaborating with organisations such as Cincinnati Children's Hospital, MILCOT Uganda and Children's Health Ireland to develop this simulated VSP, helping to provide early-career nurses across the world with leadership and digital skills.

"I would like to thank the Burdett Trust for Nursing for providing funding for this project which will offer real benefits to the health professionals of the future," she said.

For further details on any events listed, contact jean.carroll@inmo.ie

April

Saturday 2
PHN Section meeting. 10.30am via Zoom

Wednesday 6
Telephone Triage Section meeting. 11am via Zoom

Wednesday 6
ODN Section meeting. 7pm via Zoom

Thursday 7
ED Section meeting. 11am via Zoom

April 11
Nurse Midwife Education Section meeting. 2.30pm via Zoom

Thursday 21
Retired Section meeting. 11am. Richmond Education and Event Centre. Also available via Zoom

Tuesday 26
Care of the Older Person Section meeting. 12pm via Zoom

Wednesday 27
CPC Section meeting. 11am on Microsoft Teams

Thursday 28
ADON Section meeting. 2pm via Zoom

May

Saturday 14
School Nurses Section meeting. 10.30am via Zoom

Thursday 19
SALO networking group meeting. 12pm via Microsoft Teams

Saturday 28
Special Schools Section meeting. 10am via Zoom

Condolence

❖ It was with great sorrow that we learned that Ann Redmond has passed away. Ann trained as a nurse in Liverpool and worked as a nurse and midwife in Ireland, the US and England in her career. She passionately advocated for patients' rights and held a seat on the INMO National Executive from 1989 to 1991. We published an article about her struggle with progressive supranuclear palsy in *WIN* last year. We extend our deepest sympathies to her daughters Mary, Breda and Trish, her son Sean, and their extended family and friends. May she rest in peace.

INMO Professional Library Opening Hours

April

The library is closed to visitors. Please contact us by phone or email if you require assistance

For further information on the library, please contact

Tel: 01 6640 625/614
Fax: 01 01 661 0466
Email: library@inmo.ie

INMO Membership Fees 2022

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

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Breastmilk is the ideal food for newborns and infants. It gives infants 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. Breastmilk is readily available and affordable, which helps to ensure that infants get adequate nutrition.

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

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

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

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- **Year 2:** Specialty of choice
- Supported Level 9 Module of choice with UCC
- Eight structured paid CPD Days over two years
- Flexible Commencement Day

Join us at our evening Nurse Graduate Programme events on the following dates:

- Tuesday, May 24, 2022 6.30pm-9.30pm at the Viking Hotel, Waterford
- Wednesday, May 25, 2022 6.30pm-9.30pm at Bon Secours Hospital Cork
- Thursday, May 26, 2022 2pm-6pm at Aisling Hotel, Dublin

Have you qualified as a general nurse in the past 3 years?

This TWO YEAR graduate programme has been designed to support the development of newly qualified nurses both academically and professionally. Secure yourself a unique opportunity to excel your nursing career and open opportunities to travel or specialise in any chosen area. We provide an extensive range of medical and surgical specialties including but not limited to:

- Oncology
- Cardiology
- Orthopaedics
- Gastroenterology
- General Surgery

Further enquiries to: **021-4801664** or email **recruitment@bonsecours.ie**

Irish Cancer Society Nurses

The Irish Cancer Society are seeking registered nurses who can provide a minimum of two nights per week and have some palliative experience. Training will be provided.

- Job description on **www.cancer.ie**
- Email CV to **recruitment@irishcancer.ie**
- Informal enquiries to 01-231 0524 or **mferns@irishcancer.ie**

Irish Cancer Society

Irish Nurses Rest Association

A committee of management representing the Guild of Catholic Nurses of Ireland, the INMO, the Association of Irish Nurse Managers and Director of Public Health Nursing exists to administer the funds of the Irish Nurses Rest Association. It's open for applications from nurses in need of convalescence or a holiday for a limited period who are unable to defray expenses they may incur or for the provision of grants to defray other expenses incurred in purchase of a wheelchair/other medical aids.

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

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Dublin North City & County

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CHO Dublin North City and County (CHO DNCC) is responsible for providing care and services to a population of around 621,405 people. Community Health Services are the broad range of health services delivered outside of the acute hospital setting. They are delivered through the HSE and its funded agencies to people in local communities, as close as possible to their homes.

Our services
Primary care; older persons; disabilities; mental health and wellbeing; quality, safety and service improvement

Our current vacancies
We have excellent opportunities for nurses: Staff Nurse, Clinical Nurse Specialists, Clinical Nurse Managers and ADON. If you are interested in providing quality care and developing a career in nursing, we offer a wide range of opportunities with many benefits.

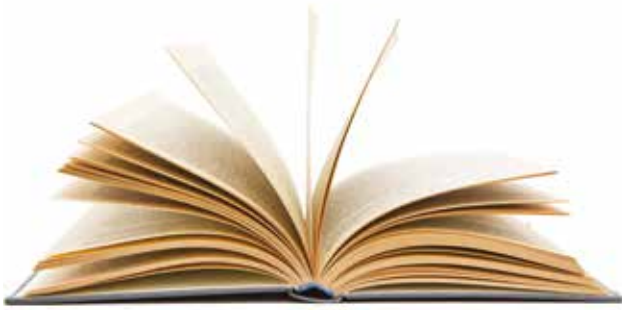
We welcome applications from all qualified individuals who meet the eligibility criteria for these roles. Further information is available in the Job Specification for each position. Search 'Rezoomo CHO DNCC Jobs' or visit **Rezoomo CHO DNCC Jobs** for all our current vacancies.

Read a good book recently? Write a review for *WIN*

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

Submit your review to nursing@medmedia.ie

Word count: 400



Diabetes Ireland

SAVE THE DATE!

Diabetes Ireland Conference & Exhibition (DICE) 2022

Friday, May 6. 8.30am-3.30pm *(fully virtual)*

'Moving on from the pandemic– how to promote patient and professional engagement in diabetes care'

Planned sessions to include prediabetes and diabetes prevention, obesity, and type 2 diabetes: reframing the conversation, Type 1 diabetes, and technology, Chronic kidney disease management and lots more.

Call 01 8428118 or email info@diabetes.ie for more information or to register

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Access the award-winning training at: www.Tork.ie/WorldHandHygieneDay

*World Health Organization, World Hand Hygiene Day 2021 Facts and Figures, https://www.who.int/campaigns/world-hand-hygiene-day/2021/key-facts-and-figures

**Survey among 1017 healthcare professionals in five markets: United States, United Kingdom, Sweden, Germany and Poland. The survey was conducted between 23 November to 7 December 2018 by United Minds on behalf of Tork and in collaboration with the panel provider CINT

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