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WIN

Journal of the Irish Nurses and Midwives Organisation

World of Irish Nursing & Midwifery

Latest INMO CPD education programme
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Meet the nurse with a passion for history
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Updated salary scales
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Person-centred care

First in-person COOP conference post pandemic

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Joyce Hanna and her father celebrating his 100th Birthday.

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"Our father was happy and secure, the whole thing from beginning to end was win win, they just had so much fun together."

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On the cover
Pictured (l-r): Michael O'Dwyer, enhanced nurse, Residential Older Persons Services; Grace Oduwole, assistant director of nursing, older persons services; Caroline Gourley, INMO second-vice president and director of nursing, older persons services; and George Jefferies, clinical nurse specialist, gerontology and frailty

NEWS & VIEWS

FEATURES

CLINICAL

LIVING

JOBS & TRAINING

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

In person event

104th ANNUAL DELEGATE CONFERENCE

3 - 5 May 2023

The Gleneagle Hotel,
Killarney,
Co Kerry

Safe Staffing

Making it happen

DELEGATES, WATCH OUT FOR YOUR ADC PACKS ARRIVING IN APRIL

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Affordable housing is a human right

WHO would have thought that evictions would be the topic causing such emotional debate in 2023, when you reflect on our history as a country and the depictions in history books of evictions in famine times? Today, only 27% of people aged between 25 and 34 own their own homes. Rent takes an increasingly large proportion of salary and in the case of many nurses and midwives, it can account for up to 77% of earnings.

In the *Irish Times* on March 18, Sally Rooney gave an apt description of this shift away from affordable home ownership to ever-increasing dependency on high rental properties: "Even aside from the financial toll of renting, consider the psychological hardship of trying to make a life for yourself and your family in what is ultimately someone else's spare house. Your home – your place in the world, your refuge, the state for all private dramas of your intimate life – can be taken away from you at any time, through no fault of your own, for the financial benefit of someone wealthier than you. This is obviously not the life most of us would choose for ourselves."

The cost of renting is an issue raised with the INMO daily, particularly by those who are coming to work here for the first time. Affordable accommodation in close proximity to healthcare settings should not be a pipe dream. We are calling for immediate provisions to be made to enable nurses and midwives to live within a reasonable distance of their place of work. Provision of housing assistance, subsidisation and zoned areas in any planning for hospital builds such as the new National Children's Hospital or the proposed new elective hospital in Cork City, should be a pre-requisite for such sites. Government should not be contemplating opening more beds without a plan to house those who will staff them

Nursing and midwifery managers advise that all cities and big towns are affected. The current recruiting model is not adequate; it is costly, time-consuming and is undermined when essential grades are not retained due to the lack of affordable accommodation.

The INMO met with Minister for Housing Darragh O'Brien last month and raised these issues directly. You can read more about this on *page 16*. Our message was clear, nurses and midwives earn modest incomes and if we want to ensure safe staffing levels and expand the number of beds and services in large urban areas, we must ensure that there are homes that nurses and midwives can afford to live in.

The INMO is a member of the 'Raise the Roof' coalition, which is a broad civil society network led by ICTU. The group recently wrote to all TDs and senators setting out our objection to the decision to lift the ban on evictions that has been in place since October 2022 – without first putting in place the measures needed to prevent people from being forced into homelessness. The letter expressed the view of the group that this decision was: "...both profoundly wrong and wholly indefensible. This deeply troubling decision has now placed thousands of households in immediate danger of being forced into homelessness, as of April 1... It is now clear that thousands of single people, young couples, families with children, extended families and older people will now be made homeless as a result of this morally untenable decision. Raise the Roof is therefore calling for the urgent and immediate restoration of the moratorium on evictions and a guarantee that it will be kept in place until the government has introduced the suite of measures and safeguards required to ensure that no family or individual will be forced into homelessness when a tenancy is ended."

I ask members to read our full submission and to support the Raise the Roof events in the coming weeks. These will be advertised on the INMO website and social media channels. Please be part of the effort to ensure housing is affordable and available to all, as a human right.

Phil Ní Sheaghdha
General Secretary, INMO

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

Nurse and Midwife Representative Training 2023

The aim of this training course is to provide members in the workplace with the knowledge, skills and confidence to represent and support members in the workplace. The representative also acts as a liaison between the INMO members, INMO officials and INMO head office.

The course takes place over two days and there are agreements within the public health service for paid released time off to attend INMO rep training courses.

The INMO also provides an Advanced Representative Training Course. This training is at advanced level, the requirement for attending the advanced representative training is to have completed the basic representative training and have been an active INMO representative in the workplace for at least one year.

If you are interested in attending a representative training course in 2023, please make contact with your INMO official and they will issue you with an "Expression of Interest Form" to complete and return.

2023 DATES*		
24 & 25	**MAY**	WATERFORD
13 & 14	**JUNE**	DUBLIN
20 & 21	**JUNE**	MIDLANDS/CAVAN
27 & 28	**JUNE**	LIMERICK
20 & 21	**SEPTEMBER**	DUBLIN
27 & 28	**SEPTEMBER**	SLIGO
03 & 04	**OCTOBER**	CORK
12 & 13	**OCTOBER**	DUBLIN

**Please note that the dates and locations are subject to change*

CONTACT YOUR INMO OFFICIAL

Dublin: 01 6640600, Cork: 021 4703000, Galway: 091 581818 and Limerick: 061 308999

A positive focus with the president

Karen McGowan, INMO president

Section conferences

THE strength of the section conferences is clear to be seen with a full house evident at the recent care of the older person conference. I wish to thank the Care of the Older Person Section for their hard work organising a wonderful day of speakers. The engagement and interest was fantastic. I now look forward to the upcoming RNID Section conference and the first ANP/CNS Section meeting both being held in the Richmond Education and Event Centre. This month I will be speaking at the Menopause Summit on the findings of the INMO survey on menopause in the workplace. It is really important that we use this platform and build on it as we are a predominantly female profession and our female members will all go through menopause.

Breastfeeding support through challenge

THIS month the focus is on breastfeeding. While working in a general hospital we often come in contact with women who have recently given birth and are breastfeeding. Breastfeeding is so important for the bond between mother and baby so I felt it was important to contact one of our specialists in this area.

I spoke with Lisa Carroll who is a mother of five with more than 25 years' experience in breastfeeding education. A clinical midwife specialist in lactation, Ms Carroll has an integrated hospital/community-based role, with responsibility for several areas, including supporting women attending the community midwifery team. Her role also involves offering support to women in both the antenatal and postnatal periods via the new breastfeeding wrap-around clinic which operates from the Rotunda Hospital. The clinic is a one-to-one service that supports women who may be high risk for breastfeeding difficulties, through harvesting colostrum and creating a plan of care that suits their needs. As part of this service, women are seen at approximately 37 weeks gestation, again on the ward after delivery and then also in the postnatal period if indicated.

Ms Carroll also provides a service to the Mater and Beaumont Hospitals through staff education in lactation with the Rotunda Outreach Lactation Service. This service established a cross-site collaborative initiative between the multidisciplinary teams in the Rotunda Hospital and Mater Hospital.

"We support women with complex medical conditions to offer their infants breastmilk as soon as possible after birth. The infants of these women are often compromised and delivered preterm, resulting in extended, intensive care. This increases their need for immunotherapy through early administration of colostrum and their mother's own breastmilk," explained Ms Carroll.

This sometimes involves enlisting the help of Blood Bikers East who offer a voluntary service delivering colostrum/maternal expressed breastmilk to infants in the Rotunda's NICU. The breast milk for these vulnerable infants is important in improving their outcomes, including in preventing sepsis and secondary infections such as NEC. It gives babies a head start at a time when their mothers are managing illness in another hospital.

As a nurse who works in a general hospital, having this service to call on is invaluable and we have called on Ms Carroll's expertise to see a number of mothers in the past year. I want to thank her for her guidance on best practice in setting up supports for women who are unwell in the general hospital and how we can best support them on their breastfeeding journey.

"It is a pleasure going to work everyday. I work with a wonderful team of colleagues – Marina, Ger and Sinead. It is also an honour to work with mothers and their babies," she told *WIN*.

Executive Council update

THE Executive Council met this month and discussed a number of national issues. There were full reports from the various committees. We were also updated on all meetings that have been attended by management in the past month.

The INMO's annual delegate conference (ADC) plans are going well and we look forward to meeting with many of you in Killarney in May. My sincere thanks to members of the Killarney Branch for all the work they are doing to ensure we have a successful ADC. I also want to thank the standing orders committee members as they face into a busy time reviewing the motions submitted for debate.

The INMO Annual Report and ADC packs have gone to print so they will be distributed soon.

The coming months have a number of important events, including the International Council of Nurses congress, which will be held Montreal in July. The Irish Congress of Trade Unions biennial delegate conference in Kilkenny also takes place in July.

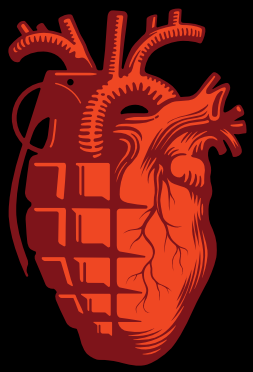
The Executive Council also approved a new data collection system called Sensemaker. This allows members to tell their stories form the last shift they worked or an incident that occurred while on duty. The software will enable us to extract the themes and trends from your working lives. This has been used by our colleagues in the Royal College of Nursing in the UK. This platform will be launched in the west, midwest and northwest regions initially. This is anonymous process and it is very easy to use. It offers nurses and midwives a fantastic opportunity to tell their story so that it can be collected as data. The INMO aims to use this information to influence decision makers so I would urge you to take part.

Get in touch

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

ATTR-CM
SUSPECT & DETECT
UNCOVER THE CLUES FOR DIAGNOSIS

SUSPECT ATTR-CM
(TRANSTHYRETIN AMYLOID CARDIOMYOPATHY)



A LIFE-THREATENING DISEASE THAT CAN GO UNDETECTED

Life-threatening, underrecognized, and underdiagnosed, ATTR-CM is a rare condition found in mostly older patients in which misfolded transthyretin proteins deposit in the heart.[1-7] It is vital to recognize the diagnostic clues so you can identify this disease.

CONSIDER THE FOLLOWING CLINICAL CLUES, ESPECIALLY IN COMBINATION, TO RAISE SUSPICION FOR ATTR-CM AND THE NEED FOR FURTHER TESTING

HFpEF — heart failure with preserved ejection fraction in patients typically over 60 years old[5-7]

INTOLERANCE — to standard heart failure therapies (ACEi, ARBs, and beta blockers)[8-10]

DISCORDANCE — between QRS voltage and left ventricular (LV) wall thickness[11-13]

DIAGNOSIS — of carpal tunnel syndrome or lumbar spinal stenosis[3,8,14-20]

ECHO — showing increased LV wall thickness[6,13,16,21,22]

NERVOUS SYSTEM — —autonomic nervous system dysfunction-including gastrointestinal complaints or unexplained weight loss[6,16,23,24]

LEARN HOW TO RECOGNIZE THE CLUES OF ATTR-CM AT:
SUSPECTANDDETECT.IE

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Date of Preparation: February 2021 GCMA code: PP-RDP-IRL-0105

Pfizer Rare Disease

Overcrowding pressure not abating

ONCE again the INMO had to call on the HSE to ensure that hospitals cancelled non-urgent elective surgeries last month as trolley numbers rose to unsafe levels, stating that the level of overcrowding in some of emergency departments warranted a national response.

More than 631 patients were on trolleys in Irish hospitals following the St Patrick's day weekend – an easily predicted situation,a bout which the INMO had issued a warning about the previous week when trolley figures were already high.

Commenting on the figures, INMO general secretary Phil Ní Sheaghdha said: "As predicted, it has been an incredibly busy weekend across all hospital sites. Over 631 admitted patients are now without beds.

"It is unacceptable that 140 patients are on trolleys in inappropriate bed spaces on hospital wards. The HSE must direct hospitals to cancel electives and concentrate on the de-escalation of trolleys from understaffed and overburdened wards.

"It is obvious that in times of severe overcrowding such as a holiday weekend and going into the week ahead, that our public hospital system cannot provide both safe emergency and elective care. The provision of safe care must be the priority."

Ahead of the weekend the INMO contacted the new chief executive officer of the HSE seeking an urgent meeting ahead of what it warned would be an extremely busy weekend for INMO members.

"It is clear that the system is now completely overwhelmed. We need targeted measures to tackle this crisis, particularly along the western seaboard and in the midwest region where the overcrowding is completely out of hand. The number of children who are on trolleys is particularly concerning. We are seeing regular patterns of high instances of children on trolleys. This needs to be tackled. "The HSE and Department of Health need to outline what exact measures they will be taking in order to minimise this level of overcrowding," said Ms Ní Sheaghdha.

In the month of February, over 10,000 patients were admitted without a bed, including 426 children under the age of 16. Once again University Hospital Limerick was the most overcrowded hospital in the country with 1,561 admitted patients on trolleys.

Ms Ní Sheaghdha said: "We have seen serious spikes of overcrowding in and across all Dublin hospitals throughout the month of February. It is clear that medium and long-term plans are needed to resolve the overcrowding issues in these hospitals.

"Nurses are working in extremely unsafe conditions. Their workplaces are not just overcrowded, they are also short staffed. When wards are not staffed correctly, it has a profound impact on the level of care our members are able to provide to patients.

"The HSE and the Minister for Health must give an update on whether the measures they introduced in January to relieve pressure on our health service have had a real impact and what they are going to do to prevent further spikes."

New online tool allows members to share their workplace experiences with the INMO

NURSES and midwives employed in the west, midwest and northwest regions will soon be able to use a new tool to anonymously share their work stories with the INMO and provide much-needed insight into their daily lives.

The tool, called Sensemaker, has been developed by research specialists Cynefin, and successfully used by our colleagues in the Royal College of Nursing.

The tool provides a platform for nurses and midwives to share their experiences and generates a rich set of data that reflects the lived experience of our members, the prevalence and root of the challenges they face, and how these challenges affect them professionally, psychologically and emotionally.

The surveys are completely anonymous and take approximately 15 minutes to complete, with respondents filling in three sections. Firstly, a brief story section in which nurses and midwives are prompted to share a specific experience from their day or their week that they feel is meaningful and reflective of some element of their working life. This can be just a few short lines describing something that happened in their work.

Respondents are then asked to evaluate their experiences on a number of scales that help us to understand what the story means to them and how it fits into a broader context.

Finally, users will be asked to provide some brief demographic details and information about the type of nursing or midwifery they work in. The tool is simple and easy to use and can even be accessed on mobile devices to allow nurses and midwives to relate their experiences at a time convenient to them.

The INMO is excited to be rolling out this tool to members in these regions of the country and to learn more about on-the-ground experiences that make nursing and midwifery in Ireland uniquely challenging and rewarding. Rolling this out to these regional groups will provide a snapshot of issues affecting the region specifically prior to a national rollout.

With a high uptake, the INMO hopes that the tool will allow it to combine storytelling with statistics to create a birds-eye view of high-level patterns in members' working lives.

In particular, we hope that the Sensemaker stories will build on our understanding of the roots of burnout and psychological stress in nursing and midwifery. This will help us to support members in their workplaces and present their experiences to decision-makers effecting changes at a national level.

It is expected that the findings of the Sensemaker surveys will help to focus the INMO's work on the areas that matter most to members and will inform the advocacy and campaigning work that the union undertakes on behalf of nurses and midwives.

The first survey was launched in March and we hope that members in these regions will take the opportunity to share their experiences so that we can build on our understanding of the issues that affect their daily working lives.

–Tony Fitzpatrick, INMO director of professional development

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

Several workplaces on cusp of action

WORKPLACE ballots for industrial action were being discussed in several locations last month, following the INMO Executive Council's decision to pre-authorise industrial action in support of the union's campaign to deal with overcrowding in acute hospitals.

Union officials have engaged with members in several locations in relation to this and action is being planned in several workplaces, including:

- Members in the ICU at University Hospital Limerick are balloting in relation to the activity level and the number of beds that are open, with a meeting of the general membership being held in the hospital and industrial action options being considered at the time of going to press.
- A consultation is being held with staff in Cork University Hospital CCU with a ballot being considered in relation to short staffing
- At Connolly University Hospital, the INMO has threatened management with a ballot for industrial action following ongoing issues relating to the inappropriate placing of patients in the endoscopy day ward. However, there has been engagement between the hospital and the INMO on this matter, and progress is being made in relation to curtailing this issue.
- The INMO has also engaged with management in the Coombe Women's and Infants University Hospital in relation to staffing shortages and, as a result the union has secured enhanced overtime rates for staff and paid meal breaks at night, as well as the deferral of the opening of a new unit until adequate staffing can be provided.

The Executive Council sanctioned ballots for industrial action on a location-by-location basis in February in pursuance of safe staffing.

Decision Support Services update

THE abolition of wardship, the operationalisation of the Decision Support Service and the introduction of a new system of tiered decision-making supports will come into effect on April 26, 2023, according to the government. This follows the enactment of the Assisted Decision-Making (Capacity) (Amendment) Act 2022 in December 2022.

While the government announced the April date in February, as there are still outstanding issues regarding the implementation of these changes, the INMO has written to the employers to request an urgent meeting to resolve and agree these outstanding items.

The INMO will update members on progress on this issue.

Extension of long Covid scheme subject to WRC talks

THE INMO expressed its concern to the Workplace Relations Commission that the temporary scheme dealing with long Covid is due to end at the end of June, so intensive engagement is urgently required to seek a solution.

A lack of mandate from the Department of Health prevented the HSE from engaging on the issue at the WRC on March 9, 2023 regarding the claim for long Covid.

The WRC has advised the INMO and other unions that it intends to issue a date shortly at which it expects all parties concerned to attend conciliation.

Covid recognition payment

Meanwhile, in relation to outstanding Covid-related issues and the National Joint Council (NJC), the unions are writing to the Minister for Health to repeat the request for a direct meeting with him on outstanding issues regarding the pandemic special recognition payment.

Members will be kept informed of this process.

Unions plan action in Section 39s' pay claim

THE INMO, Fórsa and SIPTU met last month to discuss next steps in the long-running claim for pay restoration in the voluntary and community sector (Section 39 organisations).

The HSE had indicated that it was prepared to attend the WRC on this issue but that it had not been given a mandate by the Department of Health to engage on this matter.

In view of this, the unions agreed it is now necessary to serve a claim in respect of Section 39 organisations seeking the application of the terms of Building Momentum and the link with public sector pay.

The unions are identifying locations for industrial action and expect that this will result in a referral to the WRC for resolution of the issue.

Salary grading of PHNs and directors of nursing

THE INMO sought that the Health Service Oversight Body (HSOB) agenda for March 13 include the application of recommendations 42, 43 and 44 of the Expert Review Body. These recommendations deal with grading and salaries for PHNs and directors of nursing.

Specifically, the INMO and other unions are seeking that these be dealt with within Building Momentum rather than in the next round of pay talks. At the meeting of the HSOB it was agreed that these important issues will be further discussed at the Public Service Agreement Group (PSAG) meeting in the coming weeks

The INMO also raised the claim for the buy-back of superannuation for non-sponsored PHN students. Following the Labour Court outcome, and having secured agreement that the procedures under the national agreement would be utilised given the outcome at the Labour Court, the INMO was successful at the HSOB meeting in obtaining agreement from the employer for further direct engagement on this important claim.

on recent national issues

INMO sets out key issues at WRC ED Review

THE Emergency Department Review, which was agreed under the auspices of the INMO/HSE ED Agreement at the Workplace Relations Commission, has commenced.

Independent chair Sean McHugh was appointed to oversee the process and an initial plenary session took place on March 8, 2023 to set out the steps to be taken under the review.

The INMO put forward several key matters that it had identified for consideration, including:

- A claim for health and safety leave for ED and ward-based staff
- A review of the bursary of €1,500 for ED staff
- ED security reviews
- Matters in relation to hospital escalation and de-escalation policies.

Regarding staffing issues it was agreed that management would establish the number of vacancies, the current recruitment plans and the implementation status of the Safe Nurse Staffing and Skill Mix Framework in the 29 EDs throughout the country.

The INMO also restated its opposition to trolleys being place on hospital wards and requested that the management side put forward proposals to deal with de-escalation.

A further meeting of the ED Review Group was scheduled for March 27, 2023.

Look-back on ED winter surge

THE office of the HSE Chief Operations Officer has requested a look back of the ED winter surge on an ad-hoc basis under the Joint Information and Consultation Forum (JIFC) framework.

The INMO and other unions have objected to this engagement and requested that engagement on the ED winter surge issue should be done under the auspices of the National Joint Council, rather than the JIFC.

Update on health and safety issues

THE INMO Health and Safety Group met on March 9, 2023 and discussed a range of matters, including INMO involvement in Workers' Memorial Day on March 28.

This day is held annually to commemorate all those workers who lost their lives during the course of their work in 2022, and the INMO was asked to put forward a frontline healthcare worker to speak at this event.

Health and safety rep training

The group also discussed health and safety rep training for which two online courses have been arranged on April 19 and 20, 2023.

The INMO has secured agreement from the acting CEO of the HSE that an inspector will address the training sessions to include the role of inspections and the importance of health and safety reps in the workplace.

Secondment issues

The Health and Safety Group also discussed a meeting that took place between the HSE and the INMO regarding the health and safety rep, as part of the agreement for secondment.

It was noted that a joint INMO/HSE stand will be set up at the INMO annual delegate conference in May, to be used to promote the Health and Wellbeing Unit and the role of health and safety reps.

Limerick ICU members ballot to take action to obtain safe staffing

THE INMO was preparing to commence a ballot of intensive care unit nurses working in University Hospital Limerick in pursuance of safe staffing, as we went to press.

This decision was taken following a meeting held in early March at UHL in relation to unrelenting overcrowding, constant redeployment, unsafe staffing levels, excessive nursing workloads, governance, safety, health and wellbeing of staff and the retention of nurses at UHL.

INMO assistant director of relations Mary Fogarty said: "After exhausting negotiations at local level, the INMO has been mandated by members to commence a ballot for industrial action in the ICU in University Hospital Limerick.

"The issues that exist in University Hospital Limerick have been well documented by this union. With up to 21% of the nursing positions vacant, the lack of consistent safe staffing in the ICU is having a detrimental impact on the physical and mental wellbeing of our members working in this unit and on their patients.

"Hospital management has failed to provide an appropriate contingency plan to address the nurse deficits in the ICU and to enable outstanding annual leave and time off in lieu to be taken and/or paid to nurses as requested.

INMO assistant director of relations Mary Fogarty said: *"The lack of consistent safe staffing in the ICU is having a detrimental impact on the physical and mental wellbeing of our members"*

Following the ballot of ICU members, the INMO will notify hospital management of the outcome and the plan of action.

Meanwhile, other areas within the hospital – including the paediatric unit, haemodialysis unit and inpatient wards – are also considering ballots for industrial action if sufficient progress on governance, safe nurse to patient ratios and health, safety and wellbeing of nursing staff are not adequately addressed.

INMO dealing with Covid issues case-by-case

ISSUES regarding payments related to Covid-19 are still arising in several workplaces around the country and are being dealt with on a case-by-case basis by INMO officials.

For example, two recent cases that arose in the midlands area have been dealt with by the INMO – one involved premium pay while on certified Covid-19 leave and the other involved difficulties with obtaining the pandemic special recognition payment.

Special leave with pay (SLWP)

The INMO is assisting members working in Midland Regional Hospital, Portlaoise to have the calculation of special leave with pay (SLWP) for Covid-19 to reflect their average premium payments.

Our members were incorrectly informed they did not satisfy the required conditions for inclusion of premium payment, as they had availed of parental leave the week prior to going on SLWP.

The fact they took a parental leave day in the week prior to availing of SLWP does not preclude them from premium payments. The INMO has requested an examination of their pay for this period, and all monies owed paid without any further delay.

Pandemic special recognition payment

The INMO contacted management of Midland Regional Hospital, Tullamore on behalf of a student nurse member who had not received the pandemic special recognition payment. This member had trained in one hospital and transferred to Tullamore Hospital upon graduation.

Despite numerous attempts to progress the issue, she had not received the pandemic bonus. Following engagement with management, the INMO was successful in securing the payment of the pandemic bonus to this member.

– Gráinne Walsh, IRE

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

All members advised to examine payslips closely

THE INMO provided representation to a member working in a care of the older person setting, who was on the incorrect point of the HSE consolidated salary scale for a number of years.

Our member attempted to resolve this matter locally, however the issue remained outstanding.

Following intervention by the INMO, the claim was conceded and the member was subsequently placed on the correct point of the scale and received €40,000 retrospective payment.

The INMO advises all members to check their payslips to ensure they are on the correct point of the HSE salary scale and that there are no errors.

– Moire Lafferty, IRE

Wexford members' rights protected following fire

FOLLOWING a substantial fire at Wexford General Hospital on March 1, 2023, which necessitated evacuation of the entire hospital, the INMO is engaging with management in Wexford General Hospital, with management of the Ireland East Hospital Group and with the HSE at national level to ensure the terms and conditions of employment of all INMO members are maintained while services are being resumed in the hospital.

Further to these ongoing discussions, the following has been agreed by the INMO with management of Wexford General Hospital and with the Ireland East Hospital Group:

Any redeployment of INMO members to other services is agreed as being on a voluntary basis only and no INMO member "will be forced to do anything or go anywhere that they don't want to".

Some INMO members have voluntarily redeployed to work in University Hospital Waterford or in St Luke's Hospital, Kilkenny. It is expected that these INMO members will be returned to work in Wexford General Hospital as soon as possible.

Management has confirmed that 83 patients initially relocated to other hospitals after the fire have either been repatriated to Wexford General Hospital or discharged from the service where appropriate to do so.

University Hospital Waterford continues to receive Wexford's 'new' patients into its emergency department until it can be restored to full service. Of the patients initially relocated post-fire from Wexford General Hospital, four remained in Dublin hospitals and four in St Luke's Hospital, Kilkenny, at the time of going to print.

All INMO members who voluntarily redeploy to work in other services until Wexford Hospital is fully operational again will receive the benefit of paid travel to and from the location to which they are redeployed, and will also receive subsistence payments in line with current INMO/HSE arrangements if they travel to the new location by car where public transport is not easily available to the new work location, or where alternative transport arrangements are not provided to members by the hospital.

Travel expenses will be paid to INMO members who redeploy to another service using a private car for transport, once a travel claim is made by the member concerned to management in Wexford General Hospital.

A subsistence payment will also be made to those INMO members who voluntarily redeploy to other services. This payment provides an amount of money for each member to use to buy food for themselves when redeployed. A different rate of subsistence is paid depending on the length of time a person is away from their 'base' of Wexford General Hospital on redeployment to the new work location. This is conditional on the member being unable to access meals in the new HSE work location at a subsidised rate.

Management in Wexford General Hospital has also indicated that transfer to the new work location on redeployment will be facilitated by the hospital providing private bus transfers or private taxis being made available by the hospital for those INMO members who do not wish to use their own car to travel to the new work location.

Hospital management has also advised that INMO members who agree to redeploy to other HSE services will have accommodation provided for them in a hotel close to the site of the HSE service to which they are redeployed. This is particularly relevant for members who agree to redeploy to other services and are rostered to do a number of shifts in a row. Should you be in this position, contact hospital management who will arrange this accommodation for you in a local hotel close to the service to which you have been redeployed.

The INMO has agreed with management of Wexford General Hospital and the Ireland East Hospital Group that INMO members will not be required to use their annual leave for the purposes of maintaining their basic salary and allowances (if applicable) arising only from the hospital currently functioning at less then full capacity. INMO members can, however, choose to take their annual leave or accrued leave balances should it suit them to do so but it is agreed with the INMO there is no obligation on any INMO member to do so.

Where INMO members have agreed to redeploy to work in another service, it is also agreed that they will be paid for their full contracted hours in this other service, even when that service cannot provide work for the member for all of their contracted hours of work.

Further meetings are due to take place after which members will be updated by email.

– Liz Curran, INMO IRO, South Eastern Region

World news

Nurses and midwives in action around the world

Australia
- Striking nurses offered bonus in the wake of workforce crisis
- 'Thank you' cash bonus reduced by tax as nurses work overtime during Covid-19

Canada
- 'It's going to bankrupt healthcare': Spending on temp agency nurses up more than 550% since pre-pandemic at one Toronto hospital network
- Half of Ontario nurses are considering quitting the profession for good: study

Italy
- Escalation of attacks and threats to healthcare professionals

Kenya
- Nurses demand permanent jobs as contracts expire

Portugal
- Lack of nurses is due to poor working conditions, says union

South Africa
- Specialist doctors and nurses to be imported

Spain
- Union decries just 7% increase in new university nursing places

UK
- Nurse who does six 13-hour shifts in a row says 'we are undervalued' as strike looms
- Royal College of Nursing urges members to back strike action in 'defining moment' for battle over NHS pay

US
- Threats against healthcare workers are rising – how hospitals are protecting their staff

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

Call for equity in digital education to enable nurses to harness innovations

EMPOWERING nurses through innovations in digital health would advance gender equity and improve patient care, according to the president of the International Council of Nurses (ICN), who was speaking at an International Women's Day (IWD23) event last month.

The theme of IWD23, *'DigitALL: Innovation and technology for gender equality'*, was amplified by the 67th Session of the Commission on the Status of Women (CSW-67), "Innovation and technological change, and education in the digital age for achieving gender equality and the empowerment of all women".

ICN president Dr Pamela Cipriano called for greater efforts to be made to bring about gender equality in relation to the use of digital technology in healthcare.

The ICN held a 'Digital Transformation of the Nursing Workforce' event at CSW-67 in New York on March 10. The ICN president spoke about recent advances in digital health, including delivery of virtual care, the analysis of big data, the introduction of smart wearables and the dramatic developments in artificial intelligence, which reinforce the need for nurses to be digital health experts so that they can maximise the advantages of these technologies for the benefit of their patients.

Dr Cipriano said empowering nurses through digital healthcare would advance gender equity and improve patient care. However, these benefits will only come about if sufficient attention is paid to nurses' needs in an increasingly technological world.

She also encouraged nurses to participate in the International Women's Day campaign theme – #EmbraceEquity. Its aim is to get the world talking about equity, as true inclusion and belonging require equitable action, not just equal opportunities.

In wide ranging contributions Dr Cipriano discussed how IWD23 and #EmbraceEquity celebrate the immense contribution of women to every walk of life including family and work, with nursing as a profession where 90% of workers are women.

As a predominantly female profession, nurses are acutely aware that gender inequality in healthcare is a major issue. It results in the under-representation of nurses in influential leadership positions, relatively poor pay, and a lack of respect and value of their work.

Nurses are working tirelessly for the people they serve: their expertise and dedication increase people's wellbeing and their actions save people's lives every day.

The ICN called for major efforts by governments and societies to address these and other gender equity issues so that patients can benefit from the work of nurses within a more equitable culture.

The INMO is Ireland's national nursing association in the ICN

Nurses of Ukraine send thanks for aid and support

ON THE anniversary of the invasion of Ukraine and the bitter year that has followed, the ICN has renewed its call for a ceasefire and negotiations for a lasting peace.

ICN president Pamela Cipriano said: "Nurses around the world are a force for peace and they continue to stand in solidarity, condemning this horrific aggression and the attacks on innocent people. Nurses are also a symbol of peace, and we know that health and peace go hand in hand."

The ICN is supporting those affected by the conflict through its #NursesforPeace campaign and the Humanitarian Fund.

Generous donations by ICN national nursing associations, of which the INMO is one, have enabled the ICN to get aid into the hands of the nurses in Ukraine and surrounding countries.

President of the Nursing Association of Ukraine Tetyana Chernyshenko sent a message to ICN saying: "The Association of Nurses of Ukraine sincerely thanks the ICN and all the nurses of the world for their immense help and support for Ukrainian nurses. It is extremely important for each of us to feel that our colleagues are ready to help.

"A terrible and brutal war is going on in Ukraine, as a result of the full-scale invasion by Russian troops on the territory of our country. Many women were forced to leave for other countries in Europe, to Canada, and the US to save their children, and many women joined the thousands of men who joined the ranks of our armed forces.

"Alongside the military front, the People's Medical Front was set up for our doctors, nurses, paramedics and health instructors."

The ICN heard of the thousands of civilians who have been killed in territories that have since been liberated, and how the work of nurses, doctors and paramedics holds a special place in the hearts of the Ukrainian people.

Nurses there are constantly providing medical care at the front, in hospitals and everywhere it is needed. Many Ukrainian nurses now live in the hospitals where they work, and many of the medics, after being wounded and treated, are urgently returning to the front.

The Nursing Association of Ukraine thanked all peoples and countries for the great support and help they provide.

The association also acknowledged the help of the International Council of Nurses to Ukrainian nurses which was described as a special page in today's history where it is difficult to overestimate its importance.

Ukrainian nurses were described as feeling the support and the associated knowledge that they are not alone in their struggle.

and midwifery news

Serious fall-out for maternal and child health from Turkey/Syria earthquakes

THE International Confederation of Midwives (ICM) recently considered the desperate humanitarian circumstances following the devastating earthquakes which struck Turkey and Syria.

The two earthquakes measuring magnitude 7.6 and 7.7 resulted in the death of over 50,000 people and displaced millions. As a result of this disaster, maternal, newborn and child health (MNCH) in the region is in crisis.

According to the United Nations Population Fund (UNFPA), 38,000 of the 350,000 pregnant women who survived the earthquakes were due to give birth in the month of March and are in urgent need of healthcare.

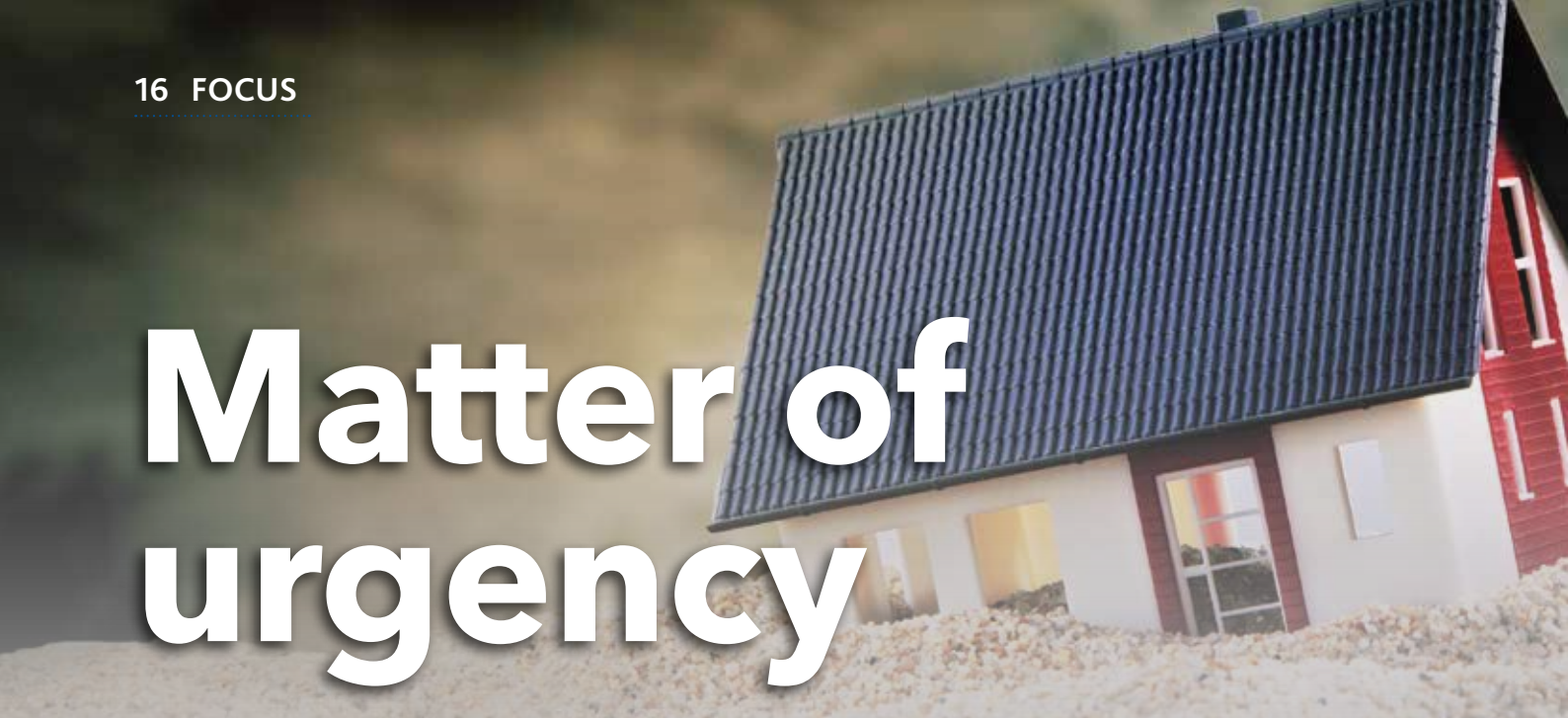
Pregnant women who have lost relatives, friends and homes in the earthquakes are being forced to put their health at risk as they take refuge in camps, with limited access to food and clean water. Women are struggling to access sexual and reproductive healthcare as thousands of buildings, including hospitals, have been destroyed. Newborn infants have been pulled from the debris, with no promise of being reunited with their mothers or family members.

Preparation for a disaster/emergency is difficult due to the unexpectedness and unpredictability of its severity. Saving lives and preventing and reducing suffering after an emergency is an enormous task, which requires preparation and competence. Responses to disasters/emergencies often start at community level, and it is only after the initial emergency phase that emergency agencies and other relevant groups are able to arrive on site.

According to the ICM, as midwives form a considerable proportion of the health workforce and often work closest to the affected community, their contribution to disaster/emergency risk reduction, preparedness and response is vital. However, midwives are often not included in emergency preparedness and response planning at local, national and international level.

The ICM is helping national member associations in Turkey to organise and obtain funding to provide essential reproductive health services in the coming weeks and months.

The INMO is Ireland's national midwifery association in the ICM



Matter of urgency

Soaring living costs are yet another barrier facing nurses and midwives. **Phil Ní Sheaghdha** calls on the government to deliver a sustainable housing model to alleviate the crisis

THE 2020 World Health Organization (WHO) *State of the World's Nursing Report* revealed a global shortage of nearly six million nurses worldwide. The International Council of Nurses (ICN) estimates that this shortage is closer to 10 million, given the number of nurses due to retire by 2030. The 2021 *State of the World's Midwifery Report* from the WHO estimated a shortage of 600,000 midwives.

Ireland is not immune to this global shortage. Currently, we are experiencing a critical shortage of nurses and midwives, which is detrimental to health service provision across the country. Over the past number of years, this shortage has been exacerbated by years of underfunding, moratoriums on recruitment and cost-saving measures imposed to reduce the workforce.

As consistently outlined by the INMO, this shortage has, over many years, been worsened by a lack of a multi-annual funded workforce plan. The workforce plan is needed urgently, and it must seek to address the increasingly difficult recruitment and retention issues across the health service by embedding robust, sustainable, long-term strategies in the workforce strategy.

To retain and attract new entrants into the professions, it is essential that we consider how the current environment can affect retention and recruitment and the intention to leave. Recruitment and retention strategies must now address the immense challenges that nurses and midwives face in dealing with the cost-of-living crisis and specifically the issue of housing, or lack thereof.

Housing crisis

The salaries of nurses and midwives are not keeping pace with the rising rent costs. For instance, if a newly qualified nurse or midwife living in Dublin or Cork is paying up to €1,800 on rent, that means more than 77% of their monthly take-home pay is going towards rent. This is not sustainable in the long term.

We regularly hear from INMO members who are struggling to pay rent or buy a property. Rents are at an all-time high and, even with controls in place, many are struggling to find suitable accommodation. Many cannot find appropriate accommodation and instead commute great distances to work daily.

Although the issue has been a significant challenge in major urban areas, the challenges are also affecting all towns and cities in the country.

A recent report from the Economic and Social Research Institute (ESRI) noted a drop in home ownership in the 35-44 age group.[3] Lower home-ownership rates mean a higher proportion of households in the rental sector and the continuation of rental payments into retirement. While 65% of this age group are likely to become homeowners by retirement, this contrasts with current home-ownership levels for over 65s, which currently stands at 90%.

Despite increases in the supply of housing to the market in recent years, it is still falling short of demand and housing prices continue to rise. The salary required for a single buyer of a property in Dublin is far beyond the salary of a staff nurse and midwife. Even as a couple, the salary necessary is at the upper end of the staff nurse/midwife salary scale. This makes the purchase of a home impossible for many nurses and midwives.

This situation is having a negative effect on the retention of nurses and midwives. The director of midwifery at the National Maternity Hospital recently described how difficult it is to recruit and retain midwives and other nursing staff in the hospital. Other directors of nursing and midwifery around the country have also stated how the lack of affordable housing directly affects their ability to retain and recruit staff to their hospitals.

The current recruitment model is not sufficient and is both costly and time consuming. It is undermined by the inability to retain the same essential grades due to a lack of available accommodation and the extraordinarily high cost of accommodation.

Recruitment and retention

The INMO has repeatedly emphasised the need for the government to embrace the importance of becoming self-reliant, ensuring an adequate number of nurses and midwives are available to the health service. The domestic production of nurses and midwives must be optimised to meet or surpass health population demand.[2]

Ensuring an adequate supply of nurses

and midwives is essential against the background of the global staffing shortage of nurses and midwives, and is an internationally recognised ethical imperative. However, the cost-of-living and housing crises are having an impact on new entrants into the professions. New graduates must not be forced to emigrate because of poor access to housing as well as other cost-of-living challenges.

The housing crisis also affects those nurses and midwives from abroad who are working in Ireland. For those who choose Ireland as a destination in which to work, we must have due regard for the needs of international recruits in the immediate phase following their arrival and in the longer term. Many overseas nurses and midwives advise the INMO that they are not prepared in advance for the lack of suitable affordable accommodation. Increasingly, the INMO is hearing reports of inappropriate accommodation being offered to international recruits. Improved social adaptation support is required for international nurses/midwives from non-EU countries, including accommodation for a longer period than currently available.

Progress must be made in providing affordable, high-quality homes to ensure that nurses and midwives can be retained in their workplaces. Every housing plan must provide subsidised rental accommodation and affordable housing options for essential workers.

Affordable accommodation in close proximity to healthcare settings should not be a pipe dream for nurses and midwives who work long hours. Immediate provision and supports must be made to allow these essential workers to live within a reasonable distance of their place of work.

In 2018, the then Minister for Housing Eoghan Murphy announced that affordable housing would be made available to essential public sector workers as part of a pilot scheme in St Michael's Estate, Inchicore. This scheme was drawn up with assistance from the European Investment Bank. The announcement at the time emphasised the importance of this project in planning for essential staff accommodation for the new National Children's Hospital. However, it appears that this scheme has run into problems.

Unsustainable

The government must invest in a capital plan to build and subsidise city-centre accommodation for essential workers. This is a feature of recruitment and retention of nurses and midwives in most big cities in the UK, US and Australia – the main countries recruiting nurses and midwives from Ireland.

When building new hospitals, the government must consider where the staff, including nurses and midwives, will live. Zoning of land must include affordable accommodation for essential frontline workers. For example, the new National Children's Hospital and the proposed new elective hospital in Cork city should establish a housing plan to provide subsidised rental accommodation and affordable housing options for these essential workers.

No health service can exist without nurses and midwives. Ireland's health service is undergoing significant changes; Sláintecare aims to provide a world-class health service underpinned by universal healthcare. However, this vision cannot be achieved without a sustainable level of nurses and midwives.

There are many concerns for nurses and midwives, including chronic overcrowding, low levels of staffing, and safety in the workplace. The ability to access affordable, appropriate accommodation is now added to the list of serious concerns and has the potential to affect recruitment and retention within the professions.

This situation must be addressed as a matter of urgency. The government must deliver an affordable, secure and sustainable housing model that addresses the imbalance in supply and demand.

INMO submission to the minister for housing

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1. WHO (2020) State of the World's Nursing Report. Available at: https://www.who.int/publications/i/item/9789240003279
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3. Slaymaker R et al. (2022) Future retirees likely to face lower homeownership which may pose challenges for retirement income adequacy. ESRI: Dublin. Available at: https://www.esri.ie/news/future-retirees-likely-to-face-lower-homeownership-which-may-pose-challenges-for-retirement

Testimonials from INMO members*

"We have found that in the past few years, greater numbers of younger graduates have been unable to afford to stay in Dublin due to high rents. We know through our own exit interview processes that over 59% of staff have left to go abroad or elsewhere in Ireland, citing cost of living pressures, leases ending or lack of affordable housing within a reasonable distance of the hospital as factors."

– Caoimhe, director of nursing in a major Dublin hospital

"I am unable to find any accommodation near my place of work. I drive 103km each way from Limerick City to Ballinasloe every day I am due to work. Three hours in the car just to go and come back from work is gruelling. This is taking a huge toll on my mental and physical health. Sometimes you think there could be a near miss on the journey after a night shift because of the exhaustion."

– Emma, staff nurse in Galway

"After my landlord gave notice that rent would be rising in my shared apartment to €1,600 a month, I made the really tough decision to move back to my parents in the west of Ireland. I loved the hospital where I was working in Dublin as there were amazing learning opportunities but it seemed like most of my wages were going into paying rent and bills. It was becoming impossible to have a balance of being able to work and also enjoy time off. I'm hoping to save now and move to London. I really want to come back to Dublin one day but only if house prices come down."

– Daire, new graduate midwife

"I moved to Cork with my small family in late 2021. Rent is incredibly high near my hospital, with family homes coming to over €2,000 a month. It was incredibly difficult to manage at first as my husband was not able to work due to constraints. When we first moved to Ireland we shared a home with another colleague and their family as it was impossible to find somewhere. This was hard for our children to deal with. I came to Ireland to save money to send to my elderly parents back in (India) but there is little to spare when renting is high, bills continue to rise and with the cost of parking near the hospital. While the hospital is fantastic, it is very hard to see how much longer working in Ireland will be attractive for people like me."

– Krishna, ICU nurse in Cork

"I travel from Co Waterford several times a week to work in a busy children's hospital. There is on-site accommodation available to us which is fantastic. I have put serious time and effort into studying my specialty. My job really fulfils me. The fact that I can stay near the hospital when I need to is brilliant. I am really worried about the move to the St James's campus where this accommodation will not be an option for me. I cannot afford to move my family up to Dublin and depend on a precarious rental market when my own children need stability when it comes to their education and extracurriculars. If on-site accommodation is not available for my colleagues and me, it will be difficult to find specialist nurses for the new National Children's Hospital.

– Sam, paediatric nurse

**All names have been changed to allow for anonymity of members*

Your story matters.

Share it with us

The INMO has launched a new platform currently open to members employed in the West, North-West and Mid-West regions.
If you're a member working in this region you can now **anonymously** share important stories from your working life on the INMO Sensemaker platform.

Scan the **QR code** to tell us about the experiences that matter most to you.

Hot topics in care of the older person

Delirium, dementia and falls were among the many topics covered at the recent Care of the Older Person Section annual conference. **Beibhinn Dunne** reports

THE INMO's Care of the Older Person Section held its first in-person annual conference since 2019 at the Midlands Park Hotel, Portlaoise in March. The conference covered a wide range of clinical aspects of caring for older people, with speakers presenting on specialist care, frailty, pharmacology, patient advocacy and the legal aspects of gerontological nursing.

Following an introduction by section chairperson Caroline Gourley and an opening address by INMO director of professional services Tony Fitzpatrick, the conference heard from Deirdre Lang, director of nursing and National Lead in Older Persons Services, on 'Updates in gerontology, a national perspective'. Ms Lang noted the growing importance of the care of the older person specialism in light of an ageing population in Ireland. She outlined the older persons service model and the importance of rehabilitation in gerontological care, with particular reference to the National Frailty Education Programme, which Ms Lang encouraged attendees to promote in their workplaces.

Pictured at the conference were (l-r): Margot Lydon, vice chair; Eileen O'Keeffe, education officer; Caroline Gourley, chair; and Noreen Watts, past secretary

Delirium

Aoife Dillon, ANP at St James's Hospital, Dublin, addressed attendees on the dangers of delirium and the importance of treating this as an acute medical condition, as well as the importance of increasing training in identifying, preventing and treating delirium. Ms Dillon also noted that delirium can often be mistaken for dementia and discussed the risk of delirium associated with hospital admissions and its prevalence among older people. She told the conference that up to 36% of nursing home residents experience delirium.

Psychotropic medications

Allcare home care pharmacists Deirdre O'Mahony and Lorna Conlon spoke about the management and recording of psychotropic medication for older people. Their presentation covered interactions with psychotropic medications and the symptoms of psychiatric disorders, as well as some of the side-effects of certain medications.

Their talk also included information on interacting with HIQA and the reporting requirements for psychotropic medications and chemical restraint. This session sparked significant conversation among attendees, with several nurses sharing their experiences and specialist knowledge on clinical guidelines.

Medico-legal issues

Nurse consultant Eithne Ní Dhomhnaill spoke about the legal aspects of documentation, stressing the importance of keeping baseline records in order to be able to establish deterioration and rapid changes in physical and cognitive condition.

Ms Ní Dhomhnaill also covered scenarios in which this documentation might be examined in clinical, regulatory and inquest settings. In particular, Ms Ní Dhomhnaill noted the importance of the nursing record for keeping the healthcare team informed of how patients are responding to specific interventions.

Cognitive impairment, frailty and falls

Later sessions focused on some of the most prevalent risks to older people, with a particular focus on dementia and Alzheimer's disease, as well as frailty and falls. Prof John Nolan, director of research nutrition at the Research Centre of Ireland, addressed attendees on an Alzheimer's disease clinical trial and the use of nutritional supplements to support eye and brain health in older people. Kevin Quaid, author and co-founder of Lewy Body Ireland and vice chair of the European Working Group of People with Dementia, addressed the conference on Lewy body dementia and the importance of a patient-centred approach to dementia care.

Dublin North ANP Daragh Rodger presented on falls awareness, while INMO regulatory services officer Joe Hoolan discussed elements of the Irish fitness to practise process, in which the INMO takes a central role in defending its members and maintaining their registration.

In the conference's final session, barrister Ciara Davin addressed attendees on assisted decision-making and capacity in the care of older people.

INMO Professional

INMO
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INMO Professional Events 2023

ONLINE AND IN-PERSON EVENTS

All conferences and webinars are Category 1 approved by NMBI

SCAN ME!

MARCH 30

RNID Section
The Richmond Education and Event Centre, Dublin

SEPTEMBER 5

Clinical Placement Co-ordinators Seminar
The Richmond Education and Event Centre, Dublin

SEPTEMBER 26

Telephone Triage Nurses Section
Midlands Park Hotel, Portlaoise, Co Laoise

NOVEMBER 16

All Ireland Midwifery Conference

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

Introducing Executive Council members

Ciaran Freeman

Student, NUI Galway

CIARAN Freeman is a general nursing student in NUI Galway. Having completed a degree in Dublin Institute of Technology, he moved to Galway and began his training to become a nurse. As a volunteer with the Order of Malta since his teens he gained valuable experience and knew teamwork and frontline work appealed to him. Currently in his intern year, he is happy he made the decision to go into the profession and hopes to specialise in paediatric haematology or oncology.

Mr Freeman has a long involvement with activism and social justice. "I like to keep myself informed but what's the point in being informed without actively trying to make positive changes? I've been a member since 2018, but when I saw what the INMO was doing for its members during the 2019 strike, I decided this is a movement I really want to engage with. It has snowballed since."

He is a member of the INMO Student Section, secretary of the Western Youth Forum and INMO representative for his college course. He was also a general nursing representative on the Clinical Placement Oversight Group in the Chief Nurse's Office at the Department of Health.

"Membership is free for students so it can only be beneficial. We are not paid on placement and we are the lowest paid interns in healthcare so we are quite vulnerable in the workplace. Any benefits and allowances we have as students have been hard won by the INMO. The union is only as strong as its members so it is essential that we engage. Our union is us.

"My priority on Executive is to make sure student voices are never sidelined. I want students to be in the most supported position they can be while on placement. I also want to be a force for ensuring new graduates are retained in future in Ireland," he said.

Grace Oduwole

ADON, Bellvilla Community Unit, Dublin

GRACE Oduwole is assistant director of nursing (ADON) at Bellvilla Community Unit, South Circular Road, Dublin. Inspired by her older sister and her cousin who are also nurses, she trained in University College Hospital, Ibadan, Nigeria as a nurse and midwife and worked there for 14 years before moving to Ireland in 2011. She worked in Portiuncula University Hospital when she first arrived and has also worked in St Vincent's Community Hospital, Co Kildare and Cherry Orchard Hospital, Ballyfermot. She has a degree in nursing studies from TCD and an MSc in nursing from the RCSI. In 2016, she attended the RCSI Leadership Institute and was awarded a BSc in nursing management in 2019.

Ms Oduwole joined the INMO in 2001 when she started working in Ireland and has been an active member of the International Section since its inception, where she held the roles of secretary and vice-chairperson.

"I always tell nurses arriving from abroad that it is essential to join the union because you need the support of the collective. Apart from the educational support, if there is any trouble at all, the INMO are the people you can turn to. I would love to see more international nurses attending conferences and taking roles on committees within the union," she said.

Staffing shortages and appropriate skill mix are priority issues for Ms Oduwole. She said that staff on the ground are "stretched beyond belief" and people are leaving the professions due to stress and burnout. She feels that giving nurses and midwives greater involvement in decision making nationally and locally would greatly boost morale and result in a more efficient health service.

"We have so much knowledge and this could be utilised better by giving us a seat at the decision-making table."

Bairbre Webb-O'Maolagáin

Paediatric liaison CNS, Cappagh Hospital, Dublin

BAIRBRE Webb-O'Maolagáin works as the paediatric liaison clinical nurse specialist in the National Orthopaedic Hospital, Cappagh, Dublin. She previously worked as a clinical nurse in CHI Temple Street for 25 years. She has a dual qualification, having originally trained as an RGN in St Vincent's University Hospital. She qualified in general nursing in 1981, then went on to qualify as a children's nurse in 1984. She moved to Cappagh in 2009.

Cappagh Kids is now part of the CHI Group but it was a small service when Ms Webb O'Maolagáin first started and has rapidly expanded. "Family and child-centred care is our motto so parents or guardians are very much part of how the children are cared for. It is essential that we don't face another winter of chaos in the health service this year though. The winter plan cannot be ignored again this year."

She is vice chair of the Children's Nurses Section and is passionate about improving working conditions, remuneration and helping staff achieve a healthy work/life balance.

"People need different rosters at different times in their lives to enable a good work/life balance and to ensure we keep our best and brightest on the wards. I would like to see more pathways to paediatric nursing with more places for people coming from pre-nursing courses. I would also love to see a greater focus on providing accommodation for nurses. Retention is a huge issue in paediatrics and affordable accommodation is a huge factor in this. There are so many qualified paediatric nurses nationwide working in other areas because the cost of living in urban centres is just too high," she said.

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Q and A Bulletin Board

With INMO director of industrial relations Albert Murphy

Paid sick leave in private sector

Q. I work in a private nursing home and have never been entitled to paid sick leave before. I heard that this is supposed to change this year?

Yes, as a result of the Sick Leave Act 2022, employees have a right to paid sick leave since January 1, 2023. The entitlement is currently three days (which may be consecutive or non-consecutive) this year, with the entitlement set to increase to five days in 2024, seven days in 2025 and finally 10 days in 2026. Employees absent from work for more than three consecutive days may apply for Illness Benefit from the Department of Social Protection where eligible.

The statutory sick leave is paid by the employer at a rate of 70% of the average hourly rate of pay (including any regular bonus or allowance the amount of which does not vary in relation to the work done by the employee, but excluding any overtime or commission). If an employee's pay changes from week-to-week, their sick pay is the average of their pay over the 13 weeks immediately before they commenced sick leave. Sick pay is capped at a maximum of €110 a day. Employers who experience severe financial difficulties may apply to the Labour Court for an exemption to pay statutory sick leave for a period of between three to 12 months.

Under the Act, an employee is required to present a medical certificate for the statutory sick leave day. Employees have an entitlement to statutory paid sick leave where they have been in continuous employment for a minimum of 13 weeks. Employees on probation may avail of the leave, however their employer may require that the probation be suspended during the period of statutory sick leave and be completed by the employee at the end of that period. The Act does not prevent an employee having more favourable terms in their contract regarding paid sick leave.

Employees retain their employment rights while on statutory sick leave and should not be penalised by their employer for availing of this leave. Absence from employment while on statutory sick leave shall not be treated as part of any other leave from employment (including annual leave, maternity leave, additional maternity leave, paternity leave, adoptive leave and parents leave). If an employee falls sick while on annual leave and they produce a medical certificate, the period of sickness should be recorded as sick leave and not as annual leave.

Compassionate leave

Q. I was recently refused compassionate leave on the grounds that I was on annual leave when I suffered a bereavement. Is this correct? My mother-in-law died and I sought the compassionate leave to attend her funeral when I returned to work. Can you please advise on entitlement to compassionate leave?

The period applicable to the taking of compassionate leave covers the time directly associated with the relative's death and subsequent funeral. Compassionate leave may not be granted at a later date, eg. where an employee has returned from annual leave, sick leave, maternity leave, etc. However, all applications for compassionate leave are assessed on an individual basis.

Compassionate leave with pay may be granted under the following conditions:

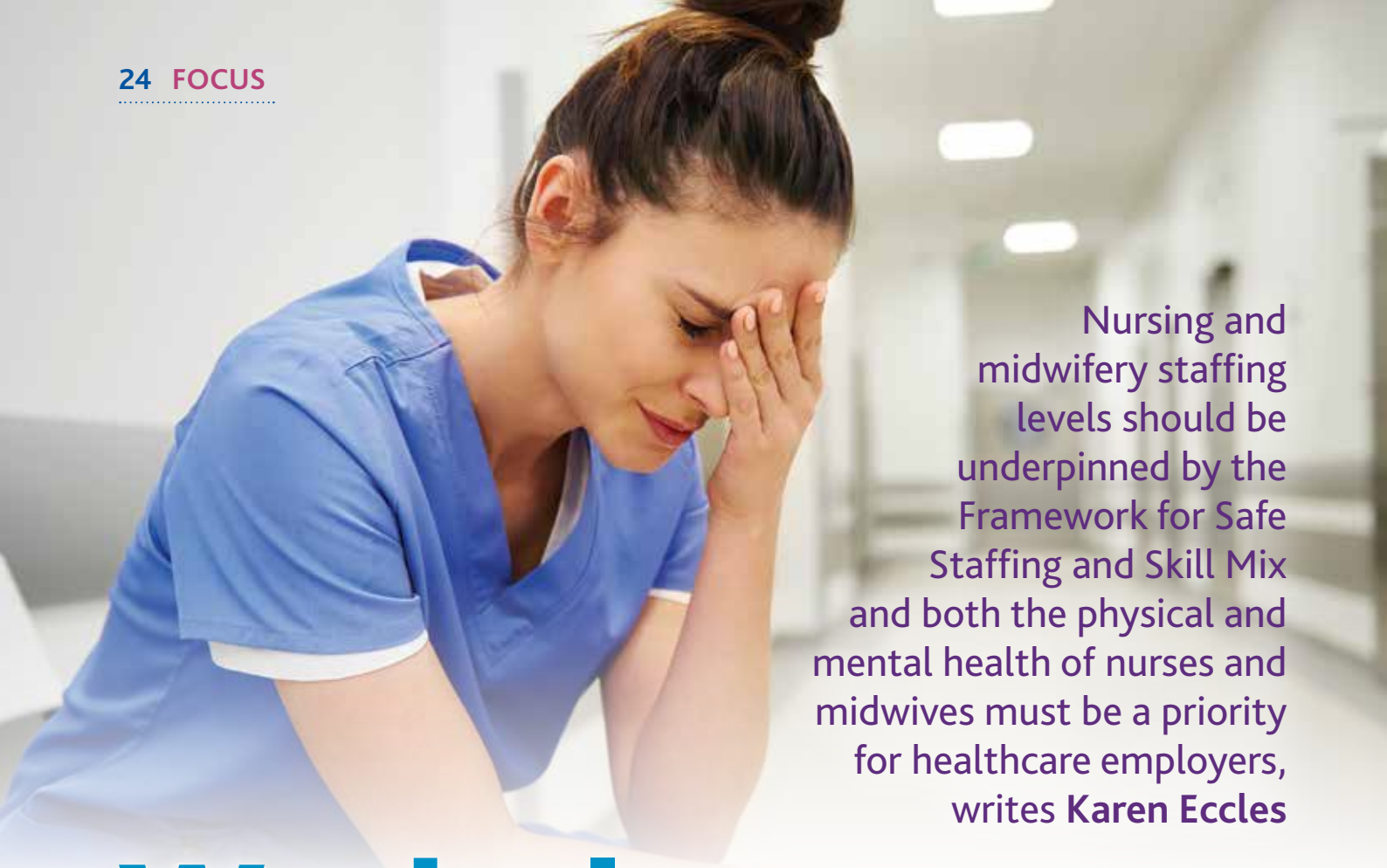
- A maximum of 20 working days may be granted on the death of a spouse (including a cohabiting partner), child (including adopted children and children being cared for on the basis of *in loco parentis*) or any person in a relationship of domestic dependency, including same-sex partners
- A maximum of five working days may be granted on the death of an immediate relative, ie. father, mother, brother, sister, mother-in-law or father-in-law
- Extra days may be allowed where an immediate relative dies abroad and you have to go abroad to take charge of funeral arrangements
- In exceptional circumstances, a maximum of three days may be granted on the death of a more distant relative, if for example, an employee has to take charge of funeral arrangements or has lived in the same house as the deceased.

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 9am-5pm; Fri 8.30am-4.30pm

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



Nursing and midwifery staffing levels should be underpinned by the Framework for Safe Staffing and Skill Mix and both the physical and mental health of nurses and midwives must be a priority for healthcare employers, writes **Karen Eccles**

Workplace stress

PSYCHOSOCIAL stress – or work-related stress as it is most commonly known – is globally recognised as an identifiable risk to the current and future delivery of healthcare.

In a recent report by the Qatar Foundation, in collaboration with the World Health Organization (WHO), it was recognised that there was now a global duty of care to protect the mental health of health and care workers.[1] Commenting on this report, Jim Campbell, WHO director of health workforce, said that: "Well into the third year of the Covid-19 pandemic, this report confirms that the levels of anxiety, stress and depression among health and care workers has become a 'pandemic within a pandemic'."

The Labour Force survey conducted by the National Statistics Office annually in the UK has also identified that work related stress, depression and anxiety accounted for around half of the cases of self-reported ill health in 2021/2022.[2]

The importance of data collection allows us to facilitate reflection, a common professional practice in the delivery of patient care but more importantly identifies red flags and provides direction for improvement. This is not a new concept – over 200 years ago Florence Nightingale, skilled in mathematics, understood the concept of health data advocating for data on sickness and disability.[3]

However, it is now time for us as nurses and midwives to reflect for ourselves specifically on the data identifying the increasing impact that occupational stress is having on our personal health and well-being, both acute and cumulative, and as a profession strive to change poor practices and cultures that support this risk.

A common definition of culture states that culture is a way of life of a group of people – the behaviours, beliefs, values and symbols that they accept generally without thinking about – that are passed along by communication and imitation from one generation to the next.

Professional culture and its importance in healthcare outcomes is understood and its impact has been amply demonstrated in the Francis report[4] and Prof Ian Kennedy's review of children's cardiac services in Bristol in 2016.[5] While I reference cultural impacts and the negative effect these can have on patient outcomes, the importance of our continued acceptance of nursing professional cultural practices, which directly negatively affect our psychosocial health, such as overcrowding, insufficient staffing levels, inadequate skill mix, shift patterns, impediments to flexible working, and violence and aggression must no longer be tolerated.

Leadership is required, to ensure safety management systems are in place, health and safety legislation and policies are adhered to, and that HSE statutory/mandatory training is provided to all nursing grades of CNM1 and above who have responsibility for undertaking occupational safety and health risk assessments.[6]

As the workloads on healthcare systems continue to grow, so have the demands on nurses and midwives, negatively affecting their working environment, and it has never been more important that we include in the historical and traditional acceptance in caring for others to also recognise the importance of caring for ourselves.

Occupational stress

The International Labour Organization (ILO) defines stress as a harmful physical and emotional response caused by an imbalance between the perceived demands and the perceived resources and abilities of individuals to cope with those demands.[7]

Examples of psychosocial hazards leading to psychosocial risks and stress include:[8]

- Excessive workloads
- Conflicting demands and lack of role clarity
- Lack of involvement in making decisions that affect the worker and lack of influence over the way the job is done
- Poorly managed organisational change
- Job insecurity
- Ineffective communication
- Lack of support from management or colleagues
- Psychological or sexual harassment and third-party violence.

Common physical and psychological effects of stress:

Physical

- Headaches
- Insomnia/loss of sleep leading to tiredness
- Backache
- Gastrointestinal disturbances
- Shortness of breath
- Cardiovascular disease
- Weight loss or gain
- Regular or lingering colds
- Consuming too much caffeine or alcohol

Psychological

- Irritability or outbursts of anger
- Low mood
- Low productivity accompanied by feelings of low achievement
- Regular absence and a higher sickness rate/presenteeism
- Being cynical and defensive
- Finding fault in everything you do
- Feeling nervous and on edge
- Finding that you are unable to 'switch off' from work
- Lacking motivation.

How are we protected?

Legislation

Under Section 8 of the Safety Health and Welfare at Work Act (2005), "every employer shall ensure, as far as is reasonably practicable, the safety, health and welfare at work of all his or her employees".[9]

As stress in the workplace under this Act is a recognised occupational hazard, it legally requires employers to put in place systems of work which protect employees from hazards which could lead to mental or physical ill health, and must be managed through the risk assessment process. Work-related stress risk assessments should be conducted at least annually, or when significant change takes place following direct consultation and participation of employees in the assessment process and recorded in the site-specific safety statement as required under section 20 of the 2005 Act.

Policy and procedure

All employers are required to assess work related stress. The HSE's central, but not exclusive, *Policy for the Prevention and Management of Workplace Stress* (2018), outlines comprehensively a structured process using six management standards to risk assess stress in the workplace.[10]

- Demands of the job
- Control
- Support
- Relationships
- Role
- Change.

One major workplace stressor identified by nurses and midwives is insufficient staffing levels. This stressor was recently identified in the HIQA Review of Inspections of Emergency Departments (2022) report where it was recorded that six out of the seven hospitals inspected did not have sufficient staffing levels on the day.[11]

Nursing and midwifery staffing levels should be underpinned by the Framework for Safe Staffing and Skill Mix and both the physical and mental health of nurses and midwives working in acute and primary care settings must now be a priority for all healthcare employers.

Work-related stress has now become central to health and safety discussion internationally because of its impact on healthcare delivery at a cost of €620 billion annually in Europe. In addition, psychosocial risk factors are also unambiguously now linked to musculoskeletal disorders (MSDs), and the combined effect of both biomechanical and psychosocial factors is substantial and workplace risk assessments should reflect this connection requiring occupational health and safety legislation to be strengthened further.[12]

We welcome the recent inspections conducted by HIQA, and the Health and Safety Authority's (HSA) strategy statement for 2022-2024,[13] where it is stated that they "will increase focus in regulation and inspections on compliance with psychosocial and occupational hazards and risks" and prioritise and promote all aspects of the role of safety representatives.

The INMO has already recognised the role of health and safety representatives in its Workplace, Health and Safety Strategy, as a result of agreements reached in 2016 and 2017 with the HSE establishing two nurse/midwife safety representatives in all work locations and one safety representative in all emergency departments.

The INMO, while recognising the importance of statutory body regulation and inspection, has also called for a dedicated division to be established within the HSA to deal directly with the health service.[14]

The role of the health and safety representative is recognised under the Safety, Health and Welfare at Work Act (2005) and it is also recognised that where you have safety representatives you have safer workplaces, which is something we all aspire to. If you are interested in this role please contact me by email at: karen.eccles@inmo.ie or ask your workplace industrial relations officer or industrial relations executive for further information.

Karen Eccles is the released representative for the INMO National Safety Health and Welfare

If you have any issues arising in your workplace please contact the INMO information office and/or your IRO/IRE assigned to your workplace for assistance

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Passion for the past

Lisa McGeeney turned her passion for genealogy and local history into an academic pursuit, resulting in a book examining the development of nursing and midwifery in rural Ireland. She spoke to **Freda Hughes**

A NEW book written by INMO member Lisa McGeeney examines the professionalisation and development of nursing and midwifery in 19th century Ireland, taking the poor-law unions of Borrisokane and Nenagh in Co Tipperary as a microcosm of the situation nationwide.

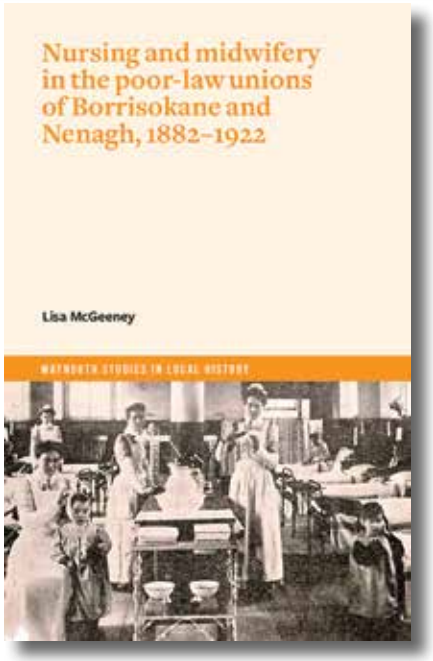
Ms McGeeney told *WIN* that she didn't go into this process with a view to an academic career as she loves nursing, but she saw a deficit in nursing and midwifery history and decided to start to rectify that. Having a background in nursing and midwifery has really assisted her research.

"As nurses and midwives, we often undervalue the knowledge we have but my thesis supervisor made me aware and proud of the knowledge I have. I've brought two very different parts of my life together and each informs the other. I find that fascinating," she said.

Ms McGeeney is a registered nurse, midwife and public health nurse. She trained in Portiuncula General Hospital and the National Maternity Hospital before going on to train as a public health nurse in University College Dublin. She worked as a PHN in Limerick and Clare and has been an early years inspector in the Civic Offices in Nenagh, covering North Tipperary for the past 21 years.

She was born in Australia and moved to Ireland aged 15 when her parents decided to move back home. She feels that this impacted her love of history and genealogical research.

"Growing up in Australia, of Irish parents, and having no relatives in Australia, I was always curious about my ancestry. I had my four grandparents until I was 24 years old and my parents are from families of seven each so I had all these aunts, uncles, cousins, grandparents and extended family in Ireland, and no close relatives in Australia. My mother and my grandfather had an interest in genealogy. He used to go up to Dublin before everything was online and spend time in the National Archives and the National Library researching our family tree. When I moved back from Australia and started studying history in school I hadn't a clue about Irish history. I was spelling Fenians with a ph! The more I read the more fascinated with history I became.



"I remember meeting a patient, when I was 19 in Ballinasloe, who said he was a distant relative. I was able to do the tracing and he said he'd rarely met a 19-year-old who had such an interest in genealogy. I suppose it was always there. As I've gotten older – and of course, as things have come online – genealogy research has become much easier. I've always had a passion for it. It's like a lifelong puzzle."

A number of years ago the old workhouse in Portumna, Co Galway was renovated and opened to the public. Ms McGeeney's first visit there inspired her to pursue her love of history and genealogy. When they were looking for volunteer tour guides she put her name forward. She started to give tours of the building once a month and enjoyed telling the stories of its history. Intrigued by the infirmary and the fact that many of the poor people who stayed there would have been expected to provide nursing care to those in poorer health than themselves, resulting in quality of care that was often quite low and not informed by medical training, she decided to do further research into healthcare in the area.

She first undertook a certificate in local history through the University of Limerick (UL) and absolutely loved it. Following on from this she went on to do a master's degree in local history, again through UL. Her thesis, which then became her book, examines how the professionalisation and development of nursing and midwifery in the 19th century was reflected in the poor-law unions of Borrisokane and Nenagh in Co Tipperary between 1882 and 1922.

It differentiates between trained and untrained nurses and midwives, examines how each type of 'nurse' was perceived and who they were. The employment opportunities for these nurses and midwives were primarily in the poor-law medical relief services as dispensary midwives or as nurses within the workhouse infirmary

and fever hospital. Between 1882 and 1922 untrained nurses and midwives were slowly replaced by their trained counterparts. This was supported by campaigns for reform of the old systems, government bodies and legislation.

Home nursing by district nurses was introduced to the area in 1909 under the auspices of the Women's National Health Association (WNHA). The district nurse provided education and home nursing to patients with tuberculosis and later to mothers and babies under the Mother and Child Welfare Scheme in 1919.

Ms McGeeney's book, which is a really interesting read, distils this information into an easy-to-read and informative account of nursing and midwifery in the region, and tells the stories of some of the women who filled these roles during that period.

As with the professions today, a significant portion of the book is about efforts to recruit and retain nurses and midwives, whether they be fully trained or partially trained. Local attitudes made a huge impact on retention. Often where there was a handywoman midwife already active in the area, professional midwives were less welcome. The money they made was often not sufficient to live off and was meant to be supplemented with private work too.

"What I found fascinating was the amount of movement of female health workers. I think that my perception about everybody in Ireland back then was that they either stayed where they were from, or they emigrated, but actually what I found was that an awful lot of women travelled to where the work was. One of my favourite characters in the book is Mary Frances Carroll who travelled from Dublin to work in Nenagh bringing one of her daughters, who later died in the 1919 influenza epidemic, with her," Ms McGeeney said.

The Women's National Health Association was set up by Lady Ishbel Aberdeen in the early 1900s to provide education and information on how to prevent tuberculosis, to lobby government for better conditions in primary schools to prevent the spread in this cohort, and to better equip buildings for the reception of patients with tuberculosis. *Sláinte* was the magazine of the WNHA. It ran for about a year in 1907 and had 12 issues which can be accessed through the National Library. Ishbel Aberdeen believed that educating women and equipping them with what they needed, would lead to huge progression towards the eradication of tuberculosis.


Lisa McGeeney

She set up a travelling exhibition and toured the country showing women how to clean and ventilate their homes, feed their families nutritious food on a small budget, and care for a family member who had TB. The exhibition visited Nenagh in 1908 and a local branch of the WNHA was established. Its first task was to fundraise for a trained nurse for the area who would "visit the sick poor in their own homes, nursing any case of illness or accident, except infectious cases". This nurse would provide a service not previously available in the region and her role would not impinge on any of the existing nurses or midwives also working in the region.

Ms McGeeney told *WIN*: "I couldn't believe that as a public health nurse I had never heard of the Women's National Health Association. It was essentially a precursor to public health nursing. All those groups of women around the country who formed branches of the WNHA fundraised to fund a nurse that would do up to 3,000 house visits a year."

There was an idea, historically, that hospitals were for poor people. If you were wealthy enough you could afford to get a doctor to visit you at home. The book aptly illustrates how much of society was governed by the poor laws. Taxes or poor-rates paid for the workhouses, dispensary doctors and nurses. Lighting, heating, roads and sanitation were also funded from these taxes.

Anyone in need of assistance would go to the poor house. However, in the early 1900s they were often barely half full and the provision of healthcare was starting to change. When the workhouses closed they came under control of the county councils and were reimagined and reorganised. Some became the county home, or mother and baby homes, while others became the local hospital.

Ms McGeeney is currently undertaking a PhD in UL and working in the early years inspectorate in Co Tipperary. Her book *Nursing and Midwifery in the Poor Law Unions of Borrisokane and Nenagh* is available to purchase from Four Courts Press at **www.fourcourtspress.ie**

COOP Section hears from experts on falls, dementia and delirium

THE Care of the Older Person (COOP) Section held its first in-person annual conference since 2019 at the Midlands Park Hotel in Portlaoise last month, with 120 members in attendance.

The conference covered patient advocacy and the medico-legal aspects of gerontological nursing, as well as important clinical topics such as delirium, dementia and falls prevention.

The conference was well evaluated by all who attended, and delegates left plenty of suggestions for the planning committee ahead of next year's conference.

Section chairperson Caroline Gourley gave an introduction to the conference, while attendees also heard an opening address from INMO director of professional services Tony Fitzpatrick.

The section wishes to thank the speakers, researchers and authors who came to share their experiences with the conference.

A full report on the COOP Section conference can be read on *page 19*.

Pictured above (left) are attendees of the conference, while pictured above are Jean Carroll, INMO section development officer, and barrister Ciara Davin (right), who addressed the conference on the medico-legal aspects of care of the older person nursing, including assisted decision-making and capacity

Events

Retired Section

- Tour of National Maritime Museum, Dun Laoghaire. Wednesday, April 19. Call 01 280 0969 to book
- Lunch at Park House Restaurant, Galway. Tuesday, June 6 at 1pm. Text 087 6402962 to confirm attendance
- Tour of Croke Park. 11am, Thursday, July 13. Book online or contact 086 397 0239 for details

RNID Section

- Online meeting on April 19 from 2pm, to be followed by 'Tools for safe practice' session facilitated by nurse consultant Michelle Russell

SEN Section

- Online CPD course on medication management. Saturday, April 22

INMO Professional

Continuing professional development for nurses and midwives

INMO EDUCATION PROGRAMMES

In the pull-out this month…

Adult asthma – getting the basics right *(online)*

Apr 14

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

Healthcare provider CPR and AED *(in person)*

Apr 25

This course has two parts; online and practical. The online theory section will be sent on to participants before the course date and must be completed before attending the practical session. This course will equip the participants with the necessary theory and skills for the provision of CPR (cardiopulmonary resuscitation) and AED (automated external defibrillation) use in emergency situations, in line with the latest guidelines recommended by the American Heart Association. The care of the adult, child and infant will be included. The certificate awarded on completion of the course has a life span of two years.

Understanding and developing care plans for nurses and midwives *(online)*

Apr 27

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.

Looking ahead with INMO Professional

Steve Pitman
Head of Education and Professional Development

THE global shortage of nurses and midwives and the continued staffing pressures experienced in the Irish healthcare system highlight the urgency to educate more nurses and midwives in Ireland. This will be fundamental to enabling the full introduction of the Framework for Safe Staffing and Skill Mix.

The number of CAO applicants in 2023 for nursing and midwifery has dropped compared with previous years. The drop in applications of 10% may be a natural fall-back following a surge in applications experienced during the pandemic. In 2021, there was a 21% rise in CAO applications for college nursing and midwifery courses. On February 1, 2023, there were 3,908 first preference applications for nursing and midwifery compared with 4,363 in 2022. In October 2022, the NMBI reported that 1,555 first-time registrants who were educated in Ireland joined the register. New registrants continued to join the register up to the end of 2022. It is estimated that 1,800 new graduates joined the nursing and midwifery registers in 2022.

The Department of Health, as part of the *Report of the Expert Review Body on Nursing and Midwifery,* recognised the need to increase undergraduate student numbers in each of the disciplines annually, in line with the projected workforce demands. During 2021 and 2022, there was an increase of 335 nursing and midwifery places on undergraduate programmes. This increase in numbers will need to continue over the coming years. To achieve the number of domestically educated nurses and midwives in the workforce to a level moving towards self-sufficiency will require a significant increase in nursing and midwifery undergraduate places. This will present challenges in the availability of clinical placements and an urgent need to review the capacity of higher education institutes to increase places. The current NMBI Fundamental Review of the Undergraduate Programmes is one of the vital components required to ensure that nursing and midwifery education can adapt to the changing nature of healthcare and the health needs of the Irish population.

NMBI

In February, the NMBI published new educational standards and requirements to regulate the practice of dual energy x-ray absorptiometry (DXA) scanning by nurses. Nurses in Ireland can undertake the practical aspects of DXA scanning if they have completed the education programme.

The NMBI is expected to publish the Digital Health Competency Standards and Requirements for Undergraduate Nursing and Midwifery Education Programmes over the coming months. These standards have been introduced in response to the changing nature and the increasing use of digital technology in healthcare. The standards aim to ensure that digital health is incorporated into education programmes.

Phase 1 of the NMBI Fundamental Review of the Undergraduate Programmes continues, with focus groups taking place over the past few months. A report on the findings of phase 1 is expected to be available in June. This will then lead to a review and consideration by NMBI on the future direction of the undergraduate programmes. This process is expected to involve significant engagement with key stakeholders, including the INMO.

The NMBI is developing standards and requirements for graduate entry to general nursing programmes. The INMO welcomes the expansion of educational pathways into nursing. In addition to graduate entry, other pathways that facilitate an increase in the number of students on nursing undergraduate registration programmes are urgently required, including students who have completed PLC QQI level 5 nursing studies and pre-nursing courses.

CJ Coleman Award

INMO Professional is delighted to offer the CJ Coleman Research and Innovation Award again for 2023. CJ Coleman has generously sponsored the 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. The award is open to all INMO members and will be announced at the ADC in May. The closing date for completed applications is April 3, 2023. Further details and a link to the application form are available on the INMO and INMO Professional websites.

'Stop the Stigma' campaign

The INMO has joined with Fórsa and the FSU in building a campaign to raise awareness for the need for menstrual and menopause welfare policies in workplaces. The 'Stop the Stigma' campaign recognises the importance of providing a supportive and an inclusive working environment for all employees, including those who experience periods and menopause. This campaign aims to create a workplace culture that acknowledges and supports the unique challenges and needs during these natural biological processes. Look for information about the campaign on the INMO website and social media.

Call for posters

The INMO is delighted that ARAG has agreed to sponsor the ADC poster competition for 2023. The competition celebrates and showcases the significant contribution that nurses and midwives make to enhancing and developing the quality of care delivered to patients and service users. INMO members are invited to submit a poster for presentation at the ADC in May in Killarney, Co Kerry. A prize of €500 will be awarded for the best poster, with further awards available. Further information and a link to the application form can be found on the INMO and INMO Professional websites.

INMO Professional

Education Programmes

Tel: 01 6640618/41
Email: education@inmo.ie

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

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

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

Apr 13 **Phlebotomy** *(in person)*

This programme provides participants with the skill and theory to perform phlebotomy in a competent and safe manner. It will cover topics such as sites used for phlebotomy, criteria for evaluating a vein, principles of an aseptic technique as well as complications that may arise during and after the procedure. Guidance will be given on how to reassure the individual in relation to the procedure and on gaining consent.
Fee: €90 INMO members; €145 non-members

Apr 14 **Adult asthma – getting the basics right**

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

Apr 17 **Introduction to effective library skills**

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 academic programmes.

Apr 19 **Leg ulcer assessment and management**

This course will advise participants on leg ulcer management. Topics will include: pathophysiology, assessment and management of leg ulcers. Participants will gain an understanding of the theory of different causes of leg ulcerations, a deeper understanding of the pathophysiology of leg ulceration, different non-invasive assessments and the importance of compression for venous leg ulcerations.

Apr 20 **Chronic obstructive pulmonary disease – getting the basics right**

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

Apr 21 **Paediatric asthma – understanding the basics**

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

Apr 25 **Healthcare provider CPR and AED** *(in person)*

This course has two parts: online and practical. The online section will be sent to participants before the course date and must be completed prior to attendance. This course will equip participants with the necessary theory and skills for the provision of CPR and AED use in emergency situations, in line with the latest American Heart Association guidelines. The care of the adult, child and infant will be included.
Fee: €135 INMO members; €175 non-members

Apr 26 **Falls reduction, assessment and review**

The purpose of this programme is to promote a consistent approach to falls reduction for older people through assessment, individualised care planning and post-falls review. It promotes excellence among nurses who provide care to the patients at risk of falls, informed by current evidence. The main aim is to assist nurses to identify those patients or residents who are at risk of falls and to reduce that risk by providing knowledge on falls reduction techniques, ultimately improving patient safety and minimising injuries in the older population.

Cancellation policy: For cancellations five days before the course due date, a full credit to transfer on to 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 27 **Understanding and developing Care Plans for Nurses and Midwives**

This course 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.

May 4 **Management skills for nurses and midwives**

This short online course will enable nurses and midwives to understand the principles of effective leadership and management in front line healthcare delivery, identify key competencies required for effective management and understand how management competencies are applied to the healthcare setting to promote quality and safety in healthcare delivery.

May 11 **Infection control risk register: regulation 27; development and review**

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

May 15 **Competency-based interview skills for nurses and midwives**

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

May 17 **Master your communication skills**

This online training will help you develop your interpersonal and communication skills at all levels in the organisation. It focuses on your key competencies for face-to-face and written communications to ensure you can understand what is being communicated to you; how to respond and how to communicate clearly and with purpose. Learn these practical skills to ensure more effective and impactful communications.

May 18 **Retirement planning seminar** *(in person)*

This short online course will enable nurses and midwives to understand the principles of effective leadership and management in front line healthcare delivery, identify key competencies required for effective management and understand how management competencies are applied to the healthcare setting to promote quality and safety in healthcare delivery. Fee: €10 INMO members; €65 non-members..

May 24 **Risk management and incident reporting**

This new online programme outlines the core principles of best practice in managing risk, underpinned by the philosophy and care needs. At the end of the session participants will be enabled to: understand key terms and definitions related to risk management in healthcare; outline the stages of the risk management process based on the international standard and framework for risk management; outline the 5 steps of risk assessment; understand the purpose and maintenance of a risk register and complete accurate records of incidents for incident reporting. Ultimately, this programme promotes best practice with risk management and patient safety.

May 31 **Subcutaneous administration of fluids** *(in person)*

This programme will educate participants in the administration of fluids by the subcutaneous route. It will cover topics such as accountability, indications for subcutaneous infusion, suitable sites and identification of fluids most commonly used. Calculation of the rate of infusion, the principles of an aseptic technique and complications which could occur before, during or after the procedure will be explored. Fee: €90 INMO members; €145 non members.

May 31 **Understanding epilepsy for nurses and midwives**

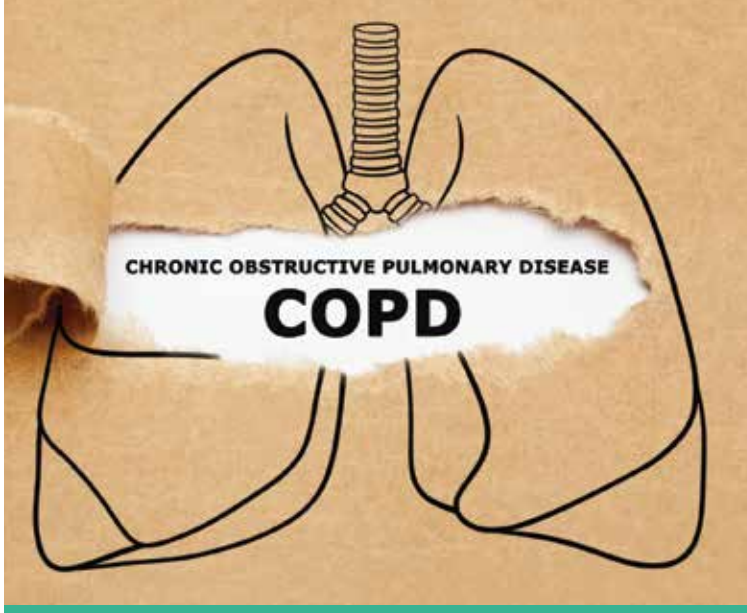
Epilepsy is a chronic disease that affects 1% of the population and can be associated with significant physical and psychosocial sequelae. A person with epilepsy often has comorbid conditions and must carefully manage their epilepsy and comorbid diseases, as well as navigate how their life is affected by their diseases. The management of patients with complex medical conditions, including epilepsy, is increasingly being overseen by nurses. Nurses who are not specialists in epilepsy can play a central role in providing optimal care, education, and support to their patients with epilepsy, given the proper tools. This course will provide a foundation on which to build increasing knowledge of epilepsy and care of the patient.

INMO Professional

INMO Irish Nurses and Midwives Organisation Working Together

Chronic Obstructive Pulmonary Disease (COPD)

Getting the Basics Right



Thursday, 20 April 2023

Online from 10.00am - 1.00pm

LIVE ONLINE EVENT

Fee: €30 INMO members; €65 non members

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

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SCAN ME!

INMO Professional

INMO Irish Nurses and Midwives Organisation Working Together

Understanding and Developing Care Plans

for Nurses and Midwives

Thursday, 27 April 2023

Online from 10.00am - 1.00pm

LIVE ONLINE EVENT

Fee: €30 INMO members; €65 non members

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.

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Jun 1 **Type 1 diabetes management for nurses and midwives**

This short online programme will provide nurses and midwives with knowledge and skills regarding Type 1 Diabetes. The literature would suggest that diabetes, chronic disease management and the self-care that is associated with it brings high incidence rates of depression, anxiety and negative thoughts. The use of different strategies, self-management, treatment options, insulin pump therapy and CGM will be looked at to improve patient self-management.

Jun 7 **The importance of documentation for nurses and midwives – getting it right**

This short programme will assist nurses and midwives in understanding their duty of care and responsibility in the area of best practice in documentation, keeping good records and their ethical and legal responsibility of getting it right. Topics will include; introduction to legal and professional requirements, the NMBI code and guidance for recording clinical practice, the relevant HIQA regulations and standards, adhering to consent and data protection legislation in record keeping, the purpose of healthcare records.

Jun 7 **Peripheral intravenous cannulation** *(in person)*

This programme provides guidance to participants in the skill of peripheral intravenous cannulation. Instruction will be provided on the sites used for peripheral intravenous cannulation, identifying criteria for evaluating a vein and the principles of an aseptic technique. The aim is for participants to be able to carry out the procedure in a competent and safe manner. While this course will provide the necessary knowledge and skills to undertake peripheral intravenous cannulation, it will be necessary for each nurse and midwife attending to ensure that they abide by their local policy on peripheral intravenous cannulation in their place of work. Participants are also required to hold the following: hand hygiene training certification (within the past two years); management and administration of intravenous drugs certification (within the past two years) and a management of anaphylaxis certification (within the past two years). €90 INMO members; €145 non members

Jun 14 **Wound management for nurses and midwives**

This short online course will advise participants on wound care management. Topics covered on the day include; wound healing, wound bed preparation and treatment options, and dressing selections. On completion of the course, participants will understand the anatomy and physiology of wound management, understand and be able to identify the factors influencing wound healing, understand and be able to identify the differences between acute and chronic wounds, understand and be able to implement a holistic assessment of individuals with wounds and understand the current modalities of different types of dressing and their application.

Jun 15 **Delegation principles and practices**

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

Jun 15 **Introduction to management and leadership skills for nurses and midwives**

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

Jun 19 **Tools for safe practice** *(Free for INMO members)*

This programme provides safe practice tools to protect the nurse and midwife and patient within current health care 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 patient 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. This programme is free for INMO members. Places must be booked on-line in advance of your attendance.

Jun 22 **Understanding and developing Care Plans for Nurses and Midwives**

This course 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.

Jun 28 **Phlebotomy** *(in person)*

This programme provides participants with the skill and theory to perform phlebotomy in a competent and safe manner. It will cover topics such as sites used for phlebotomy, criteria for evaluating a vein, principles of an aseptic technique as well as complications that may arise during and after the procedure. Guidance will be given on how to reassure the individual in relation to the procedure and on gaining consent. Fee: €90 INMO members; €145 non-members

INMO Professional Cornmarket

Retirement Planning Seminar

Thursday, 18 May 2023

IN PERSON EVENT

Time: 9.30am - 5.00pm

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

Fee: €10 INMO members; €65 non members

INMO Professional in partnership with Cornmarket Financial Services have developed an in person seminar to help support members planning for retirement.

Topics covered on the day will be: Superannuation, calculation of the lump sum, options for increasing benefits, AVCs, planning your finances in retirement, investment goals, personal taxation and budgeting and money saving tips.

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INMO Professional INMO Irish Nurses and Midwives Organisation Working Together

Tools for Safe Practice

for nurses and midwives

Thursday, 18 May 2023 SOLD OUT

Monday, 19 June 2023

LIVE ONLINE EVENT

Online from 10.00am - 1.00pm

Practical advice on:

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

FREE

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SCAN ME!

Evidence-based practice

This month Niamh Adams focuses on the Joanna Briggs Institute Evidence Based Practice Database, which is available to members through the online library

THE Joanna Briggs Institute Evidence Based Practice Database (JBI EBP) aims to support nurses, midwives and other healthcare professionals in delivering the best care with simple and effective global evidence content. The Joanna Briggs Institute is an internationally renowned research and development centre and a leading body in evidence-based practice. As its name suggests, this resource is centred on evidence-based practice and provides nurses and midwives with a broad range of evidence-rich content. It offers a wide range of subject-specific areas and would appeal to both student and clinician groups. The database includes a comprehensive range of resources, including more than 4,500 full text records in seven publication types.

Why use the JBI EBP?

Like the Cochrane Library, JBI EBP provides access to systematic reviews, and these can be very useful when undertaking research or assignments including systematic reviews. However, the database goes further to show this research in practice with evidence summaries, evidence-based recommended practices, best practice information sheets and consumer information sheets. These can be useful at the point of care and for keeping current on recommended practices. All of the content available in this resource is full text.

Getting the most out of the database

Searching JBI EBP is a little easier than some other databases, as it is not as big as some other databases. It is available on the OVID platform and users can avail of the advanced search option which will allow searching by keyword, title or journal. The resource uses MeSH headings and these can be searched using the advanced search option. We recommend using a keyword search for this database, as performing a subject heading search is a little tricky. When searching, users can also apply several useful limits. Searches can be limited by subject area, including midwifery care, chronic disease, and aged care. Another useful limitation to include is publication type. For example, if you only want to find updated information on practice/procedures, you simply limit by publication type "Recommended Practices".

To provide you with an idea of the type of content included, the library team have highlighted some recently published and updated topics. These articles can be accessed directly through the JBI EBP Database or by contacting the library.

Midwifery

- Antenatal: Blood Pressure (2023) - Recommended Practice
- Maehara, Kunie, et al. "Experiences of transition to motherhood among pregnant women following assisted reproductive technology: a qualitative systematic review". JBI Evidence Synthesis 20.3 (2022): 725-760. JBI EBP Database

Cardiovascular

- Hypertension: Diagnosis (2023) – Recommended Practice

Cancer

- Magtoto, LS (2023) Cancer Patients: Improving Symptom-Related Communication Skills – Evidence Summary (Research Question: What is the best available evidence regarding improving symptom-related communication skills for patients with cancer?)

Community Health

- Queiroz, Ana Beatriz (2023) Indwelling Catheter: Community Care – Evidence Summary (Research Question: What is the best available evidence regarding indwelling catheterization in community care settings?).

Aged care

- Mathew, Saira (2023) Falls (Older Person): Preventative Interventions in Acute Settings – Evidence Summary (Research Question: What is the best available evidence regarding interventions to prevent falls, and harm from falls, in older adults in acute care or hospital settings?)

Palliative care

- Silva, Rita Santos et al. Forgiveness facilitation in palliative care: a scoping review. JBI Evidence Synthesis 18.11 (2020): 2196-2230. JBI EBP Database.

Library news

We are currently rolling out Open Athens as a method for our members to access the online library. Although only in the early stages of implementation, if you are interested in registering for Open Athens access, please visit **https://inmo.ie/Library** or contact niamh.adams@inmo.ie

Literature Searching Service

Let us assist you with your searching. The library offers a literature searching service which is available to members for a small fee and can be useful if you are having difficulty finding relevant articles or if you do not have enough time to complete your search yourself.

Other library services

For further information on this or any of the library services, please call: 01 6640614/25 or email: library@inmo.ie If you wish to visit the library, please make an appointment in advance so we can ensure that there will be a staff member available to assist you. The library opening hours are Monday to Thursday: 8.30am-5.00pm, Friday: 8.30am-4.30pm.

Online – Introduction to Effective Library Search Skills

Next course date: Monday, April 17, 2023

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

A practical guide to neonatal jaundice

The latest RCM i-Learn module we are highlighting provides midwives with a guide to recognise and manage newborn jaundice

JAUNDICE is a common condition that affects 60-80% of newborn babies in their first weeks of life. When babies have jaundice their skin, whites of the eyes and mucous membranes turn yellow because of the build-up of a yellow waste product in the body called bilirubin. Jaundice is a normal adaptation to life outside of the womb and usually lasts one to two weeks. Very few babies will experience serious problems and jaundice will usually go away on its own without the need for treatment. The medical term for jaundice is hyperbilirubinaemia.

Midwives will know from their own practice that jaundice is a commonly seen symptom in newborn babies. Part of the role as a midwife is to identify when jaundice is considered to be normal or pathological, requiring treatment. In most babies, early jaundice is harmless. However, a baby that is jaundiced will require a documented care plan based on evidence and including the rationale for actions taken.

This module will take approximately three hours to complete.

Why this topic is important

Newborn jaundice usually appears around the second or third day of life. It begins at the head and progresses downward. A jaundiced baby's skin will appear yellow first on the face, followed by the chest and stomach, and finally, the legs. It can also cause the whites of an infant's eyes to appear yellow.

Jaundice can make babies sleepy, which in turn can lead to feeding problems as a sleepy baby may not wake itself to feed and/or maintain a strong latch. This in turn can lead to significant weight loss (>10% of body weight). Because of this, it is recommended that jaundiced babies be fed frequently, even if it means waking them.

Extremely high levels of bilirubin – usually above 20mg – can cause deafness, cerebral palsy, or brain damage in some babies. In rare cases, jaundice may indicate the presence of hepatitis.

Role of the midwife

The midwife has an essential role in monitoring the wellbeing of the baby and supporting the parents with the care and planning of any care packages if the baby requires investigations and treatment.

The challenges to midwifery practice include:

- Identification of babies that are at higher risk of significant jaundice
- Identification of the jaundiced baby that requires intervention and needs to be referred for a neonatal opinion
- Undertaking the necessary investigations safely both in hospital and community
- Formulation of a dynamic care plan and continual evaluation of mother and baby
- Ensuring that information is clear and understood by the mother and family.

Babies with jaundice may be very sleepy and will find it difficult to co-ordinate sucking and swallowing, midwives can support infant feeding by assisting the mother with breastfeeding. If considered necessary, the midwife might need to help the mother to express breast milk, feed the baby with a bottle, nasal gastric tube (NGT) or if awake a cup depending on the mother's preference, medical discussion and agreement on what is appropriate for the individual baby and mother.

Education and support can help parents better understand what is happening and support partnership of care. This can be a very stressful time for parents. The baby may require a longer stay in hospital and it may be distressing to see the baby under the light.

Learning outcomes

Having completed this module you will be able to:

- Explain the normal physiology of bilirubin metabolism
- Understand the consequences of hyperbilirubinaemia
- Identify the baby at increased risk
- Recognise the clinical signs of unconjugated and conjugated hyperbilirubinaemia in the newborn
- Use the NICE bilirubin charts appropriately and confidently
- Understand the role of phototherapy and exchange transfusion
- Identify common causes of prolonged jaundice.

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

Nursing/midwifery salary scales

Application of 2% due on March 1, 2023

Incremental point	1	2	3	4	5	6	7	8	9	10	11	12
Student nurse/midwife/ intellectual disability	18,321 (*degree students 36 weeks rostered placement)*											
Staff nurse/midwife (post qualification, pre registration)	28,539											
Staff nurse/midwife	33,193	35,126	36,113	37,418	39,063	40,706	42,341	43,756	45,174	46,585	47,998	49,385
LSI after three years on maximum												50,865
Senior staff nurse/midwife	53,280											
Enhanced nurse/midwife Dual qualified nurse/midwife	40,077	42,536	43,849	44,859	45,971	47,452	48,895	51,018				
LSI after three years on maximum												52,512
Senior enhanced nurse/midwife Dual qualified nurse/midwife	55,026											
Clinical nurse/midwife manager 1	51,933	52,875	54,204	55,555	56,899	58,250	59,757	61,160				
Clinical nurse/midwife manager 2/ specialist	56,353	57,287	58,076	59,365	60,789	62,187	63,585	65,160	66,622			
(plus allowance of €903 per annum payable on a red-circle basis to theatre/night sisters who were in posts on 5/11/'99)												
Clinical instructor	58,799	59,751	60,455	61,762	63,080	64,502	65,931	67,359	68,784			
Clinical nurse/midwife manager 3	64,845	66,129	69,372	70,648	71,931	73,231						
Nurse tutor	66,326	67,226	68,124	69,026	69,926	70,829	71,724	72,628	73,529	74,428		
Principal nurse tutor	69,560	70,872	72,070	75,815	77,124	77,172	78,703	80,792				
Specialist co-ordinator nursing/ midwifery	66,326	67,226	68,124	69,026	69,926	70,829	71,724	72,628	73,529	74,428		
Student public health nurse	37,189											
Public health nurse	54,915	55,820	56,597	57,822	59,230	60,594	61,969	63,513	64,952			
(plus allowance of €1,807 per annum payable on a red-circle basis to staff who were in posts on 5/11/'99)												
Assistant director of public health nursing	64,850	68,412	69,876	71,226	72,588	74,454						
Director of public health nursing	85,136	87,717	90,306	93,003	95,479	98,068						
Advanced nurse practitioner	65,472	66,740	67,963	71,718	72,901	74,274	75,559	76,834	80,796			
Advanced nurse practitioner candidate	64,845	66,129	69,372	70,648	71,931	73,231						
Assistant director of nursing band 1	65,472	66,740	67,963	71,718	72,901	74,274	75,559	76,834	80,796			
Assistant director of nursing non band 1 hospitals	62,177	63,502	64,850	68,412	69,876	71,226	72,588	74,453				
Director of nursing band 1	86,843	89,257	91,676	94,085	96,497	98,919	101,330					
Director of nursing band 2	80,903	83,181	85,464	87,739	90,027	92,307	94,590					
Director of nursing band 2a	80,256	81,688	83,124	84,554	85,990	87,420	88,854					
Director of nursing band 3	75,764	76,242	77,867	79,541	81,207	82,887	84,554					
Director of nursing band 4	70,792	72,934	75,069	77,213	78,161	80,321	82,476					
Director of nursing band 5	66,226	67,659	69,091	70,520	71,951	73,388	74,822					
Area director – nursing & midwifery planning development unit	91,878	94,715	97,523	99,931	102,616	105,356	108,057					
Director – nursing & midwifery planning development unit	83,436	85,772	88,345	91,172	94,271	97,454						
Director centre of nurse education	76,147	77,332	79,710	82,110	84,507	86,907	89,304	91,805				
Hospital group director of nursing and midwifery	112,746	117,756	122,767	127,775	132,789	137,798						

Location and qualification allowances

2% due on March 1, 2023

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

Grade	Nature of Allowance	€
Registered general nurses	**Employed on duties in the following locations:** Accident and emergency departments, theatre/operating room, renal units, intensive/coronary care units, cancer/oncology units, geriatric units/long-stay hospital or units in county homes, high dependency units, neonatal units (ICU), endoscopy units, specialist ambulatory, dialysis units, units for severe and profoundly handicapped in mental handicap services, acute admission units in mental health services, secure units in mental health services, dedicated care of the elderly (excluding day care centres) and Alzheimer's units in mental health services and the intellectual disability sector (including psycho-geriatric wards, elderly mentally infirm units, psychiatry of later life services), medical/surgical wards, maternity departments. *(Allowance effective from March 1, 2019)*	2,516
Registered nurses	**a) Employed on duties in specialist areas appropriate to the following qualifications where they hold the relevant qualifications:** • Accident and emergency nursing course • Anaesthetic nursing course • Behaviour modification course • Behavioural therapy course • Burns nursing course • Child and adolescent psychiatry nursing course • Coronary care course • Diabetes nursing course • Ear, nose and throat nursing course • Forensic psychiatry nursing course • Gerontological nursing course • Higher diploma in midwifery • Higher diploma in paediatrics • Infection control nursing course • Intensive care nursing course • Neurological/neurosurgical nursing course • Operating theatre nursing course (including paediatric operation theatre) • Ophthalmic nursing course • Orthopaedic nursing course • Higher diploma in cardiovascular nursing/diabetes nursing/oncological nursing/palliative care nursing/accident and emergency nursing • Rehabilitation nursing course • Renal nursing course • Stoma care nursing course	3,778
With effect from March 1, 2002, payment of the Specialist Qualification Allowance is extended to all specialist courses confirmed as Category II or equivalent by the NMBI.		
Registered general nurses	b) Holding recognised post-registration qualifications in midwifery or sick children's nursing and employed on duties appropriate to their qualification	3,778
Public health nurses and assistant directors of public health nursing	Qualification Allowance	3,778
With effect from March 1, 2019, the location allowance is extended to public health nurses not holding a midwifery qualification but engaged in provision of midwifery services as part of their duties.		
Public health nurses		2,516

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

(a) Nurses who were paid on the dual qualified scale on October 1, 1996 and in receipt of a location allowance at August 1, 1998 or eligible for a new location/qualification allowance from March 31, 1999. In such cases the value of the location/qualification allowance is **€1,573** which they receive in addition to their dual qualified scale.

(b) With effect from November 26, 2003, nurses who are paid on the dual qualified scale and who then move to an area that attracts a location/qualification allowance will continue to be paid on the dual qualified scale and will also receive the abated value of the location/qualification allowance of **€1,573.** Payment of the allowance will cease if the nurse moves out of the qualifying area.

Other allowances

2% due on March 1, 2023

Grade	Nature of allowance	€
Public health nurses	Island inducement allowance*	1,992
Public health nurses	Fixed payment	31.75
Weekend work	First call on Saturday and first call on Sunday Each subsequent call on Saturday and Sunday Payment in lieu of time off for emergency work	42.14 21.11 31.71
Theatre nurses/midwives who participate in the on-call/standby emergency services	**On-call with standby – each day** Monday to Friday Saturday Sunday and public holidays *All of these figures based on a 12-hour period. Pro rata to apply after hours.*	 47.76 61.35 82.93
	Call-out rate – Monday to Sunday (a) Fee per operation per 2 hours (17.00-22.00 hours) (b) (i) Operation lasting > 2 hours and up to 3 hours (17.00-22.00 hours) (ii) Operation lasting > 4 hours and up to 5 hours (c) Fee per operation per hour (after 22.00 hours)	 47.76 71.63 119.39 47.76
	On-call without standby (i) Fee per operation, call-in without standby (ii) overruns from roster at normal overtime rates (no time back in lieu)	95.52
	On-call over weekend In situations where no roster duty is available over the weekend, the following will apply on a pro-rata basis (ie. appropriate rate divided by 12, then multiplied by number of hours available). No time back in lieu will apply.	
	Nurse co-ordinator allowance A shift allowance of €20.40 will be paid to a staff nurse who undertakes the role of formalising the reporting and accountability relationship with the theatre superintendent. The allowance only applies to a nurse who fulfils specified duties when called in (DOH circular refers).	
Specialist co-ordinator allowance		4,872
Caseload allowance (RGNs in the community undertaking certain specified duties of the PHN)		4,184
How to work our hourly rate of pay for nurses/midwives: Example: senior enhanced salary scale €55,026. Take €55,026, divide by 52.18 and divide by 37.5, equals hourly rate of pay €28.12. This formula applies for all grades.		

Know your rights and entitlements

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

Catherine Hopkins and Catherine O'Connor at
Tel: 01 664 0610/19
Email: catherine.hopkins@inmo.ie,
catherine.oconnor@inmo.ie
Mon to Thur 9am-5pm; Fri 8.30am-4.30pm

- Annual leave
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- Flexible working
- Public holidays
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- Injury at work
- Agency workers
- Incremental credit

Preparing for a job interview

Róisín O'Connell advises internship students on how best to approach job interviews

IN RECENT weeks I have received many queries from internship students across the country about interviews and how to prepare for them. Few people enjoy job interviews, particularly at the start of their career. They can seem daunting and scary due to the element of uncertainty, especially if you are not prepared. It's important to remember that everyone gets nervous in the lead-up to an interview. However, if you prepare well beforehand, you will be ready on the day.

Interviews for nursing and midwifery roles are often done by panels, meaning that you could have two or three people interviewing you. There will likely be someone from HR present, as well as someone from the clinical area and a member of senior management. Usually, while one person is asking you a question, another will be documenting your answers. Try not to be distracted by this.

The questions asked are usually competency based, but some questions may be designed to let the employer know how you might fit into their organisation. It is a good idea to prepare some answers for general questions that you might be asked, such as: 'Why did you want to become a nurse or midwife?' or 'Tell me a bit about yourself'. This is your opportunity to stand out and tell the employer why they should choose you. You must familiarise yourself with your CV or application, as anything you have written may be asked about during the interview.

Before the interview

Interview preparation should begin well before the day of the interview. Some employers will look up candidates online before the interview. Search your name to see what comes up and if there is anything there that you would like to remove.

Researching your prospective employer is always beneficial. It helps if you can show a genuine interest in the organisation. This includes knowing about the ethos of the organisation or if it is known for its work in a particular specialty. It is important to review the job description to see how well your skillset and CV match the role.

It is important to try to sleep well the night before, have a good breakfast and stay hydrated as these will all help you to focus and perform well. Know exactly where the interview is to take place to ensure you have allowed adequate time to get there. Aim to arrive 10 minutes early and allow time for unexpected delays.

Turn your phone off, discard any chewing gum and dress appropriately. Wear smart but comfortable clothes. Some interviews may be held online, but the same principles should apply. If your interview is via a video call, be mindful of what is visible in the background.

During the interview

Make eye contact and smile when greeting your interviewers. Be aware of your body language and the way you communicate. Some people tend to slouch, fidget or speak too quickly when they become anxious. Similarly, some people tend to punctuate sentences with 'um' or 'ah' when nervous. Practising with friends/family beforehand and asking for honest feedback can help to make you aware of what to look out for.

If you are unsure of a question, simply ask the interviewer to repeat it. This will offer you time to calm yourself down and think about your answer.

The 'STAR' technique *(see Table)* can be helpful when answering competency-based questions, as it can be used to demonstrate previous experience, for example: 'How would you prioritise your patient caseload?' or 'Tell me about a time you managed conflict on your ward'.

'STAR' technique	
Situation	Describe the event or situation that you were in
Task	Explain the task you had to complete
Action	Describe the specific actions you took to complete the task
Result	Close with the results of your efforts

Some questions may be skills- or knowledge-based, eg. 'Tell me about the ISBAR',* while others will focus on your professional development, eg. 'How do you keep up to date in your practice?'

Remember that you are applying for a staff nurse/midwife position, and so you should avoid limiting yourself by using phrases like 'I can't do that as I'm only an intern'. Instead, you could say what you would do as a staff nurse/midwife.

After the interview

Interviewers will often ask candidates if they have any questions and it can be helpful to come up with a few to demonstrate your interest. Thanking your interviewers for their time will leave them with a positive impression.

Whether or not the interview goes well, you can ask for feedback on the interview after you are contacted with a result. This can help you to improve your interview skills for the next occasion.

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

** ISBAR (Identify, Situation, Background, Assessment and Recommendation) is a mnemonic created to improve safety in the transfer of critical information.*

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SCAN ME!

A column by Maureen Flynn

Quality & Safety

Explore the QPS Education and Learning Programmes

EVERYTHING we do as nurses and midwives is about providing safe quality patient care. In this month's column we introduce a new publication that brings together, in one place, information on a wide range of Quality and Patient Safety (QPS) learning programmes.[1]

A key commitment of the Patient Safety Strategy 2019-2024 strategy[2] is to empower and engage staff and patients to improve patient safety. The National Quality and Patient Safety Directorate (NQPSD) work in partnership with HSE operations, patient representatives and other partners to improve patient safety and quality of care. We aim to honour this commitment by supporting a culture of continual learning through education programmes, resources and learning opportunities.

QPS prospectus

The annual prospectus provides information about the education and learning programmes available to staff, students and patient partners through e-learning, virtual learning and face to face workshops. The programmes cover key areas relating to quality and patient safety such as:

- Quality improvement
- Incident management
- Open disclosure
- Clinical audit
- Human factors.

This year we have expanded the prospectus to include contributions from colleagues in the HSE National Governance and Risk, National Complaints, Governance and Learning, the National Safeguarding Office, Antimicrobial Resistance and Infection Control (AMRIC) Organisation Development, Change and Innovation as well as information about programmes offered by the Library Services to support education, learning and research.

Programme topics

- Quality improvement
- Incident management
- Open disclosure
- Clinical audit
- Human factors
- Schwartz rounds
- Liberating structures
- Data for decision making NPQSD
- Complaints, governance and learning
- Governance and risk
- Safeguarding
- Antimicrobial resistance and control (AMRIC)
- Change and innovation
- Library services
- Connecting with QPS

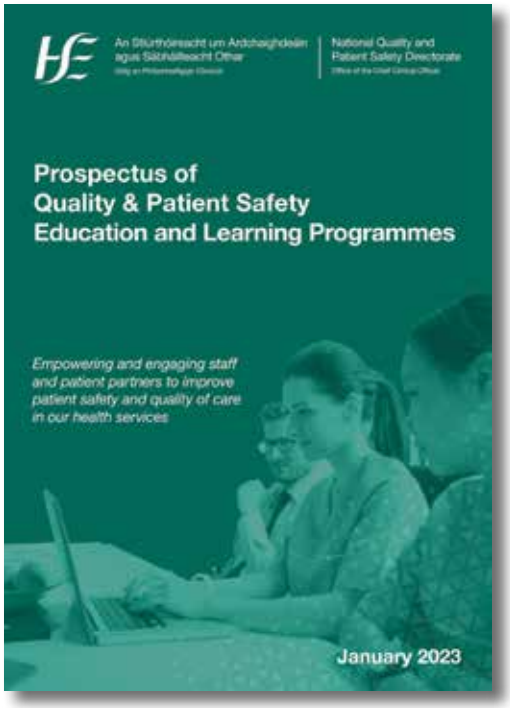
The prospectus also contains information on ways to connect, network and keep engaged. Following on from your learning programme you can join in QPS events and networking opportunities. You can register for QPS TalkTime and Open Disclosure webinars, listen to "Walk and Talk Improvement" podcast episodes, follow us on social media (Twitter, LinkedIN, YouTube), subscribe to our newsletter or join the QPS Ireland Network Map. Information and links are contained in the prospectus and at: **www.hse.ie/nqpsd**

How it helps you

This resource will help you identify learning programmes that will support you in your day to day work to improve quality and patient safety and it will also support you in planning your personal or professional development. Many of the programmes are eligible for continuing education units (CEUs) from the Nursing and Midwifery Board of Ireland. You might consider talking about the prospectus programmes at your next team, ward, or department meeting.

Access

The QPS Prospectus can be found at:



www.hse.ie/nqpsd or by scanning the QR code. For further information you can contact the team by email at QPS.EDUCATION@hse.ie.

We hope you find it a useful resource to support you in your own development and we look forward to welcoming you onto our programmes in 2023.

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

Acknowledgements:
Thank you to my colleagues Dr Mary Browne and Veronica Hanlon from the QPS Education team for their assistance in writing this column. We are very grateful for everyone's important contribution and appreciate the collaboration in the preparation of this new resource

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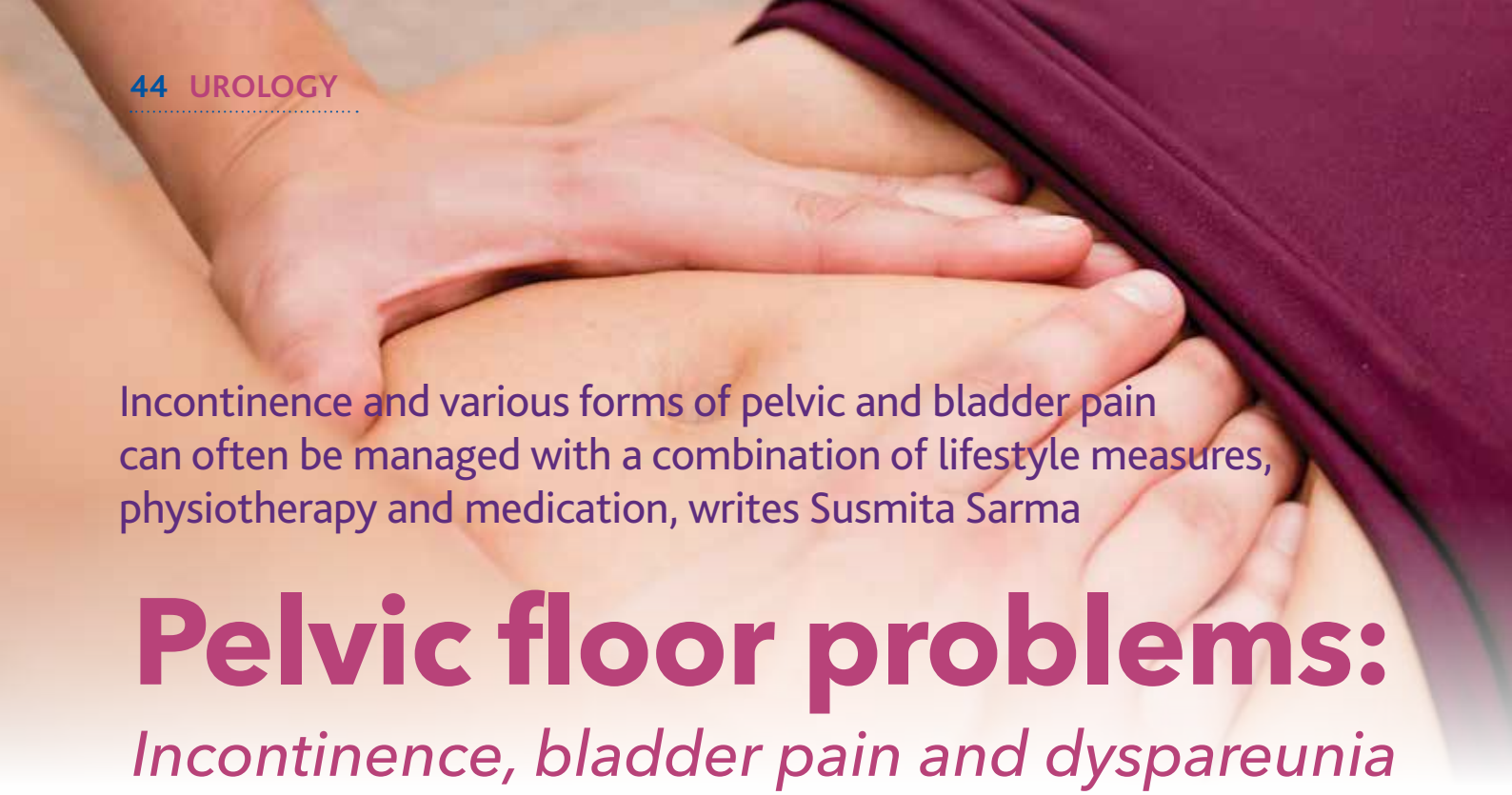

Incontinence and various forms of pelvic and bladder pain can often be managed with a combination of lifestyle measures, physiotherapy and medication, writes Susmita Sarma

Pelvic floor problems:

Incontinence, bladder pain and dyspareunia

URINARY incontinence is the complaint of any involuntary passage of urine. It is further classified as:

- Stress urinary incontinence (SUI) – involuntary urine leakage on effort or exertion or on sneezing or coughing
- Urge urinary incontinence (UUI) – involuntary urine leakage accompanied or immediately preceded by urgency (a sudden compelling desire to urinate that is difficult to defer).

Some patients may experience mixed symptoms. The true incidence of incontinence is not known as many patients do not disclose having symptoms due to feelings of embarrassment and it is often present for many years prior to seeking assistance.

Prevalence data on incontinence vary between countries and on how the data is gathered. Some studies report up to 30% of women of all ages having symptoms and the incidence increases with age. While Irish data is limited, the Irish Longitudinal Study on Ageing (TILDA) has shown an incidence of 1:7 adults rising to 1:3 in older adults with only 40% reporting incontinence to a healthcare professional.[1,2] There is a known association with poorer quality of life; however, many patients believe that it is a normal part of the ageing process and are unaware that there are treatments available. Urinary incontinence commonly occurs during pregnancy, affecting 26-70% of women. Irish data from the MAMMI study estimates that up to 34% of young women experience stress incontinence before their first pregnancy.[3]

There are many risk factors for the development of urinary incontinence including pregnancy, pelvic surgery, postmenopausal atrophy, tumours, infections, medications, high impact sports etc.

Assessment

The initial clinical assessment is aimed at defining the woman's type of incontinence into stress incontinence, urge incontinence/overactive bladder (OAB) or mixed urinary incontinence (MUI).[4] By defining the type of incontinence, initial treatment can then be started. A detailed history and examination are required with consideration given to modifiable risk factors that may affect incontinence such as obesity, fluid intake and medication as well as practical issues such as toilet access and mobility. Examination and history taking will highlight which patients need referral. Concerns over the presence of pelvic masses, haematuria, prolapse beyond the introitus, pain or suspected neurological disorder should all prompt a specialised referral.

A pelvic exam to rule out pelvic masses and significant pelvic organ prolapse should be followed by a urinalysis to rule out urinary tract infection (UTI). Perineal excoriation secondary to frequent contact with urine should be looked for and barrier creams advised if necessary. Bladder diaries recorded over three days give valuable information on fluid intake, variation between day and night, and bladder capacity.

In the absence of concerning features such as haematuria or previous surgery, there is no indication for invasive investigations such as cystoscopy or urodynamics before starting conservative treatments. If women have a history suggestive of a voiding dysfunction or recurrent UTIs, then they should have an assessment of post-void residual. This can be done by bladder scan or ultrasound. There is no other imaging required in the routine assessment of incontinence.

Treatment

Treatment for urinary incontinence covers conservative/lifestyle changes, physical therapy, pharmacotherapy and surgical interventions. For many women, exercise, weight loss and cigarette cessation have been recommended but there is a lack of evidence for these interventions with minimal randomised trials published. There is an association between obesity and both SUI and UUI, with evidence for weight loss and improvement in SUI symptoms in morbidly obese women, but less so in moderately obese patients.

Weight loss is recommended for all women with a BMI > 30.[4] While there is evidence for the implication of cigarette smoking and constipation in the pathogenesis of incontinence, again the evidence for improvement with intervention is lacking.

In women who have documented excessive or restricted fluid intake, intervention may be required. Too little fluid can predispose to UTIs, constipation and dehydration, too much can result in excessive frequency. A high fruit intake can also result in excessive urinary frequency. Some women may benefit from a reduction in caffeinated and carbonated fluids as well as alcohol. Studies are few but do show in urge symptoms an association with caffeine and an association of both SUI and UUI with carbonated drinks.

Some women may benefit from supportive underwear which gives direct perineal and urethral support. There is also

an increasing number of intravaginal continence devices which can offer relief from symptoms such as the incontinence ring pessary, Contiform pessary and the disposable Contrelle Activgard.

Pelvic floor muscle training

Pelvic floor muscle training (PFMT) under the supervision of a physiotherapist has been shown to be effective in reducing SUI in 40-60% of women and has become the mainstay of treatment in recent years. The distinction between pelvic floor muscle training with and without a physiotherapist must be emphasised as 50% of women cannot perform a correct pelvic floor muscle contraction.[5] There is huge importance in teaching pelvic floor muscle training during a first pregnancy, and this has been shown to reduce the incidence of post-partum incontinence.

The goal of PFMT is to improve the strength/timing of a pelvic floor contraction and is recommended as first-line treatment for SUI and mixed urinary incontinence (MUI) in women.[4] There is variation in pelvic floor programmes which makes comparison difficult. NICE guidelines recommend a programme of at least eight contractions performed at least three times a day.[4] A minimum of three months duration is suggested before an improvement in symptoms may be noted.

Bladder training

Bladder training or bladder drill can be a useful tool in the treatment of UUI and MUI. It aims to increase the time intervals between voids and reduce incontinence episodes. NICE guidelines recommend a minimum of six weeks training as first-line management of UUI and MUI as well as in cases of resistant OAB along with antimuscarinic treatment.[4] Prompted and timed voiding/toileting regimes are recommended for women who are incapable of independent toileting or impaired cognitive function.

Role of urodynamics

Urodynamic testing is an invasive procedure and does not need to be carried out prior to starting treatment for urinary incontinence, however, it is useful for women who have failed multiple medications for OAB/UUI. It is not considered necessary prior to surgical treatment for stress incontinence but in practice is usually carried out before same. It can help bring clarity where the type of incontinence is unclear from history and examination and if there are symptoms suggestive of voiding dysfunction. It is also helpful where there has been a history of previous surgery for stress incontinence.

Medications

Medication for the overactive bladder is based on the inhibition of acetylcholine, which stimulates detrusor contractions via muscarinic receptors. Most anticholinergics have similar efficacy with adverse effects depending on receptor selectivity, peak serum levels and route of delivery. Typical antimuscarinic side-effects include dry mouth, constipation, blurred vision and drowsiness

Before starting medication, it is important to explain to women that 60% of users will see an improvement, to also explain the common side-effects and that the likelihood is that it may take over four weeks to see an improvement in symptoms. NICE guidelines recommend using the medication with the lowest acquisition cost.[4] HSE guidelines recommends tolterodine ER for first-line choice for this reason, not because of better success rates.[6] See *Table 1* for list of OAB medications.

OAB and UUI increase as we age but there is concern with the use of OAB medication in patients, with conflicting reports of adverse cognitive effects from antimuscarinics that have anticholinergic properties. The ageing brain is deficient in cholinergic neurotransmission and muscarinic receptors. The older less selective antimuscarinics were shown to decrease cognitive function in women, while the relatively newer antimuscarinics with more selective affinity for muscarinic receptors have been shown to be safe in older people.[4]

Transdermal oxybutynin can be especially useful for women who do not tolerate oral medication and as it bypasses hepatic metabolism, it has a very favourable side-effect profile.

Desmopressin can be used for troublesome nocturia. It is a synthetic analogue of anti-diuretic hormone and reduces urine production. Clinically significant hyponatraemia is reported in 5% of patients and sodium levels should be monitored. There is reasonable data for its use in over 65s short-term but no long-term data. Caution is also needed in those with cystic fibrosis and in over 65s with cardiovascular disease or hypertension.

There have also been several studies which looked at the combination of anticholinergic medication where monotherapy has not sufficiently controlled symptoms and these have shown dual therapy to be safe and effective.

Table 1: List of OAB medication

- Fesoterodine 4mg and 8mg
- Mirabegron 25mg and 50 mg
- Solifenacin 5mg and 10 mg
- Tolterodine 2mg and 4mg extended release
- Oxybutynin 5mg and transdermal patch 3.9mg/24 hour
- Trospium 20mg
- Propiverine 15mg BD or 30 mg extended release

Vaginal oestrogen is safe and effective in treating vaginal atrophy and can be useful in treating women with OAB.[4] Oestrogen treatment results in the increased thickness of the epithelium and bladder and can help reduce OAB symptoms.

Medication for stress incontinence

Duloxetine is the only medication licensed for use for stress incontinence. Duloxetine is a balanced dual serotonin and norepinephrine reuptake inhibitor and acts on Onuf's nucleus of the sacral spinal cord. It results in a stronger urethral contraction and persistent sphincter tone during the storage phase. Nausea is the most common side-effect and the main reason for discontinuation. It is not recommended for first-line treatment for stress incontinence but does have use for women who have failed conservative treatment and where further treatment such as surgery is not available.

Other treatments

Botox

Patients who fail conservative measures and have trialled two or more anticholinergic medications can be offered botulinum toxin. Botox causes full or partial paralysis and weakening of overactive muscle, with a median duration of effect of six months. Adverse effects include UTI and voiding dysfunction. The majority of patients who commence treatment with botox will require long-term repeat treatments.

Sacral neuromodulation

Sacral neuromodulation (SN) was introduced for wet OAB patients in 1997 and multiple studies have shown its safety and efficacy. Although SN has been shown to have short-term and long-term efficacy, 30-40% of patients experience complications within the first five years, with 33% needing surgical correction by year one due to pain and infections.[7]

Cystoplasty and diversion

Augmentation cystoplasty and urinary diversion are rare surgical procedures for intractable urge incontinence. Augmentation cystoplasty is used in paediatric urology and refractory OAB.

Long-term problems include metabolic disturbance, bacteriuria, urinary tract stones, incontinence, perforation, the need for intermittent self-catheterisation and carcinoma.

For some patients, the creation of an ileal conduit urinary diversion remains another viable option, particularly for those who might be deemed unsuitable for reconstructive bladder surgery. Complications include the risks of recurrent urinary sepsis, and upper tract dilatation, and the possibility of renal function deterioration in the longer term.

Urethral bulking agents

Urethral bulking agents are a minimally invasive surgical treatment for SUI, involving the injection of synthetic materials around the urethra. Urethral bulking agents have typically been used in women wishing to avoid major surgery or mesh tapes or who failed primary surgery.

Intramural bulking agents can be considered for SUI if alternative surgical procedures are not suitable or acceptable to the woman. There is limited evidence on long-term efficacy and adverse events. Side-effects include urinary tract infection, pain and 3% risk of urinary retention.

Autologous rectus fascial sling

A fascial sling uses a strip of rectus fascia harvested from the abdominal wall and placed underneath the urethra to support the urethra during movement. Success rates are up to 85% with 10% risk of retention and 14% of *de novo* detrusor overactivity.

Laser treatment for SUI

Laser treatment was adopted from dermatology and two types are used: non-ablative photothermal Erbium:YAG (Er:YAG) and microablative fractional CO2-laser. These were introduced initially for the treatment of vaginal atrophy and then later for pelvic organ prolapse and urinary incontinence.

Studies have reported improvement for objective and subjective outcome measures; however, these remain small and lack RCTs comparing to other treatments. Side-effects include mild pain, burning and a sense of warmth and after treatment an increase in vaginal discharge. NICE guidelines of May 20218 state that the evidence for laser therapy for SUI shows no short-term safety concerns but there is inadequate evidence on long-term safety and efficacy. NICE suggests it should only be used in the context of research. There is likely to be an increase in data on laser use in the future.

Susmita Sarma is a consultant obstetrician/gynaecologist at Galway University Hospital

Part 2 of this article will discuss the surgical management of pelvic floor problems, faecal incontinence and its treatment, dyspareunia, vulvodynia and bladder pain syndrome

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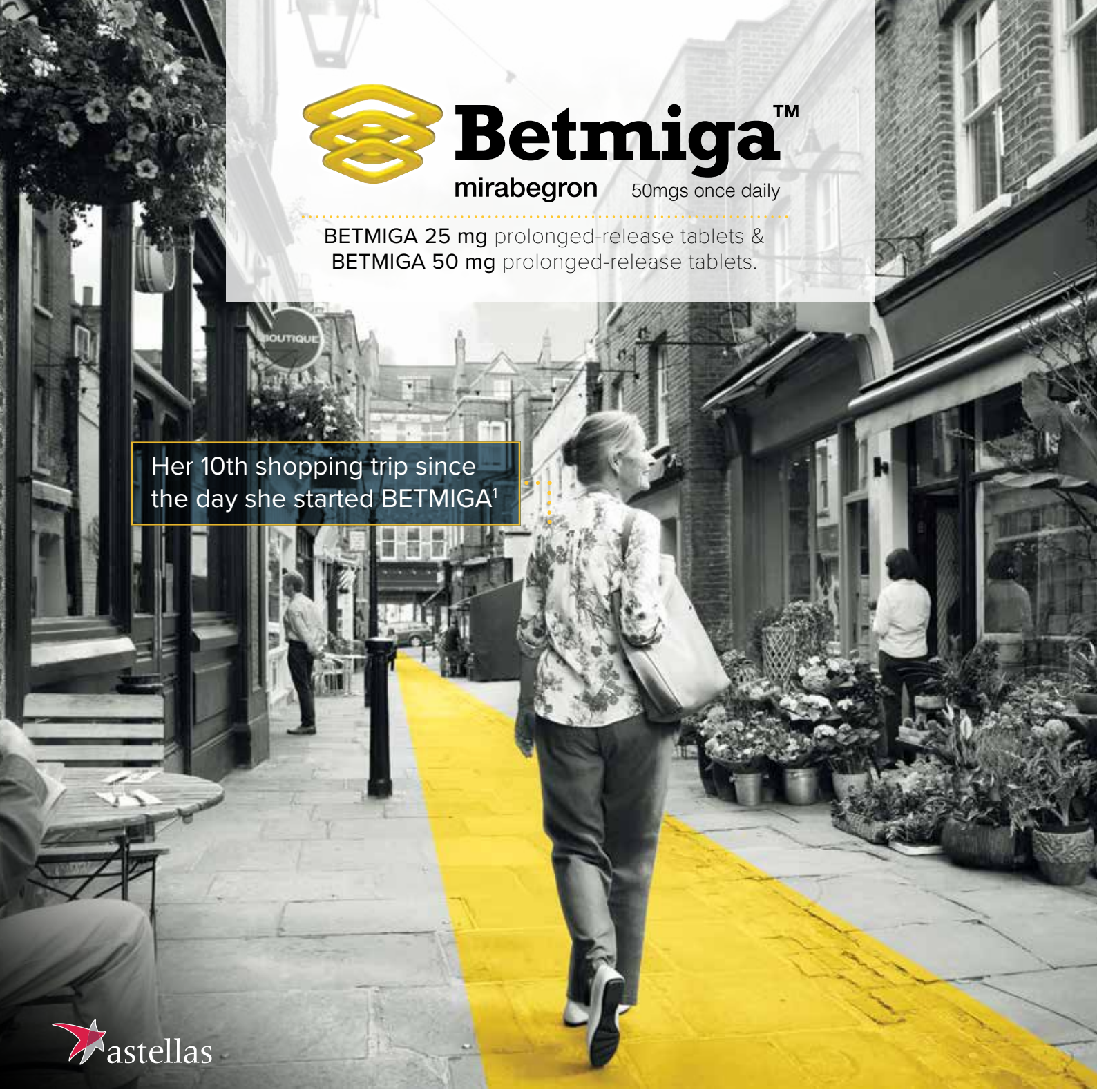

Prescribing Information: BETMIGA™ (mirabegron)
For full prescribing information, refer to the Summary of Product Characteristics (SPC). **Name:** BETMIGA 25 mg prolonged-release tablets & BETMIGA 50 mg prolonged-release tablets. **Presentation:** Prolonged-release tablets containing 25 mg or 50 mg mirabegron. **Indication:** Symptomatic treatment of urgency, increased micturition frequency and/or urgency incontinence as may occur in adult patients with overactive bladder (OAB) syndrome. **Posology and administration:** The recommended dose is 50 mg orally once daily in adults (including elderly patients). Mirabegron should not be used in paediatrics for OAB. A reduced dose of 25 mg once daily is recommended for special populations (please see the full SPC for information on special populations). The tablet should be taken with liquids, swallowed whole and is not to be chewed, divided, or crushed. The tablet may be taken with or without food. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients listed in section 6.1 of the SPC. Severe uncontrolled hypertension defined as systolic blood pressure ≥ 180 mm Hg and/or diastolic blood pressure ≥ 110 mm Hg. **Warnings and Precautions:** Renal impairment: BETMIGA has not been studied in patients with end stage renal disease (eGFR < 15 ml/min/1.73 m^2 or patients requiring haemodialysis) and, therefore, it is not recommended for use in this patient population. Data are limited in patients with severe renal impairment (eGFR 15 to 29 ml/min/1.73 m^2); based on a pharmacokinetic study (see section 5.2 of the SPC) a dose of 25 mg once daily is recommended in this population. This medicinal product is not recommended for use in patients with severe renal impairment (eGFR 15 to 29 ml/min/1.73 m^2) concomitantly receiving strong CYP3A inhibitors (see section 4.5 of the SPC). Hepatic impairment: BETMIGA has not been studied in patients with severe hepatic impairment (Child-Pugh Class C) and, therefore, it is not recommended for use in this patient population. This medicinal product is not recommended for use in patients with moderate hepatic impairment (Child-Pugh B) concomitantly receiving strong CYP3A inhibitors (see section 4.5 of the SPC). Hypertension: Mirabegron can increase blood pressure. Blood pressure should be measured at baseline and periodically during treatment with mirabegron, especially in hypertensive patients. Data are limited in patients with stage 2 hypertension (systolic blood pressure ≥ 160 mm Hg or diastolic blood pressure ≥ 100 mm Hg). Patients with congenital or acquired QT prolongation: BETMIGA, at therapeutic doses, has not demonstrated clinically relevant QT prolongation in clinical studies (see section 5.1 of the SPC). However, since patients with a known history of QT prolongation or patients who are taking medicinal products known to prolong the QT interval were not included in these studies, the effects of mirabegron in these patients is unknown. Caution should be exercised when administering mirabegron in these patients. Patients with bladder outlet obstruction and patients taking antimuscarinics medicinal products for OAB: Urinary retention in patients with bladder outlet obstruction (BOO) and in patients taking antimuscarinic medicinal products for the treatment of OAB has been reported in postmarketing experience in patients taking mirabegron. A controlled clinical safety study in patients with BOO did not demonstrate increased urinary retention in patients treated with BETMIGA; however, BETMIGA should be administered with caution to patients with clinically significant BOO. BETMIGA should also be administered with caution to patients taking antimuscarinic medicinal products for the treatment of OAB. **Interactions:** Caution is advised if mirabegron is co-administered with medicinal products with a narrow therapeutic index and significantly metabolised by CYP2D6. Caution is also advised if mirabegron is co-administered with CYP2D6 substrates that are individually dose titrated. In patients with mild to moderate renal impairment or mild hepatic impairment, concomitantly receiving strong CYP3A inhibitors, the recommended dose is 25 mg once daily. For patients who are initiating a combination of mirabegron and digoxin (P-gp substrate), the lowest dose for digoxin should be prescribed initially (see the SPC for full prescribing information). The potential for inhibition of P-gp by mirabegron should be considered when BETMIGA is combined with sensitive P-gp substrates. Increases in mirabegron exposure due to drug-drug interactions may be associated with increases in pulse rate. **Pregnancy and lactation:** BETMIGA is not recommended in women of childbearing potential not using contraception. This medicinal product is not recommended during pregnancy. BETMIGA should not be administered during breast-feeding. **Undesirable effects:** Summary of the safety profile: The safety of BETMIGA was evaluated in 8433 adult patients with OAB, of which 5648 received at least one dose of mirabegron in the phase 2/3 clinical program, and 622 patients received BETMIGA for at least 1 year (365 days). In the three 12-week phase 3 double blind, placebo controlled studies, 88% of the patients completed treatment with this medicinal product, and 4% of the patients discontinued due to adverse events. Most adverse reactions were mild to moderate in severity. The most common adverse reactions reported for adult patients treated with BETMIGA 50 mg during the three 12-week phase 3 double blind, placebo controlled studies are tachycardia and urinary tract infections. The frequency of tachycardia was 1.2% in patients receiving BETMIGA 50 mg. Tachycardia led to discontinuation in 0.1% patients receiving BETMIGA 50 mg. The frequency of urinary tract infections was 2.9% in patients receiving BETMIGA 50 mg. Urinary tract infections led to discontinuation in none of the patients receiving BETMIGA 50 mg. Serious adverse reactions included atrial fibrillation (0.2%). Adverse reactions observed during the 1-year (long term) active controlled (muscarinic antagonist) study were similar in type and severity to those observed in the three 12-week phase 3 double blind, placebo controlled studies. Adverse reactions: The following list reflects the adverse reactions observed with mirabegron in adults with OAB in the three 12-week phase 3 double blind, placebo controlled studies. The frequency of adverse reactions is defined as follows: very common (≥ 1/10); common (≥ 1/100 to < 1/10); uncommon (≥ 1/1,000 to < 1/100); rare (≥ 1/10,000 to < 1/1,000); very rare (< 1/10,000) and not known (cannot be established from the available data). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. The adverse events are grouped by MedDRA system organ class. *Infections and infestations:* Common: Urinary tract infection, Uncommon: Vaginal infection, Cystitis. *Psychiatric disorders:* Not known (cannot be estimated from the available data): Insomnia*, Confusional state*. *Nervous system disorders:* Common: Headache*, Dizziness*. *Eye disorders:* Rare: Eyelid oedema. *Cardiac disorders:* Common: Tachycardia, Uncommon: Palpitation, Atrial fibrillation. *Vascular disorders:* Very rare: Hypertensive crisis*. *Gastrointestinal disorders:* Common: Nausea*, Constipation*, Diarrhoea*, Uncommon: Dyspepsia, Gastritis, Rare: Lip oedema. *Skin and subcutaneous tissue disorders:* Uncommon: Urticaria, Rash, Rash macular, Rash papular, Pruritus, Rare: Leukocytoclastic vasculitis, Purpura, Angioedema*. *Musculoskeletal and connective tissue disorders:* Uncommon: Joint swelling. *Renal and urinary disorders:* Rare: Urinary retention*. *Reproductive system and breast disorders:* Uncommon: Vulvovaginal pruritus. *Investigations:* Uncommon: Blood pressure increased, GGT increased, AST increased, ALT increased. * signifies adverse reactions observed during post-marketing experience. Prescribers should consult the SPC in relation to other adverse reactions. **Overdose:** Treatment for overdose should be symptomatic and supportive. In the event of overdose, pulse rate, blood pressure, and ECG monitoring is recommended. **Basic NHS Cost:** Great Britain (GB)/Northern Ireland(NI): BETMIGA 50 mg x 30 = £29, BETMIGA 25 mg x 30 tablets = £29. Ireland (IE): POA. **Legal classification:** POM. **Marketing Authorisation number(s):** (GB): PLGB 00166/0415-0416. NI/IE: EU/1/12/809/001-006, EU/1/12/809/008-013, EU/1/12/809/015-018. **Marketing Authorisation Holder:** GB: Astellas Pharma Ltd., 300 Dashwood Lang Road, Bourne Business Park, Addlestone, United Kingdom, KT15 2NX. NI/IE: Astellas Pharma Europe B.V. Sylviusweg 62, 2333 BE Leiden, The Netherlands. **Date of Preparation of Prescribing information:** January 2023. **Job bag number:** MAT-IE-BET-2023-00001. **Further information available from:** GB/NI: Astellas Pharma Ltd, Medical Information: 0800 783 5018. IE: Astellas Pharma Co. Ltd., Tel.: +353 1 467 1555. For full prescribing information, please see the Summary of Product Characteristics, which may be found at: GB: www.medicines.org.uk; NI: https://www.emcmedicines.com/en-GB/northernireland/; IE: www.medicines.ie.

United Kingdom (GB/NI)
Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to Astellas Pharma Ltd. on 0800 783 5018.

Ireland
Adverse events should be reported. Healthcare professionals are asked to report any suspected adverse reactions via: HPRA Pharmacovigilance, Website: www.hpra.ie or Astellas Pharma Co. Ltd. Tel: +353 1 467 1555, E-mail: irishdrugsafety@astellas.com.

Date of preparation: January 2023

References: 1. Freeman R, et al. Current Medical Research and Opinion 2017. https://doi.org/10.1080/03007995.2017.1419170.

MAT-IE-BET-2023-00002

KISQALI®
ribociclib

KISQALI—the only CDK4/6 inhibitor with statistically significant overall survival across all 3 phase III trials[1–3]

NCCN RECOMMENDED

National Comprehensive Cancer Network® (NCCN®) now recognizes ribociclib (KISQALI®) + ET, a Category 1 preferred treatment option, for showing an **OS BENEFIT IN 1L PATIENTS** with HR+/HER2- mBC[4]

KISQALI is not indicated for concomitant use with tamoxifen[4]

1L, first line; **2L,** second line; **ET,** endocrine therapy; **LHRH,** luteinizing hormone-releasing hormone, **aBC**, advanced breast cancer.

ESMO - European society of medical oncology **SABC -** San Antonio Breast Cancer Conference **ASCO -** American Society of Clinical Oncology

REFERENCES:

1. Hortobagyi GN, Stemmer SM, Burris HA, et al. Overall survival results from the phase III MONALEESA-2 trial of postmenopausal patients with HR+/HER2– advanced breast cancer treated with endocrine therapy ± ribociclib. Presented at: European Society of Medical Oncology; September 16-21, 2021.
2. Im S-A, Lu Y-S, Bardia A, et al. Overall survival with ribociclib plus endocrine therapy in breast cancer. *N Engl J Med.* 2019;381(4):307-316.
3. Slamon DJ, Neven P, Chia S, et al. Overall survival with ribociclib plus fulvestrant in advanced breast cancer. *N Engl J Med.* 2020;382(6):514-524.
4. Referenced with permission from the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Breast Cancer V.4.2022. © National Comprehensive Cancer Network, Inc. 2021. All rights reserved. Published June 21, 2022. Accessed July 29, 2022. To view the most recent and complete version of the guideline, go online to NCCN.org. NCCN makes no warranties of any kind whatsoever regarding their content, use, or application and disclaims any responsibility for their application or use in any way.

ABBREVIATED PRESCRIBING INFORMATION

Please refer to Summary of Product Characteristics (SmPC) before prescribing.
Kisqali (ribociclib) 200 mg film-coated tablets

Presentation: Film coated tablets (FCT) containing 200 mg of ribociclib and 0.344 mg soya lecithin.

Indications: Kisqali is indicated for the treatment of women with 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 fulvestrant as initial endocrine-based therapy, or in women who have received prior endocrine therapy

In pre or perimenopausal women, the endocrine therapy should be combined with a luteinising hormone releasing hormone (LHRH) agonist.

Dosage and administration:

Adults: The recommended dose is 600 mg (3 x 200 mg FCT) taken orally, once daily for 21 consecutive days followed by 7 days off treatment, resulting in a complete cycle of 28 days.

Kisqali should be used together with 2.5 mg letrozole or another aromatase inhibitor or with 500 mg fulvestrant.

When Kisqali is used in combination with an aromatase inhibitor, the aromatase inhibitor should be taken orally once daily continuously throughout the 28 day cycle. Please refer to the Summary of Product Characteristics (SmPC) of the aromatase inhibitor for additional details.

When Kisqali is used in combination with fulvestrant, fulvestrant is administered intramuscularly on days 1, 15 and 29, and once monthly thereafter. Please refer to the SmPC of fulvestrant for additional details.

Treatment of pre and perimenopausal women with the approved Kisqali combinations should also include an LHRH agonist in accordance with local clinical practice.

Management of severe or intolerable adverse reactions (ARs) may require temporary dose interruption, reduction or discontinuation of Kisqali. Please see section 4.2 of SmPC for recommended dose modification guidelines.

Kisqali can be taken with or without food (see section 4.5).The tablets should be swallowed whole and should not be chewed, crushed or split prior to swallowing.

Special populations: ♦*Renal impairment:* Mild or moderate: No dose adjustment is necessary. Severe: A starting dose of 200 mg is recommended in patients with severe renal impairment. Kisqali has not been studied in breast cancer patients with severe renal impairment. Caution should be used in patients with severe renal impairment with close monitoring for signs of toxicity. ♦*Hepatic impairment:* Mild: No dose adjustment is necessary. Moderate or severe: Dose adjustment is required, and the starting dose of 400 mg once daily is recommended. ♦*Elderly (>65 years):* No dose adjustment is required. ♦*Pediatrics(<18 years):* Safety and efficacy have not been established.

Contraindications: Hypersensitivity to the active substance or to peanut, soya or any of the excipients.

Warnings/Precautions: ♦***Neutropenia*** was most frequently reported AR. A complete blood count (CBC) should be performed before initiating treatment. CBC should be monitored every 2 weeks for the first 2 cycles, at the beginning of each of the subsequent 4 cycles, then as clinically indicated. Febrile neutropenia was reported in 1.4% of patients exposed to Kisqali in the phase III clinical studies. Patients should be instructed to report any fever promptly.Based on the severity of the neutropenia, Kisqali may require dose interruption, reduction, or discontinuation. ♦***Hepatobiliary toxicity*** - increases in transaminases have been reported. Liver function tests (LFTs) should be performed before initiating treatment. LFTs should be monitored every 2 weeks for the first 2 cycles, at the beginning of each of the subsequent 4 cycles, then as clinically indicated. If grade ≥ 2 abnormalities are noted, more frequent monitoring is recommended.

Recommendations for patients who have elevated AST/ALT grade ≥ 3 at baseline have not been established. Based on the severity of transaminase elevations, Kisqali may require dose interruption, reduction, or discontinuation. ♦***QT interval prolongation*** has been reported with Kisqali. The use of Kisqali should be avoided in patients who have already or who are at significant risk of developing QTc prolongation. The ECG should be assessed prior to initiation of treatment. Treatment with Kisqali should be initiated only in patients with QTcF values <450 msec. The ECG should be repeated at approximately Day 14 of the first cycle and at the beginning of the second cycle, then as clinically indicated. In case of QTcF prolongation during treatment, more frequent ECG monitoring is recommended Appropriate monitoring of serum electrolytes (including potassium, calcium, phosphorous, and magnesium) should be performed prior to initiation of treatment, at the beginning of the first 6 cycles, and then as clinically indicated. Any abnormality should be corrected before the start of Kisqali treatment. Based on the observed QT prolongation during treatment, Kisqali may require dose interruption, reduction, or discontinuation. Based on the E2301 study QTcF interval data, Kisqali is not recommended for use in combination with tamoxifen. ♦***Critical visceral disease.*** The efficacy and safety of ribociclib have not been studied in patients with critical visceral disease. ♦***Severe cutaneous reactions*** Toxic epidermal necrolysis (TEN) has been reported with Kisqali treatment. If signs and symptoms suggestive of severe cutaneous reactions (e.g. progressive widespread skin rash often with blisters or mucosal lesions) appear, Kisqali should be discontinued immediately. ♦***Interstitial lung disease/pneumonitis*** ILD/pneumonitis has been reported with CDK4/6 inhibitors including Kisqali. Based on the severity of the ILD/pneumonitis, which may be fatal, Kisqali may require dose interruption, reduction or discontinuation as described in SmPC.

Patients should be monitored for pulmonary symptoms indicative of ILD/pneumonitis which may include hypoxia, cough and dyspnoea and dose modifications should be managed in accordance with Table 5 (see section 4.2)

♦***Blood creatinine increase*** ribociclib may cause blood creatinine increase – if this occurs it is recommended that further assessment of the renal function be performed to exclude renal impairment.

♦**CYP3A4 substrates.** ribociclib may interact with medicinal products which are metabolised via CYP3A4, which may lead to increased serum concentrations of CYP3A4 substrates (see section 4.5). Caution is recommended in case of concomitant use with sensitive CYP3A4 substrates with a narrow therapeutic index and the SmPC of the other product should be consulted for the recommendations regarding co administration with CYP3A4 inhibitors.

Pregnancy, Fertility and Lacation

♦***Pregnancy:*** Pregnancy status should be verified prior to starting treatment as Kisqali can cause foetal harm when administered to a pregnant woman.

♦***Women of childbearing potential*** who are receiving Kisqali should use effective contraception (e.g. double-barrier contraception) during therapy and for at least 21 days after stopping treatment with Kisqali. ♦***Breast feeding:*** Patients receiving Kisqali should not breast feed for at least 21 days after the last dose. ♦***Fertility:*** There are no clinical data available regarding effects of ribociclib on fertility. Based on animal studies, ribociclib may impair fertility in males of reproductive potential.

♦***Effects on ability to drive and use machines*** Patients should be advised to be cautious when driving or using machines in case they experience fatigue, dizziness or vertigo during treatment with Kisqali.

Interactions: ♦Concomitant use of strong CYP3A4 inhibitors should be avoided, including, but not limited to, clarithromycin, indinavir, itraconazole, ketoconazole, lopinavir, ritonavir, nefazodone, nelfinavir, posaconazole, saquinavir, telaprevir, telithromycin, verapamil, and voriconazole. Alternative concomitant medicinal products with less potential to inhibit CYP3A4 should be considered. Patients should be monitored for ARs. If concomitant use of a strong CYP3A4 inhibitor cannot be avoided, the dose of Kisqali should be reduced (see section 4.2 of SmPC). ♦Grapefruit or grapefruit juice should be avoided. ♦Concomitant use of strong CYP3A4 inducers should be avoided, including, but not limited to, phenytoin, rifampicin, carbamazepine and St John's Wort *(Hypericum perforatum).* An alternative medicinal product with no or minimal potential to induce CYP3A4 should be considered. ♦Caution is recommended when Kisqali is administered with sensitive CYP3A4 substrates with narrow therapeutic index (including, but not limited to, alfentanil, ciclosporin, everolimus, fentanyl, sirolimus, and tacrolimus), and their dose may need to be reduced. ♦Concomitant administration of Kisqali at the 600 mg dose with the following CYP3A4 substrates should be avoided: alfuzosin, amiodarone, cisapride, pimozide, quinidine, ergotamine, dihydroergotamine, quetiapine, lovastatin, simvastatin, sildenafil, midazolam, triazolam. ♦Caution and monitoring for toxicity are advised during concomitant treatment with sensitive substrates of drug transporters P-gp, BCRP, OATP1B1/1B3, OCT1, OCT2, MATE1 and BSEP which exhibit a narrow therapeutic index, including but not limited to digoxin, pitavastatin, pravastatin, rosuvastatin and metformin. ♦Co-administration of Kisqali with medicinal products with known potential to prolong the QT interval should be avoided such as anti-arrhythmic medicinal products (including, but not limited to, amiodarone, disopyramide, procainamide, quinidine and sotalol) and other medicinal products known to prolong the QT interval including, but not limited to, chloroquine, halofantrine, clarithromycin, ciprofloxacin, levofloxacin, azithromycin, haloperidol, methadone, moxifloxacin, bepridil, pimozide and intravenous ondansetron. **Kisqali is not recommended for use in combination with tamoxifen.**

Adverse reactions: ♦Very common: Infections, neutropenia, leukopenia, anaemia lymphopenia, decreased appetite, headache, dizziness, dyspnoea, cough, nausea, diarrhoea, vomiting, constipation, stomatitis, abdominal pain, dyspepsia alopecia, rash, pruritus, back pain, fatigue, peripheral oedema, asthenia, pyrexia, abnormal liver function tests. ♦Common:, thrombocytopenia, febrile neutropenia, hypocalcaemia, hypokalaemia, hypophosphataemia, vertigo, lacrimation increased, dry eye, syncope, dysgeusia, , hepatotoxicity, erythema, dry skin, vitiligo, dry mouth, oropharyngeal pain, blood creatinine increased, electrocardiogram QT prolonged. ♦Please refer to SmPC for a full list of adverse reactions.

Legal Category: POM

Pack sizes: Unit packs containing 21, 42 or 63 FCTs. Not all pack sizes may be marketed.

Marketing Authorisation Holder:
Novartis Europharm Limited
Vista Building, Elm Park, Merrion Road, Dublin 4 Ireland

Marketing Authorisation Numbers:
EU/1/17/1221/003 & 005.

Full prescribing information is available on request from Novartis Ireland Ltd, Vista Building, Elm Park Business Park, Dublin 4. Tel: 01 2601255 or at www.medicines.ie

Prescribing information last revised: April 2022

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

NOVARTIS

KISQALI® ribociclib

Novartis Ireland Ltd,
Vista Building, Elm Park Business Park,
Merrion Road, Dublin 4, D04 A9N6

November 2022 | IE253121

Focus on: Breast cancer

WIN takes a look at some recently published breast cancer research

Scientists discover a new way to help prevent breast cancer 'time bomb'

RESEARCHERS have discovered why breast cancer cells that have spread to the lungs may 'wake up' following years of dormancy to form incurable secondary tumours. Their research, published in the journal *Nature Cancer,* has uncovered the mechanism that triggers this breast cancer 'time bomb'.

Patients with oestrogen receptor positive (ER+) breast cancer, the most common type, have a continued risk of their cancer recurring in another part of their body for many years or even decades after their original diagnosis and treatment.

The research showed how molecular changes within the lung that occur during ageing can support the growth of these secondary tumours. The team at the Institute of Cancer Research, London, found that the PDGF-C protein, which is present in the lung, plays a key role in influencing whether inactive breast cancer cells stay dormant or 'wake up'.

They discovered that if the level of PDGF-C increases, which is more likely in an ageing lung or when its tissue becomes damaged or scarred, it can cause the dormant cancer cells to grow and develop into secondary breast cancer. The researchers then explored whether blocking PDGF-C activity could help prevent the 'reawakening' of these cells and the growth of secondary tumours.

Working with mice with ER+ tumours, researchers in the Breast Cancer Now Toby Robins Research Centre at the Institute of Cancer Research targeted PDGF-C signalling with an existing cancer growth blocker called imatinib, which is currently used to treat patients with chronic myeloid leukaemia. The mice were treated with the drug both before and after the tumours had developed. For both groups, the cancer growth in the lung was significantly reduced. Up to 80% of primary breast cancers are ER+.

Dr Frances Turrell, postdoctoral training fellow in the Division of Breast Cancer Research at the Institute of Cancer Research, London, said: "Cancer cells can survive in distant organs for decades by hiding in a dormant state. We've discovered how aging lung tissue can trigger these cancer cells to 'reawaken' and develop into tumours, and uncovered a potential strategy to 'defuse' these 'time bombs'. We now plan to better unpick how patients might benefit from the existing drug imatinib, and in the long term aim to create more specific treatments targeted at the 'reawakening' mechanism."

Dr Simon Vincent, director of research, support at Breast Cancer Now, which funded the study, said: "We know that for years after finishing breast cancer treatment many women fear the disease returning. This discovery brings us closer to understanding how we can slow down or stop the development of ER+ secondary breast cancer in the lung. It has the potential to benefit thousands of women living with this 'time bomb' in the future, ensuring fewer patients receive the devastating news the disease has spread."

DOI: 10.1038/s43018-023-00525-y

AI can predict the effectiveness of breast cancer chemotherapy

Engineers have developed artificial intelligence (AI) technology to predict if women with breast cancer would benefit from chemotherapy prior to surgery. The new AI algorithm, part of the open-source Cancer-Net initiative led by Dr Alexander Wong, a director of the VIP Lab and the Canada research chair in artificial intelligence and medical imaging, could help unsuitable candidates avoid the serious side effects of chemotherapy and pave the way for better surgical outcomes for those who are suitable.

"Determining the right treatment for a given breast cancer patient is very difficult right now, and it is crucial to avoid unnecessary side effects from using treatments that are unlikely to have real benefit for that patient," said Dr Wong.

"An AI system that can help predict if a patient is likely to respond well to a given treatment gives doctors the tool needed to prescribe the best personalised treatment for a patient to improve recovery and survival."

In a project led by graduate student Amy Tai, the AI software was trained with images of breast cancer made with a new magnetic image resonance modality, invented by Wong and his team, called synthetic correlated diffusion imaging (CDI). With knowledge gleaned from CDI images of old breast cancer cases and information on their outcomes, the AI can predict if pre-operative chemotherapy treatment would benefit new patients based on their CDI images.

Known as neoadjuvant chemotherapy, the pre-surgical treatment can shrink tumours to make surgery possible or easier and reduce the need for major surgery such as mastectomies.

"I'm quite optimistic about this technology as deep-learning AI has the potential to see and discover patterns that relate to whether a patient will benefit from a given treatment," said Dr Wong.

The new AI algorithm and the complete dataset of CDI images of breast cancer have been made publicly available through the Cancer-Net initiative so other researchers can help advance the field.

DOI: 10.48550/arXiv.2211.05308

FOR THE RIGHT PATIENT, AT THE RIGHT TIME

Otezla® (apremilast) 30mg tablets

OTEZLA is the simple oral choice for your adult patients with moderate to severe psoriasis or active psoriatic arthritis[1]

- Long-term safety and efficacy profile spanning 5 years in psoriasis (PsO) and psoriatic arthritis (PsA)[1,2]
- Improved quality of life sustained up to 5 years[1,2]
- No laboratory pre-screening or ongoing drug-specific monitoring[1]
- No label warning against use with live vaccines[1]
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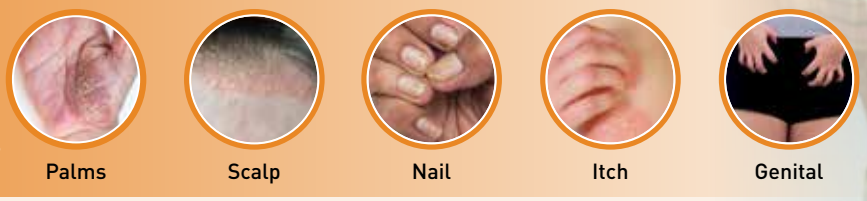

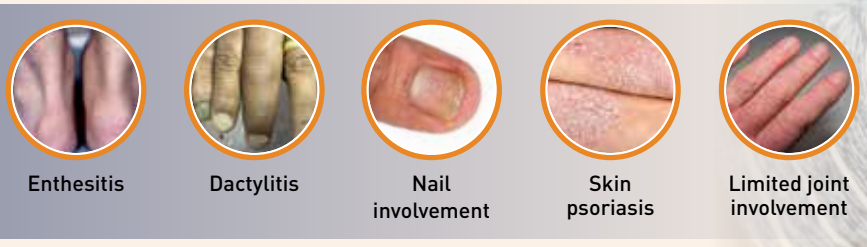

Is now the right time to move your patients on to OTEZLA?

Images depict fictional patients.

OTEZLA is an intracellular PDE4 inhibitor with demonstrated efficacy in high-impact areas, which can improve your patient's quality of life[1–7]

OTEZLA® (apremilast) 10mg, 20mg and 30mg film coated-tablets
Brief Prescribing Information
Refer to the Summary of Product Characteristics (SPC) before prescribing
Further information is available upon request
Presentation: 10mg, 20mg and 30mg film coated-tablets.
Indications: Psoriatic arthritis: OTEZLA, alone or in combination with Disease Modifying Antirheumatic Drugs (DMARDs), is indicated for the treatment of active psoriatic arthritis (PsA) in adult patients who have had an inadequate response or who have been intolerant to a prior DMARD therapy. 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.

Abbreviations: PDE4, phosphodiesterase-4; PsA, psoriatic arthritis; PsO, psoriasis.

References: 1. OTEZLA (apremilast). Summary of Product Characteristics; **2.** Kavanaugh A, et al. *Arthritis Res Ther.* 2019;21:118; **3.** Augustin M, et al. *J Eur Assoc Dermatol Venereol.* 2021;35:123–134; **4.** Wollenhaupt J, et al. Presented at EULAR 2020; 3–6 June 2020; Virtual: Poster FRI0365; **5.** Crowley JA, et al. Presented at the 73rd Annual Meeting of the American Academy of Dermatology; 20–24 March 2015; San Francisco, CA: P894; **6.** Rich P, et al. *J Am Acad Dermatol.* 2016;74(1):134–142; **7.** Reich K, et al. *Dermatol Ther.* 2022;12:203–221.

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

IE-OTZ-0622-00004

Date of preparation: August 2022

AMGEN®

Psoriasis focus

WIN looks at some new research examining the link between psoriasis and depression or anxiety in paediatric patients

A RECENT analysis was conducted by reviewing studies that examined the connection between psoriasis and depression or anxiety in paediatric patients. In a research literature review, an association was identified between paediatric psoriasis and anxiety or depression, although a causal link either proving or disproving this remained unidentified.

Psoriasis is a chronic papulosquamous inflammatory skin disease that presents with abnormal hyperproliferation of the epidermis, resulting in demarcated scaly pink-coloured plaques in white skin and hyper-pigmented brownish-grey plaques in skin of colour.

Due to the presentation of psoriasis as a highly visible skin disease that often causes discomfort as well as symptoms such as skin shedding and hair loss, the study's investigators acknowledged the associated psychological burden that the condition can place on younger patients due to feelings of unattractiveness and social stigmatisation.

This study which examined the consequences of these effects was led by Emily Strouphauer at Baylor College of Medicine, Houston in the US. The authors observed that due to the skin's role in psychosocial development, in addition to its importance in maintaining biological function, first impressions, self esteem and social perceptions are all affected by the appearance of the skin. Therefore, cutaneous disorders can have a harsh impact on psychological wellbeing.

The authors noted that children and adolescents were particularly at risk as identity formation is highly malleable and receptive to changes in external appearance, while at the same time this population group is vulnerable to negative evaluations and perceptions from others, and must navigate increasing exposure to idealised images via social media.

The authors observed that although the association between psoriasis and mental health disorders in adults is widely accepted, there is inadequate research to generalise these findings to paediatric populations.

"In this review of the literature, we discuss the prevalence of anxiety and depression among paediatric patients with psoriasis in hopes of raising awareness of these associations and advocating for psychological screening and intervention in dermatology practice."

Method

The investigators conducted a search on relevant studies published over the past 15 years, with search terms including 'psoriasis,' 'depression' and 'paediatrics' used in their analysis. The criteria employed to select the studies included those that featured patients from birth up to the age of 18 years who had been diagnosed with psoriasis.

The research team's searches resulted in a total of 90 articles found across PubMed and Ovid Medline. They designated 41 of these articles to be given a full-text review, due to their criteria for inclusion.

Findings

The study's results followed an independent assessment of both article relevance and eligibility, resulting in 10 of their gathered studies being chosen. These 10 studies had different approaches, including cross-sectional, case-control, cohort and interview-based designs.

The researchers found that seven of the 10 studies examined used both depression and anxiety as primary outcomes, and noted that every one of the seven studies contained data unanimously supporting a substantial correlation between psoriasis and depression in paediatric patients.

They found that while they were limited, a number of current investigations generally supported a positive relationship between paediatric psoriasis and the onset of anxiety and depression.

"It is difficult to determine a causal relationship however because there is evidence that psoriasis and psychiatric illnesses exacerbate one another. For example, paediatric psoriasis patients may present with other psychiatric comorbidities, such as excoriation (skin picking) disorder, or obsessive compulsive disorder, resulting in body-focused repetitive behaviours that worsen psoriatic plaques," observed the authors.

They further state that this complication emphasises the importance of mental health screening in paediatric patients with psoriasis.

"Mitigating any potential effects of psychiatric illness on psoriasis activity may improve both cutaneous and mental health outcomes. However, the biological mechanisms that relate improvements in mental health to improvements in skin disease remain unclear, including in the paediatric population."

The authors believe that there is a need for more research to be carried out in this area.

"There exists an opportunity for future studies to observe how early psychiatric identification and intervention may improve holistic health outcomes in paediatric patients with psoriasis, atopic dermatitis and other inflammatory skin disorders. Above all, clinicians must be mindful of the invisible burdens of psoriasis on the vulnerable youth population," they observed.

The study, *Manifestation of anxiety and depression among pediatric patients with psoriasis: A review*, was published online in the journal *Pediatric Dermatology*.

DOI: 10.1111/pde.15185

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*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

TORK®

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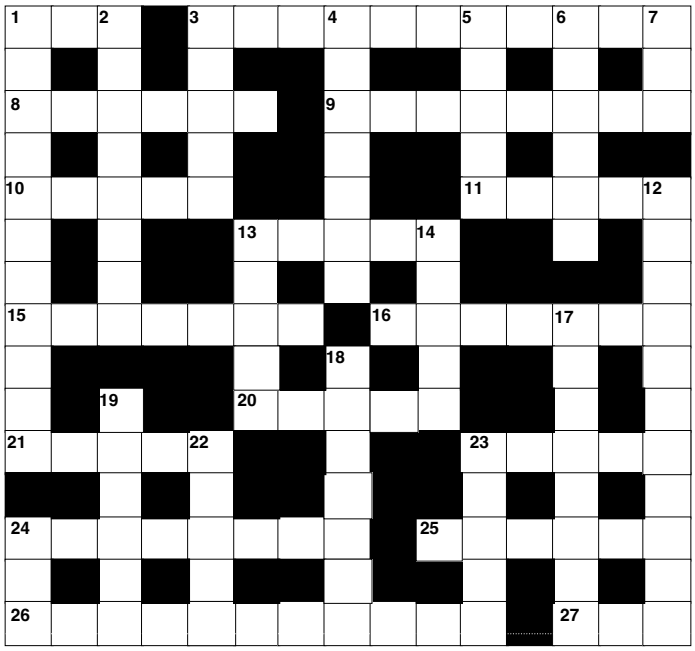
Across

1 Cut grass (3)
3 Make a pioneering contribution - while causing fires en route? (5,1,5)
8 In an overt way (6)
9 Virtue (8)
10 Joint just above the foot (5)
11 As well as mauls, these form during a game of rugby (5)
13 See 7 down
15 & 16 This salad ingredient is probably not used in the Titanic Quarter! (7,7)
20 Young nocturnal bird of prey (5)
21 O save a concoction of this dry Italian wine (5)
23 Surname shared by Nobel-winning husband, wife and daughter (5)
24 Most hirsute (8)
25 Traditional Spanish rice dish (6)
26 Must you swap your car for a horse when you avail of this facility? (4,3,4)
27 Enquire (3)

Down

1 Inflammation of the heart muscle can be caused literally by a dirty mosaic! (11)
2 Debris, rubble (8)
3 Swelling (5)
4 Progresses in a series of sharp turns (7)
5 The royal line of Henry VIII (5)
6 Dealership (6)
7 & 13a Save gals touring an American city (3,5)
12 One who works high up on buildings (11)
13 Star sign of those born in late August or early September (5)
14 Item of bed linen (5)
17 Brolly (8)
18 The learner in the sailing ship will fill the place with useless items (7)
19 Long, slender sword (6)
22 Ms Doolittle, of 'Pygmalion' and 'My Fair Lady' (5)
23 Large box (5)
24 Pelvic joint (3)



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 and putting *'Crossword Competition'* in the subject line. Closing date: **April 20, 2023.** If preferred you can post your entry to: WIN Crossword, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Dublin A96E096

March crossword solution

Across: 1 Infections 6&26 Camp David 10 Put up 11 Dalai Lama 12 Jubilee 15 Sonar 17 Roma 18 Fail 19 Norse 21 Nestled 23 Obese 24 Judo 28 Ascends 33 Bald eagle 34 Glean 35 Efts 36 Esplanades

Down: 1 Imps 2 Fettucine 3 Capri 4 Indie 5 Nile 7 Again 8 Prairie dog 9&21 Pins and needles 13&25a Lake Erie 14 Eritrea 16 Affordable 20 Roundhead 22 Epic 27 Veldt 29 Steel 30 Elgin 31 Ages 32 Onus

The winner of the March crossword sponsored by MedMedia is: Mary Roche, Fermoy, Co Cork

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NMBI seeks feedback on digital competency of nurses and midwives

Public consultation on digital health standards launched

THE Nursing and Midwifery Board of Ireland (NMBI) has launched a public consultation on its draft digital health competency standards and requirements for undergraduate nursing and midwifery education programmes.

The draft document aims to ensure that digital health is incorporated into education programmes that lead to registration to ensure that nurses and midwives learn about digital tools as part of their education. The draft standards aim to align with national and international evidence-based practice in an ever-changing digital health environment.

NMBI CEO Sheila McClelland said: "The provision of healthcare is evolving and it is essential that how we educate future generations of nurses and midwives evolves to meet these challenges. The Report of the Expert Review Body on Nursing and Midwifery, the Sláintecare Implementation Strategy and Action Plan 2021–2023, the HSE service plan and the Health Services People Strategy 2019–2024 all set digital health as a key enabler to support the significant redesign of services required to implement the Sláintecare model of care.

"These draft standards and requirements aim to ensure that digital health skills and competencies are embedded within nursing and midwifery school curricula, training and continuing professional development activities," Ms McClelland continued.

NMBI director of education, policy and standards Carolyn Donohoe added: "The draft standards and requirements have been developed with input from key stakeholders to ensure undergraduate nursing and midwifery students are equipped with the digital health competencies required to support and enable person-centred connected care.

"We now want to hear feedback from registered nurses and midwives, recent graduates, those working in education bodies, people using services and those with further expertise in the field of digital health. All feedback will be analysed and used to inform the final standards and recommendations, which will be published following approval by NMBI board."

Take part in the consultation online at **www.nmbi.ie** by 5pm on Tuesday, April 11, 2023.

HSE Public Health survey aims to estimate prevalence of long Covid

HSE Public Health, the branch of the Executive with a remit that includes the investigation and control of infectious diseases in the community, recently launched the online 'Follow-up After Disease Acquisition' (FADA) survey. The survey aims to estimate the prevalence of long Covid in the community and help the HSE to understand how people who had a previous Covid diagnosis are feeling now.

People who tested positive for the virus during the pandemic and are living in counties Longford, Westmeath, Laois, Offaly, Kildare, West Wicklow and South Dublin (HSE Public Health Area B) will be invited by SMS message to take part in the online survey. The survey may later be extended to a wider area depending on responses and findings from HSE Public Health Area B.

Dr Paul Kavanagh, specialist in public health medicine, said: "If over the coming weeks you get a text invite to take part in our online FADA survey, we encourage you to click the link and take part. This is your chance to make your voice heard to help shape the health service as we recover from Covid-19.

"Even if you are fully recovered, we still want to hear from you. We want to know how many people who get Covid-19 make a full recovery and if there are any reasons why some people take longer to recover," Dr Kavanagh explained.

What is the FADA survey?

Some people who previously contracted Covid-19 have continued to experience health problems related to the virus long after their infection has resolved.

Participants will be asked questions about when they had Covid-19 and how their health is now, as well as details of their recovery, recent symptoms and socioeconomic factors.

Dr Úna Fallon, consultant in public health medicine, said: "Public Health spent the pandemic years working together with the people of Ireland to keep us all safe. Now let's continue to work together to make sure our health service can develop to meet our needs. Long Covid is also important as part of this because it can cause different problems that change over time for people. We want to hear from those who have long Covid, and we ask that you share your experience with us."

What is long Covid?

Most people who get a Covid-19 infection recover within four weeks. People with long Covid carry one or more symptoms with them for longer than four weeks, even after the initial infection period has cleared. Long Covid can also manifest as new health problems that develop after the infection is resolved.

The most common symptoms of long Covid are:

- Breathlessness, cough or chest pain
- Fatigue
- Pain
- Brain problems, such as trouble focusing, headaches, dizziness or sleeping problems
- Stomach issues, such as pain, nausea, diarrhoea or loose stool, loss of appetite and weight loss
- Mental health problems, such as depression and anxiety
- Skin problems like unusual rashes
- Changes in taste or smell, earaches, sore throat or tinnitus.

The survey can be found at: **www.hse.ie/fadasurvey** and will take between 10 and 20 minutes to complete

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The INMO recognises the significant contribution that nurses and midwives make to enhancing and developing the quality of care delivered to patients and service users. To showcase the innovations in practice, nurses and midwives are invited to submit a poster for presentation* at the Annual Delegates Conference (ADC) the first week in May in Killarney, Co Kerry.

PLEASE NOTE: To use this form you are required to use or setup a Google account.

DATE EXTENDED

SUBMISSION DEADLINE
Friday, 14th April 2023

Notification of successful submissions - Friday, 14th April 2023

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ONLINE COURSE

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and
Thursday, 20 April 2023

The INMO are delighted to announce further training for **health and safety representatives** in the workplace.

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Current arrangements and legislation means INMO members are entitled to receive time off to attend safety representative training.

If you have recently been appointed as a health and safety rep this is the course for you.

For further details please contact Cora on **cora.duffy@inmo.ie**

DoH welcomes 'significant advances' in women's health services

"Still much more to do to transform women's healthcare experience"

MINISTER for Health Stephen Donnelly, Minister for Public Health, Wellbeing and the National Drugs Strategy Hildegarde Naughton and Minister for Mental Health and Older People Mary Butler have highlighted what they call "significant advancements in women's health provision".

Speaking during Women's Health Week in March, a year on from the launch of the Women's Health Action Plan 2022-2023, Mr Donnelly said: "It is incredible to reflect on all the milestones that we have reached in just one year, proving that the long-overdue revolution of women's healthcare in Ireland is well underway."

In that time, there have been several developments in the provision of care for women across all life stages, including the roll-out of a free contraception scheme for women aged 17-26 and the establishment of regional fertility hubs.

The Department of Health also pointed to significant investment in the National Maternity Strategy, investment in two supra-regional endometriosis specialist centres for complex care and five interdisciplinary teams to support the holistic treatment of endometriosis in each of the maternity networks, as well as specialist menopause clinics.

"I have made it a priority as Minister for Health to listen to women and respond to their requests for improved services at all levels, and equality of access to those services," Mr Donnelly added.

"We're working to ensure that women all over the country get the care they need at the time they need it and I've had the opportunity to meet with patients who are already benefiting from these improvements."

The Department of Health also launched the new national Menopause Awareness Week and a dedicated website with the aim of improving knowledge, awareness and support so that women can manage their experience of menopause.

Ms Naughton said: "The Women's Health Action Plan 2022-2023 is a landmark in policy making – putting women at the heart of the policy-making process. It enables us to offer better and more timely care to women with tailored services across all age groups, increasing opportunities for women to become partners in their own healthcare.

"Women should never feel as if their gender is a burden and we're helping to address gender health inequalities through numerous initiatives, such as the period poverty programme and free contraception scheme," Ms Naughton continued. "We're also working to promote a proactive approach to health by improving uptake of screening services, particularly among marginalised groups."

Mr Donnelly added that despite the progress the Department of Health believes it has made in the past year, "we still have much more to do to transform women's healthcare experience in Ireland".

Cancer patients' attendance at EDs reduced due to new nursing service set up following the Covid-19 pandemic

IN RESPONSE to the Covid-19 pandemic, the HSE National Cancer Control Programme (NCCP) has funded 26 acute oncology nurses in hospitals nationwide. Patients undergoing active cancer treatment who become ill at home can contact acute oncology nurses via a dedicated phone service instead of attending the emergency department. This programme of work is supported by the Department of Health Cancer Policy Unit.

The specialist nurses assess the patient's symptoms using an evidence-based tool and advise on the most appropriate care and management required.

An audit of the 1,383 calls received in December 2022 by acute oncology nurses during the 8am-4pm service showed that 84% of patients with cancer who contacted the service did not require ED attendance or admission.

Of the patients who required further assessment in hospital, where possible, these patients were seen in the medical assessment unit or oncology day ward. In some instances, where clinically appropriate following assessment by the acute oncology nurse, some patients had to attend the ED due to the seriousness of their symptoms.

Terry Hanan, National Clinical Lead for Cancer Nursing, HSE National Cancer Control Programme (NCCP), said: "During recent pressures in EDs, the NCCP nursing team received feedback from services highlighting the valuable impact that the Acute Oncology Nursing Service has made. This service ensures that vulnerable cancer patients are assessed, and where possible, avoid ED attendance.

"The service is currently available from 8am to 4pm, Monday to Friday. We also link in with community services such as community intervention teams (CITs), GPs and public health nurses to provide additional support to patients where required. Our aim is to build resilience to expand this service further, beyond Covid-19, so that more patients being treated for cancer can avail of the service," Ms Hanan added.

Patient Joan Lube from Newbridge, Co Kildare, who attended the service at Tallaght University Hospital said: "I needed to contact the triage service on two or three occasions since commencing my cancer treatment, and I have always been amazed by the direct access to the team first and foremost, and the prompt response to any issues or concerns that I had. I knew I was not alone during treatment and I could always ask for help and advice. Receiving a phone call has been so reassuring and has made my cancer journey much easier."

April

Monday 17
National Children's Nurses Section 11am on Zoom

Tuesday 18
Retired Section meeting. Richmond Education and Event Centre, 11am and online via Zoom

Wednesday 19
Retired Section tour of National Maritime Museum, Dun Laoghaire. 12pm. See *page 28* for more details

Wednesday 19
RNID Section meeting. 2pm via Zoom. To include educational talk

Saturday 22
Midwives Section 9.30am on Zoom

Saturday 22
Special Education Section meeting. 10am via Zoom. To include a talk on medication management

Saturday 22
PHN Section meeting. 10.30am via Zoom

Monday 24
CIT Section meeting. 11am via Zoom

Tuesday 25
Radiology Nurses Section meeting. 7pm via Zoom

Wednesday 26
CPC Section meeting. 11am via Zoom

Thursday 27
Assistant Directors Section meeting. 2.30pm via Zoom

May

Thursday 18
SALO meeting. 12pm at the Richmond and online via Zoom

Saturday 20
Midwives Section meeting. 9.30am via Zoom

June

Monday 12
ANP/AMP Section meeting. 11am at the Richmond and online

Tuesday 13
Third Level Student Health Nurses' Section 10am at the Richmond

Saturday 17
PHN Section 10.30am via Zoom

Thursday 22
ADON Section 2.30pm via Zoom

Monday 26
Nurse/Midwife Education Section meeting. 9am via Zoom

Wednesday 28
CPC Section meeting. 11am via Zoom

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

Other events

- Richmond class of September 1975 – reunion on April 23 and 24 at the Heritage Hotel Killenard, Co Laois. Contact Paula Golden for further details at paulaggolden@gmail.com
- Uncertainty and loss in maternity and neonatal care. Joint RCM/SANDS Conference, June 15, Dunsilly Hotel, Antrim. Midwives, MSWs, neonatal nurses, children's nurses, gynaecology nurses all welcome to attend. See **https://www.rcm.org.uk/**

INMO Membership Fees 2023

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

Condolences

- INMO staff and executive council send our deepest sympathies to staff member Martina Dunne and her family on the recent passing of her sister Peggy. Our thoughts are with them at this difficult time. *Ar dheis Dé go raibh a h-anam.*
- Our thoughts are with INMO staff member David Cummins and his extended family after the recent passing of his mother Angela De La Mere. She will be sadly missed and fondly remembered by her loving family.
- INMO staff and Executive Council extend our sincere condolences to staff member Kylie McNichols on the recent passing of her sister Nicole in Australia. We're thinking of you and your family as you cope with this loss. May she rest in peace.
- The INMO extends deepest sympathy to Declan McNamara, group director of nursing and midwifery, University Hospitals Limerick Group, on the recent loss of his father Myles. May he rest in peace.
- We were saddened to hear of the death of Mary Moylan (Geraghty), mother of Galway Brothers of Charity rep and INMO member Coleman Geraghty and sister of retired INMO member Carmel Connaughton. May her gentle soul rest in peace.

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Contact us today to find out more."

Irish Cancer Society Night Nurses

The Irish Cancer Society are seeking Registered General Nurses who can provide a minimum of 6 nights per month and have some palliative experience.
Training will be provided.
Job description on **www.cancer.ie**
Email CV to **recruitment@irishcancer.ie**
Informal enquiries to Amanda on 01-2310532 or **awalsh@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

HSE
Eagraíocht Cúram Sláinte Pobail
Tuaisceart Chathair & Tuaisceart Chontae Baile Átha Cliath
Community Healthcare Organisation
Dublin North City & County

Nursing Positions Available

Who are we?
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 etc. 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 by emailing chodncc.recruit@hse.ie Search 'Rezoomo CHO DNCC Jobs' or visit **Rezoomo CHO DNCC Jobs** for all our current vacancies.


Submit a poster for presentation at the
Annual Delegate Conference 2023?
Poster Competition
Showcasing Nursing & Midwifery Innovations In Practice
Sponsored by
ARAG
MULTIPLE CASH PRIZES TO BE WON!
INMO
Irish Nurses and Midwives Organisation
Working Together
The INMO recognises the significant contribution that nurses and midwives make to enhancing and developing the quality of care delivered to patients and service users. To showcase the innovations in practice, nurses and midwives are invited to submit a poster for presentation* at the Annual Delegates Conference (ADC) the first week in May in Killarney, Co Kerry.
PLEASE NOTE: To use this form you are required to use or setup a Google account.
DATE EXTENDED
SUBMISSION DEADLINE
Friday, 14th April 2023
Notification of successful submissions - Friday, 14th April 2023
education@inmo.ie or 01 6640618/41
www.inmoprofessional.ie
SCAN ME!


INMO
Irish Nurses and Midwives Organisation
Working Together
Recruit a Friend
And We Will Give You a €20 One4all Gift Card*
One4all Gift Cards
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.

Join the Nursing Guild in Ireland

Scottish Nursing Guild
Part of Acacium Group

Why join us?

- Earn up to €57/hour with more for bank holidays
- Flexible shifts so you can work when you want
- Top up your pay to save for special events or holidays
- Paid NMBI fees for nurses and midwives
- Mileage costs reimbursed
- Book shifts online via our Quick Nurse app
- Bonus incentives for referring your nursing friends

We have immediate shifts available throughout the country for:

- Hospitals
- Nursing homes
- Complex care at home
- Intellectual disability settings
- Mental health settings
- Public health nursing
- Private sector

Supporting our clients when no-one else can

Are you looking for a last-minute staffing solution to cover sickness, an influx of patients or emergencies in your place of work? If so, The Nursing Guild can help. For more information, phone our dedicated client management team on 021 212 8922 for Cork or 01 9023080 for Dublin.

Ready to join?

Scan this QR code and register on our website

"I love working with The Nursing Guild. The rates are excellent. The staff are very helpful, they always find work to suit me. I have worked with other agencies in the past and SNG are by far the best. I cannot praise them enough."

Trustpilot

It's not too late to vaccinate against HPV

Many adults continue to be at risk of new HPV infections throughout their lifetime[1]

Recommend Gardasil 9 to prevent future infections against 9 of the most common high risk HPV types

GARDASIL® 9
Human Papillomavirus 9-valent Vaccine (Recombinant, adsorbed)

9-VALENT HPV PROTECTION

Gardasil 9 is available to order privately from MSD. **msd@united-drug.com** **Freephone orderline 1800 200 845** **Freefax orderline 1800 200 846**

GARDASIL® 9 (Human Papillomavirus 9-valent Vaccine (Recombinant, adsorbed)).

ABRIDGED PRODUCT INFORMATION Refer to Summary of Product Characteristics before prescribing. **PRESENTATION** Gardasil 9 is supplied as a single dose pre-filled syringe containing 0.5 millilitre of suspension. Each dose of vaccine contains highly purified virus-like particles (VLPs) of the major capsid L1 protein of Human Papillomavirus (HPV). These are type 6 (30 µg), type 11 (40 µg), type 16 (60 µg), type 18 (40 µg), type 31 (20 µg), type 33 (20 µg), type 45 (20 µg), type 52 (20 µg) and type 58 (20 µg). **INDICATIONS** Gardasil 9 is a vaccine for use from the age of 9 years for the prevention of premalignant lesions and cancers affecting the cervix, vulva, vagina and anus caused by vaccine HPV-types and genital warts (condyloma acuminata) caused by specific HPV types. The indication is based on the demonstration of efficacy of Gardasil 9 in males and females 16 to 26 years of age and on the demonstration of immunogenicity of Gardasil 9 in children and adolescents aged 9 to 15 years. The use of Gardasil 9 should be in accordance with official recommendations. **DOSAGE AND ADMINISTRATION** *Individuals 9 to and including 14 years of age at time of first injection:* Gardasil 9 can be administered according to a 2-dose schedule. The second dose should be administered between 5 and 13 months after the first dose. If the second vaccine dose is administered earlier than 5 months after the first dose, a third dose should always be administered. Gardasil 9 can be administered according to a 3-dose (0, 2, 6 months) schedule. The second dose should be administered at least one month after the first dose and the third dose should be administered at least 3 months after the second dose. All three doses should be given within a 1-year period. *Individuals 15 years of age and older at time of first injection:* Gardasil 9 should be administered according to a 3-dose (0, 2, 6 months) schedule. The second dose should be administered at least one month after the first dose and the third dose should be administered at least 3 months after the second dose. All three doses should be given within a 1-year period. It is recommended that individuals who receive a first dose of Gardasil 9 complete the vaccination course with Gardasil 9. The need for a booster dose has not been established. Studies using a mixed regimen (interchangeability) of HPV vaccines were not performed for Gardasil 9. Subjects previously vaccinated with a 3 dose regimen of quadrivalent HPV types 6, 11, 16, and 18 vaccine (Gardasil or Silgard), hereafter referred to as qHPV vaccine, may receive 3 doses of Gardasil 9. The use of Gardasil 9 should be in accordance with official recommendations. *Paediatric population (children <9 years of age):* The safety and efficacy of Gardasil 9 in children below 9 years of age have not been established. No data are available. The vaccine should be administered by intramuscular injection. The preferred site is the deltoid area of the upper arm or in the higher anterolateral area of the thigh. Gardasil 9 must not be injected intravascularly, subcutaneously or intradermally. The vaccine should not be mixed in the same syringe with any other vaccines and solution. **CONTRAINDICATIONS** Hypersensitivity to any component of the vaccine including active substances and/or excipients. Individuals with hypersensitivity after previous administration of Gardasil 9 or Gardasil /Silgard should not receive Gardasil 9. **PRECAUTIONS AND WARNINGS** In order to improve traceability of biological medicinal products, the name and batch number of the administered product should be clearly recorded. The decision to vaccinate an individual should take into account the risk for previous HPV exposure and potential benefit from vaccination. As with all injectable vaccines, appropriate medical treatment and supervision should always be readily available in case of rare anaphylactic reactions following the administration of the vaccine. The vaccine should be given with caution to individuals with thrombocytopaenia or any coagulation disorder because bleeding may occur following an intramuscular administration in these individuals. Syncope, sometimes associated with falling, can occur before or after vaccination with Gardasil 9 as a psychogenic response to the needle injection. Vaccinees should be observed for approximately 15 minutes after vaccination; procedures should be in place to avoid injury from faints. Vaccination should be postponed in individuals suffering from an acute severe febrile illness. However, the presence of a minor infection, such as a mild upper respiratory tract infection or low-grade fever, is not a contraindication for immunisation. As with any vaccine, vaccination with Gardasil 9 may not result in protection in all vaccine recipients. Gardasil 9 will only protect against diseases that are caused by HPV types targeted by the vaccine. The vaccine is for prophylactic use only and has no effect on active HPV infections or established clinical disease. The vaccine has not been shown to have a therapeutic effect and is not indicated for treatment of cervical, vulvar, vaginal and anal cancer, high-grade cervical, vulvar, vaginal and anal dysplastic lesions or genital warts. It is also not intended to prevent progression of other established HPV-related lesions. Gardasil 9 does not prevent lesions due to a vaccine HPV type in individuals infected with that HPV type at the time of vaccination. Vaccination is not a substitute for routine cervical screening. There are no data on the use of Gardasil 9 in individuals with impaired immune responsiveness. Safety and immunogenicity of a qHPV vaccine have been assessed in individuals aged from 7 to 12 years who are known to be infected with human immunodeficiency virus (HIV). Individuals with impaired immune responsiveness, due to either the use of potent immunosuppressive therapy, a genetic defect, Human Immunodeficiency Virus (HIV) infection, or other causes, may not respond to Gardasil 9. Long-term follow-up studies are currently ongoing to determine the duration of protection. There are no safety, immunogenicity or efficacy data to support interchangeability of Gardasil 9 with bivalent or quadrivalent HPV vaccines. **PREGNANCY AND LACTATION** There are insufficient data to recommend use of Gardasil 9 during pregnancy; therefore vaccination should be postponed until after completion of pregnancy. The vaccine can be given to breastfeeding women. No human data on the effect of Gardasil 9 on fertility are available. **SIDE EFFECTS** Very common side effects include: erythema, pain and swelling at the injection site and headache. Common side effects include: pruritus and bruising at the injection site, dizziness, nausea, pyrexia and fatigue. The post-marketing safety experience with qHPV vaccine is relevant to Gardasil 9 since the vaccines contain L1 HPV proteins of 4 of the same HPV types. The following adverse experiences have been spontaneously reported during post-approval use of qHPV vaccine and may also be seen in post-marketing experience with Gardasil 9: urticaria, bronchospasm, idiopathic thrombocytopenic purpura, acute disseminated encephalomyelitis, Guillain-Barré Syndrome and hypersensitivity reactions, including anaphylactic/anaphylactoid reactions. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **PACKAGE QUANTITIES** Single pack containing one 0.5 millilitre dose pre-filled syringe with two separate needles. **Legal category:** POM **Marketing authorisation number:** EU/1/15/1007/002 (pre-filled syringe with two separate needles).**Marketing Authorisation holder:** Merck Sharp & Dohme B.V., Waarderweg 39, 2031 BN Haarlem, The Netherlands. **Date of revision:** April 2022. T054 & II-053

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: 01-299 8700)

References:
1. https://www.hse.ie/eng/health/immunisation/hcpinfo/guidelines/chapter10.pdf

MSD
Red Oak North, South County Business Park,
Leopardstown, Dublin D18 X5K7 Ireland

IE-GSL-00116 **Date of Preparation:** March 2023