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# WIN

World of Irish Nursing & Midwifery

INMO

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

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# Beyond breaking point

## INMO serves strike notice over ED crisis




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# When enough really is enough

AS I am preparing this editorial, the Organisation is continuing to prepare for the commencement of a campaign of industrial action, involving the withdrawal of labour, in emergency departments (EDs) up and down the country. This follows on from our ED members voting by a margin of 92% in support of this campaign.

The details of the action, including our four key goals, are detailed on *page 6*. Our members made it clear, in the meetings surrounding the ballot, that they want strong forceful action, including strike action, as they do not believe health employers fully understand the extent of the crisis or will be willing to do what is necessary without such radical action.

At the outset it should be said that it would be very hard to find a group of workers, in the public or private sector or in any type of employment, who have shown more patience and fortitude than our members in EDs over recent years. Against the background of ever increasing levels of overcrowding, recruitment bans, flawed hospital reorganisations and increasing levels of demand, they have always strived to provide the best possible care, to very ill patients, in intolerable environments. They have asked, on an ongoing basis through the INMO, for remedial action but, in response, all they received is broken promises and broken agreements.

While nursing numbers were being reduced due to the recruitment embargo, the numbers of doctors and allied health professionals were, correctly, being increased. However, the reality is you cannot have a quality assured health service, you cannot have quality care for patients and you cannot have the best outcomes for patients without the necessary number of registered nurses. The fact is our EDs are grossly understaffed and, as a result, care standards are consistently, and repeatedly, compromised through no fault of the staff.

To add insult to injury, when ED nursing staff have raised concerns, like nursing and midwifery staff in other areas, they have been told that they will have to 'get on with it' or 'make do'. Indeed our experience shows that management, at both local and national level, only do what is right and required with regard to overcrowding, when they are faced with adverse publicity and negative media attention. This certainly seems to generate corrective action in contrast to the lack of action forthcoming when nursing staff, concerned about professional standards, raise misgivings only to have them fall on deaf ears.

However, on the back of the recent ballot, our members have now said, and I am absolutely certain they mean it, that they have had enough, they will suffer no longer and, in the interests of patients' health and their own wellbeing, they will take whatever action is necessary to secure an improved environment within our EDs.

It should be noted that this decision and this campaign of action recognises that ED overcrowding, and admitted patients on trolleys, will remain a daily reality for the Irish public health service. That is why the demands being made as part of this campaign, are all designed to improve the environment, for patient care, in EDs and to provide sufficient staff to protect safe practice and, indeed, the personal health and wellbeing of our members working in these departments.

As you would expect in such a situation, efforts will undoubtedly be made to avoid strike action, with the assistance of the Workplace Relations Commission (formally Labour Relations Commission). However, arising from the decision and the strong mandate from our members, all parties, particularly government, the Minister for Health and the HSE, must realise token gestures and vague promises will not suffice on this occasion. What is required is a radical new approach to managing and staffing our EDs. Patients have had enough, staff have had enough and now government and management must deliver or face the consequences.

Liam Doran

**Liam Doran**
**General Secretary, INMO**

# ED members set for strike action

## Over 92% vote for action up to and including withdrawal of labour

INMO members working in emergency departments are set to begin strike action on Tuesday, December 15, following an overwhelming vote in favour of a campaign of industrial action. This is due to the persistent and deepening levels of overcrowding, inadequate staffing levels and the ongoing compromising of patient care in EDs throughout the country.

More than 92% of INMO members working in all the country's EDs voted in favour of taking industrial action, involving the withdrawal of labour, saying they have simply had enough of broken promises.

The INMO has served formal notice on the HSE and all relevant health service employers, that the campaign of industrial action, including strike action, will commence on December 15, unless the government and hospital management address specified issues. In keeping with the agreed health service protocol, the INMO provided three weeks' notice and indicated its availability to agree contingency measures.

The INMO Executive Council ratified a national campaign involving all of the country's EDs, as follows:

- Each hospital to establish a strike committee immediately
- Strike action will begin on Tuesday, December 15 and will initially involve action in a number of EDs on a simultaneous/rolling basis
- Further days of strike action will take place, involving remaining EDs, again on a simultaneous/rolling basis, in the new year
- The campaign will ultimately involve a nationwide strike involving all EDs.

The exact location and timing of the strike action on the first day will be advised to the HSE in a formal notice. The action will involve all members with the exception of a standby emergency response team, requiring the hospital, effectively, to go off emergency call.


***Enough of broken promises:*** *INMO President Claire Mahon and general secretary Liam Doran announcing that 92% of ED members had voted in favour of strike action due to the deepening levels of overcrowding and understaffing in emergency departments throughout the country*

The INMO is taking this campaign of industrial action as a last resort after 10 years of discussions and broken promises. Members are particularly frustrated at the daily acceptance by those in authority of ED overcrowding and, in many hospitals, ward overcrowding due to extra trolleys.

Against this background the campaign is seeking:

- Safe, adequate and consistent staffing levels (including recruitment and retention initiatives) for all EDs
- Additional, separate nursing staff to look after admitted patients who are on trolleys, thus ensuring the ED nursing staff can ensure safe practice in each ED
- The designation of all EDs as specific places of employment, under the Safety, Health and Welfare at Work Act, requiring regular inspections to ensure staff's health and wellbeing
- Proper, full and 24/7 implementation of agreed escalation policies to minimise overcrowding in EDs and on wards.

The INMO pointed out that this campaign commenced against the background of ED overcrowding being at record levels despite all of the commitments that it would be reduced. The latest figures, up to the end of November 2015 *(see Table)*, show that in the first 11 months of this year almost 87,000 patients admitted for care found themselves on trolleys awaiting a bed. A breakdown of these figures show that in the month of November alone 7,407 admitted patients waited on trolleys in EDs/overcrowded wards.

November 2015 was the 16th month in a row in which overcrowding increased, demonstrating that care is being compromised on a long-term and ongoing basis. In addition, the situation is getting worse not better. The figures confirm that the measures taken to date have failed to address the problem and ensure that admitted patients can be cared for by adequate numbers of nursing staff, in a safe clinical environment, providing dignity and privacy.

During the consultation process ahead of the ballot for action, members also expressed their growing concern about increasing delays in patients being initially assessed (triaged). Members confirmed that, due to the pressure in the whole ED, members of the public are not being seen, in a timely manner, consistent with best practice.

INMO general secretary Liam Doran said: "This action, which will involve strike action, is being taken in recognition that overcrowding will continue requiring special, sustained, measures to be introduced in our EDs, to safeguard patient care and the health and wellbeing of staff.

"This campaign is also necessary as a direct result of the failure of government and health service management, over many years, to recognise this overcrowding crisis and to allocate the necessary resources to properly address it. Our members will no longer tolerate having to go to work, every day, to face constant overcrowding where both the care of patients, and the health and wellbeing of staff, is compromised without anyone, in authority, seeming to recognise the consequences.

"Members have had enough, patients have had enough, and it is now up to government and management to address these issues, in dialogue with us, if this campaign of strike action is to be avoided."

At the time of going to press, talks had commenced in the Workplace Relations Commission (WRC), formerly the LRC, in an effort to avert the planned strike action on December 15.

## Table 1. INMO trolley and ward watch analysis January-November 2006-2015

| Hospital | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 ED & ward watch total | 2014 ED & ward watch total | 2015 ED & ward watch total |
|---|---|---|---|---|---|---|---|---|---|---|
| Beaumont Hospital | 4,017 | 5,730 | 7,509 | 8,097 | 7,649 | 6,831 | 5,915 | 6,465 | 5,930 | 7,731 |
| Connolly Hospital, Blanchardstown | 2,270 | 2,569 | 2,493 | 2,484 | 3,102 | 4,075 | 3,677 | 5,533 | 4,785 | 4,855 |
| Mater Misericordiae University Hospital | 3,925 | 4,721 | 5,504 | 4,581 | 5,105 | 3,560 | 4,014 | 2,730 | 3,211 | 4,468 |
| Naas General Hospital | 3,002 | 1,161 | 2,009 | 3,517 | 3,032 | 4,237 | 1,942 | 1,740 | 2,612 | 3,072 |
| St Colmcille's Hospital | 1,245 | 703 | 958 | 2,339 | 1,957 | 2,006 | 2,102 | 1,130 | n/a | 0 |
| St James's Hospital | 1,926 | 929 | 2,265 | 2,256 | 1,254 | 1,483 | 1,217 | 1,611 | 1,949 | 2,512 |
| St Vincent's University Hospital | 4,026 | 5,594 | 5,252 | 4,990 | 5,764 | 5,986 | 4,374 | 2,746 | 2,115 | 4,681 |
| Tallaght Hospital | 4,907 | 3,642 | 5,233 | 5,575 | 6,400 | 4,642 | 1,809 | 3,680 | 3,500 | 4,541 |
| **Eastern** | **25,318** | **25,049** | **31,223** | **33,839** | **34,263** | **32,820** | **25,050** | **25,635** | **24,102** | **31,860** |
| Bantry General Hospital | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | 130 | 219 |
| Cavan General Hospital | 2,731 | 2,608 | 1,988 | 1,812 | 2,973 | 4,379 | 2,457 | 1,911 | 447 | 867 |
| Cork University Hospital | 3,669 | 3,438 | 4,115 | 4,118 | 6,335 | 6,202 | 3,980 | 3,846 | 3,201 | 4,363 |
| Kerry General Hospital | 1,102 | 456 | 724 | 301 | 602 | 647 | 541 | 669 | 886 | 1,322 |
| Letterkenny General Hospital | 2,865 | 1,229 | 349 | 361 | 429 | 554 | 491 | 1,129 | 2,696 | 2,708 |
| Louth County Hospital | 199 | 88 | 141 | 143 | 25 | n/a | n/a | n/a | n/a | 0 |
| Mayo General Hospital | 2,169 | 1,283 | 1,066 | 1,271 | 1,657 | 598 | 1,400 | 1,043 | 1,631 | 1,736 |
| Mercy University Hospital, Cork | 1,398 | 1,208 | 1,370 | 1,173 | 1,696 | 1,800 | 1,715 | 2,387 | 2,006 | 2,063 |
| Mid Western Regional Hospital, Ennis | 780 | 931 | 252 | 359 | 375 | 398 | 276 | 333 | 0 | 122 |
| Midland Regional Hospital, Mullingar | 162 | 90 | 166 | 365 | 1,780 | 3,004 | 2,242 | 2,729 | 3,499 | 4,046 |
| Midland Regional Hospital, Portlaoise | 461 | 271 | 395 | 272 | 329 | 1,753 | 527 | 731 | 1,434 | 1,959 |
| Midland Regional Hospital, Tullamore | 59 | 33 | 63 | 75 | 626 | 1,731 | 1,245 | 1,052 | 3,524 | 2,484 |
| Monaghan General Hospital | 97 | 276 | 270 | 119 | n/a | n/a | n/a | n/a | n/a | 0 |
| Nenagh General Hospital | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | 58 |
| Our Lady of Lourdes Hospital, Drogheda | 3,279 | 2,638 | 2,660 | 3,415 | 3,151 | 7,009 | 6,371 | 3,070 | 5,642 | 7,280 |
| Our Lady's Hospital, Navan | 471 | 768 | 759 | 1,073 | 416 | 1,350 | 688 | 886 | 964 | 948 |
| Portiuncula Hospital | 349 | 268 | 302 | 578 | 832 | 930 | 732 | 765 | 786 | 1,068 |
| Roscommon County Hospital | 548 | 636 | 715 | 706 | 926 | 719 | n/a | n/a | n/a | 0 |
| Sligo Regional Hospital | 755 | 688 | 584 | 842 | 1,645 | 1,429 | 1,924 | 912 | 1,845 | 2,266 |
| South Tipperary General Hospital | 715 | 695 | 835 | 463 | 639 | 648 | 1,952 | 2,550 | 1,866 | 1,834 |
| St Luke's Hospital, Kilkenny | n/a | n/a | n/a | n/a | 121 | 922 | 621 | 1,640 | 1,800 | 3,212 |
| University Hospital Galway | 1,563 | 2,253 | 3,225 | 3,157 | 3,854 | 6,181 | 3,960 | 3,533 | 4,891 | 6,012 |
| University Hospital Limerick | 1,698 | 1,235 | 1,503 | 2,274 | 3,431 | 3,359 | 3,346 | 5,104 | 5,543 | 6,835 |
| University Hospital Waterford | N/A | N/A | 434 | 554 | 1,183 | 1,062 | 1,461 | 1,977 | 1,979 | 2,303 |
| Wexford General Hospital | 2,754 | 712 | 1,306 | 1,759 | 2,312 | 3,719 | 882 | 1,339 | 1,157 | 1,299 |
| **Country total** | **27,824** | **21,804** | **23,222** | **25,190** | **35,337** | **48,394** | **36,811** | **37,606** | **45,927** | **55,004** |
| **NATIONAL TOTAL** | **53,142** | **46,853** | **54,445** | **59,029** | **69,600** | **81,214** | **61,861** | **63,241** | **70,029** | **86,864** |

**Comparison with total figure only:**

Increase between 2014 and 2015: 24%
Increase between 2013 and 2015: 37%
Increase between 2012 and 2015: 40%
Increase between 2011 and 2015: 7%
Increase between 2010 and 2015: 25%
Increase between 2009 and 2015: 47%
Increase between 2008 and 2015: 60%
Increase between 2007 and 2015: 85%
Increase between 2006 and 2015: 64%

# St Vincent's work to rule suspended during talks

INMO members working in the emergency department of St Vincent's University Hospital (SVUH), Dublin, engaged in industrial action in the form of a work to rule for a week in October due to intolerable working conditions and the inability to provide safe care to their patients.

However, following a request from the LRC to engage in intensive conciliation, which hospital management agreed to, INMO members agreed to suspend industrial action for the duration of the talks.

INMO IRO Philip McAnenly said: "The INMO approached these talks with the aim of reaching an agreed outcome, as the working environments and the conditions under which nurses are attempting to provide a level of safe care cannot continue.

"We believe that some improvements can be arrived at through the process set out by the LRC and we welcome their assistance in this regard".

# INMO called for Mater ED to go off-call due to overcrowding

IN THE days following the vote for national industrial action in EDs, the INMO called for the Mater Hospital, Dublin to go off call due to severe overcrowding in the emergency department.

The trolley watch figures recorded 29 patients on trolleys on the morning of November 26. However, the INMO then learned that the figure was much higher with 45 admitted patients on trolleys. The INMO expressed extreme concern at the situation in the ED in particular, and in the hospital in general.

Following a meeting of the INMO with hospital management, the situation in the ED significantly improved after discharge of patients.

Management and the INMO agreed to further talks regarding nursing shortages in the hospital where there are currently 100 nursing vacancies.

**– Albert Murphy, INMO IRO**

# National conference explores future funding of Irish health service

A WORLD class health service must be properly funded – this was the key message to emerge from the INMO's national conference on December 2. Debate centred on how Ireland should fund its health service, the level of funding needed and how to convince the political system of the need to invest in the service.

Arising directly from a motion adopted at ADC 2015, the conference was convened to produce a policy document outlining the INMO's position on the future of the health service.

Opening the conference, INMO president Claire Mahon said: "We are demanding a properly-funded clinical environment where safe practice and safe care can always be maintained within a working environment that respects the health and welfare of nurses and midwives. Safe care can only be provided when you have a safe working environment within which acceptable ratios must exist.

"No one except nurses and midwives can determine what care can be delivered safely and no one must be allowed to overrule this decision. Care is being compromised by the decisions of those who never see a patient and are only concerned with budgets," she said.

INMO general secretary Liam Doran said: "The INMO is doing its part in bringing forward a cohesive plan for health. We only have overcrowding in EDs because we have not convinced the public yet that this is wrong; the public in turn must convince the politicians that the health service must be properly funded."

## Funding models

The various models of funding a health service were outlined by Prof Charles Normand, professor of health policy and management at TCD. He asked whether the Irish funding model has adapted to the needs of the population. The main objective in financing a health system is to use resources efficiently, with fairness and equity. He said you must contain costs and ensure sustainability.

*Pictured at the INMO national conference in Croke Park were conference speakers (l-r): Tom Healy, director of Nevin Economic Research Institute (NERI); Paul Goldrick-Kelly, NERI; Claire Mahon, INMO president; Geraldine Cunningham, associate director of culture change, Barts Health NHS Trust; Liam Doran, INMO general secretary; Dr Peter Carter, former CEO/general secretary of the RCN; Edward Mathews, INMO director of regulation and social policy; and Prof Charles Normand, TCD professor of health policy and management*

Exploring the concept of universal healthcare, Prof Normand asked if Ireland wanted access to essential care to depend on ability to pay, especially as those with greatest need have the least resources. There is little evidence that user fees lead to less wasteful use of services, he said.

"Universal coverage can be organised so as to give appropriate incentives to both users and providers of health. Partial coverage can lead to worse health and typically less efficient use of services," he said.

He pointed out that increased prescription charges has led to people stopping some medications and developing worse health outcomes, which are more expensive to manage in the long-term. Whether funded directly or indirectly by government, all systems of health finance come from the taxpayer so, he said, the only question is how affordable can we make it. The more straightforward the funding system is, the less it will cost to administer and the more there will be available for services and to pay frontline workers.

"If it is cheap to manage, it won't cost as much to collect," he said, pointing to Universal Social Charge as a fair and equitable tax that is easy and cheap to collect.

"The current financing system of the health service isn't the problem; the problem is our unwillingness to devote more money to it," he added.

## Future funding requirements

Speaking from the perspective that health is a social 'good' as well as a private individual 'good', Tom Healy, director of Nevin Economic Research Institute (NERI), addressed the future funding requirements for health.

He was concerned at the way health has become a commodity and how its funding is discussed in very narrow terms.

"We are speaking on it as a current expenditure, rather than a long-term investment. Health funding is a shared responsibility between public, private and voluntary sectors. There is huge pressure on resources. The total public health budget is about €13 billion – about 7% of GDP. We are looking at a very large and complex system," he said.

Paul Goldrick-Kelly, also from the NERI, put the funding of Ireland's health system in context with other systems in Europe. These can be broken down into two system types – the classic Beveridge model, funded by general taxation such as the NHS, or the Bismarck system, funded by payroll, such as in Germany. Ireland has a complex duplicate system of public and private provision. The question is do we want to fund public health by general tax revenue or via payroll contributions.

Mr Healy returned to the essential question of how much health will cost in the future, answering succinctly by saying: "A lot more! How much more will depend on demographic changes in population, how long people live and morbidity."

He identified four possible ways forward:

- Reform the health service to be more cost effective
- Invest in early intervention and prevention to save spending on health in the long run
- Make the service more equitable – there is evidence that societies that are more equal in terms of income and wealth are healthier. At the moment government policies are making Ireland more inequitable
- Involve employees – those working in the health service,

**Ready for change:** *INMO branch and section officers and representatives at the national conference in Croke Park on December 2*

including nurses/midwives, can lead innovation by participating effectively when asked.

## Models of service delivery

Geraldine Cunningham, associate director of culture change at Barts Health NHS Trust, spoke on how the delivery of the health service must meet the changing needs of the population.

After 17 years working outside the NHS, Ms Cunningham said: "On my return what I see is a lot of inefficiencies in a lot of the systems. I see people who are very good at managing a crisis but very poor at planning. So how do we get better at managing systems that will do what we need them to do? We won't do this by filling a vacuum for a day that then becomes somebody else's problem a week later.

"When staff are clear about their purpose, clear about their team objectives, they have better results – lower mortality rates, lower lengths of stay and reduced costs. That is because people are clear about what they have to do, feel supported in their roles and are valued, and their opinions count. They are able to challenge poor behaviour when they see it. This leads to happier patients also," she said.

She demonstrated how small changes in health provision can make big differences. Nurses/midwives alone can save by paying more attention to small inefficiencies, for example by rationalising procurement of supplies in a department.

According to Ms Cunningham, reform of care of older people is essential to a more efficient health service.

"The last place we want older people to be is in an acute hospital. We want them to be cared for nearer their own home, in their community, where they will be happier and therefore healthier. The longer a patient stays in the ED, the longer their stay in hospital will be. Hospitals are dangerous places, especially for older people."

## Human resources challenges

It is essential to ensure that the health service has enough staff, particularly nurses and midwives, to meet demand, said Peter Carter, former CEO/general secretary of the RCN. He said the UK erred in cutting back on its nurse/midwife training programmes to save money, and is now paying the price and having to 'raid' other countries, including Ireland, in order to supply the needs of the NHS.

He said this was a complex time in all health services and we were constantly searching for new solutions.

"Nurses and midwives often say that when things go wrong, they are the ones left to pick up the pieces. But it is usually the fault of a systems failure, with a nurse at the end of the system."

He observed that with changing demographics, people are living longer, many with long-term conditions such as MS, motor neurone disease, rheumatic conditions, type 2 diabetes or heart conditions.

"The workforce needs to be geared up to address these changing health needs. Specialist nurses help to stabilise people with complex health problems. People have shorter hospital stays when they get specialist care."

He said that ED overcrowding was the most visible health service problem but that with good community services, fewer people will present to EDs. And on the other end, he said that people can't leave hospital if community nursing services aren't there for them.

Mr Carter said the majority of care in nursing homes was done by HCAs, many of whom were untrained.

"The care of older people is simply not good enough. There is an affordability factor and a reality factor. If HCAs are educated, trained and properly supervised by RGNs, this will go a long way to addressing the deficits in the care of older people. We are not doing older people justice. We need the nursing care for them, but we also need the infantry of trained HCAs."

Mr Carter reflected on the question of whether nurses have they lost their compassion? "If you are overworked, overstressed and underpaid, compassion can be drained out of you. Policy makers need to look at this."

He stressed: "The workload should be evenly distributed; too much reliance should never be placed on one individual. Communication is critical to ensuring effective teamwork and leadership. Working in the health service generally, and nursing specifically, is highly pressurised and stressful. The need to support each other has never been greater."

## Debate

A lively debate chaired by Edward Mathews, INMO director of regulation and social policy, followed the presentations. Patricia Marteinsson, of the INMO PHN Section, said: "If there is any money saved by efficiencies, it needs to be channelled particularly into care of the elderly. We need to keep them at home under the care of PHNs," she said.

Mary Leahy, PHN and INMO Executive Council member, said: "The more you do, the more you're asked to do. It's crisis management. We need to focus on the staff we have and how to retain them. We need a programme in place to stop burnout."

Martina Harkin-Kelly, INMO Executive Council member, said: "Economics is a crucial factor but nurses/midwives need to be informed of the spend so that we can influence where the funds are spent."

Geraldine Talty, INMO vice president, said: "The HSE and the Department of Health have to recognise our worth. We are constantly being talked about as a cost. The question is how can we get government and the HSE to listen? We know that when you have an adequate number of nurses, you have better patient outcomes."

From the expert panel, Geraldine Cunningham responded: "The main message for government is that poor care costs more than good care. We cannot accept the unacceptable."

Peter Carter stressed that "Quality costs – if you don't put the investment in, there is little wonder that you compromise quality of care. If you don't put the money in, you simply can't have a quality health service."

**– Report by Tara Horan**

# Update on major current issues

A NATIONAL meeting of branch/section officers and nurse representatives followed the health policy debate at the INMO national conference on December 2.

Reports summarised the Organisation's activities in current critical areas including:

## Campaign of Excellence – ID sector

General secretary Liam Doran gave an update on this campaign, which is aimed at:

- Highlighting the damage done by budget and staffing cuts in recent years, and to call for the proper funding for services in the ID sector
- Ensuring the full utilisation of the RNID, the unique honours degree programme dedicated to optimising potential and wellbeing of the person with an intellectual disability, in all areas of service delivery.

To date, the campaign has involved:

- A very successful conference, held by the Section in March, attended by over 200 RNID members
- Local protests about staffing and standards with a number of service providers
- A protest outside the Dáil attended by over 100 representatives from across the country
- Meetings with a number of interested parties including HIQA, the Federation of Voluntary Bodies and the Department of Health.

In addition, the Section has produced a booklet summarising the role of the RNID in all stages of life.

The meeting was assured that the campaign will continue with a particular focus on:

- Further engagement with HIQA on the issues of the person in charge (PIC) and membership of inspection teams
- A possible joint initiative with the Federation of Voluntary Bodies aimed at a fuller understanding of the total skill set held by the RNID
- Further engagement with the Department of Health, and specifically the Minister for Disability, on the issue of policies/funding for ID services.

## Taskforce on Staffing and Skill Mix in Nursing

Mr Doran, who is a member of this Taskforce, updated the meeting on the current status of this important initiative.

He reminded the meeting that the INMO commenced a safe staffing campaign at ADC 2014, which led to then Minister for Health, James Reilly, establishing a Taskforce on Staffing and Skill Mix in September 2014, with phase one of its activities focusing on medical/surgical wards/units.

The Taskforce has now produced an interim report, making a number of recommendations including:

- CNM2 post to be 100% supervisory
- Staffing levels to be determined by use of an agreed dependency tool (with nursing hours per patient day as per in New South Wales, Australia)
- Enhanced role for senior nurse management to establish, and maintain, safe and stable levels at ward/unit level
- Initial 80/20 skill mix between nursing and healthcare assistants.

The Minister for Health has now confirmed his acceptance of the interim report and the exercise now moves into a pilot phase. The immediate next step is to agree pilot sites. The pilot will commence, as quickly as possible, with the outcome being referred back to the national Taskforce for consideration, further amendment where necessary, and, hopefully, publication of a final report in late 2016.

## Industrial relations update

Phil Ní Sheaghdha, director of industrial relations, provided the meeting with a comprehensive update on key IR issues including the implementation of the Lansdowne Road Agreement and pay restoration measures, which begin on January 1, 2016. In addition, Ms Ní Sheaghdha gave the current situation on:

- The transfer of four tasks leading to the restoration of the time and one-sixth payment between 6pm and 8pm
- INMO demand for improvements in student nurse/midwife pay and conditions, and incremental credit for graduating nurses/midwives
- Application for revised pay rate for group directors of nursing
- Measurement of all hours actually worked by nurses/midwives.

These issues are covered in full *on page 14* of this issue and ongoing on **www.inmo.ie**

Ms Ní Sheaghdha also gave updates on a range of other issues including:

- The passage of the Workplace Relations Act 2015 and the changes to industrial relations bodies and procedures
- A range of collective claims, from the INMO, in such areas as: PHN training and transfer panel; general health service transfer panel; recording of sick leave; injury at work schemes; regularisation of acting; fixed term appointments; higher post salaries (Labour Court hearing Dec 10); and agreement to review Dignity at Work policy following the INMO survey on workplace bullying and presenteeism in the health service
- The latest staffing figures from the HSE *(see page 14)*.

The director of IR now publishes a monthly bulletin on the website, updating members of general developments in the IR area.

## Midwifery Workforce Planning Project

Director of professional development Elizabeth Adams advised the meeting of significant remaining difficulties with the final report emerging from the HSE's Midwifery Workforce Planning Project.

Despite strenuous efforts, she said that the Organisation still has significant concerns about the work of the project, specifically about the methodology applied which was leading to recommendations of one midwife to 35 births in large and medium hospitals, and a ratio ranging from one to 29 to one to 43 midwives to births in smaller units.

The INMO is demanding that any report published at this time must include a dissenting comment from the INMO, to indicate that the Organisation felt that further work was required to meet the original terms of reference.

## PDC and library update

Ms Adams also provided the meeting with an update on recent developments and growth, within the Professional Development Centre, which continues to expand its range of services, including:

- The PDC now provides over 120 different programmes
- A calendar of events is now available on the website with discounts for INMO members
- Expansion of library services
- The continuing discussions between the INMO and UCD on a partnership leading to university credits for those undertaking INMO courses
- The ongoing popularity of section meetings
- The ongoing development of the INMO professional website, dedicated to the PDC
- The ongoing INMO/UCD evaluation of missed care and workforce planning in Irish community nursing – to be published in February 2016.


# Call for sex buyers law by Christmas

## Men show solidarity with survivors of prostitution outside Dáil

MEN representing all aspects of Irish life gathered at Leinster House recently to show solidarity with survivors of prostitution by calling for the introduction of sex buyer laws by Christmas.

Representatives from the 73 organisations which make up the Turn Off the Red Light Campaign, including the INMO, called on male politicians from all parties to support the Sexual Offences Bill, which has been introduced by the Minister for Justice and Equality, Frances Fitzgerald.

The legislation, which will switch the focus of the law on to sex buyers who fuel demand for prostitution and sex trafficking, is currently before the Oireachtas.

INMO general secretary Liam Doran said: "Persons who are prostituted are overwhelmingly vulnerable, mistreated, and in need of support and protection. Men, who generate the demand for prostitution, must understand the hardship and hurt they visit on those who are prostituted, and they must realise that it amounts to nothing more than gross exploitation.


*Pictured (l-r) outside Leinster House were: Alan O'Neill, the Men's Development Network; John Cunningham, the Irish Immigrant Council of Ireland; and Liam Doran, INMO general secretary, who issued a joint statement demanding the introduction of sex buyers law by Christmas. They joined representatives (pictured top of page) from the 73 organisations that make up the Turn Off the Red Light campaign outside the Dáil recently*

"Nurses and midwives see first-hand the harm caused by prostitution, and the associated desire to exit prostitution. We must criminalise demand and support those who are prostituted and we must do so now."

Alan O'Neill, chief executive of the Men's Development Network said: "We welcome this opportunity for us to show our support for women who have suffered the worst effects of some men's abusive attitude to women and to stand shoulder to shoulder in solidarity with those who suffer physical and sexual abuse in prostitution.

"As the one national men's organisation that consciously takes a lead in changing our behaviour for the better in order to achieve our goal of 'Better Lives for Men, Better Lives for All', we believe the proposed laws represent a key moment for Ireland. We are uniting to call on men to make their voices heard by demanding a change in the law which will decriminalise women who are being prostituted, and criminalise buyers."

John Cunningham, chair of the Immigrant Council of Ireland, said: "Prostitution is a brutal, exploitative and abusive criminal enterprise which must be targeted at source – and the small minority of men who buy sex who have brought organised crime to every part of our country.

"As a frontline organisation and independent law centre which supports victims of sex trafficking, we know first-hand the human misery which lies at the core of these crimes. Men must now stand up and be counted and tell politicians it is time to act."

Survivors of prostitution welcomed the action at Leinster House. Author and campaigner Rachel Moran, of SPACE International (Survivors of Prostitution-Abuse Calling for Enlightenment), said: "The majority of men are not willing to buy sexual access to the bodies of socially vulnerable women and girls and it is so important that they stand up to the toxic minority of men who are and say 'not in our name'. I am glad to see that evidenced by the presence of men here and by the support of male politicians and activists at every step of this process."

Survivor and campaigner Mia de Faoite concluded: "Prostitution and sexual exploitation can and will end but only when all humans come together to do it, which of course includes men".

# Executive Council election – call to all candidates

ELECTIONS to the INMO Executive Council for the period May 2016 to May 2018, will commence early in the new year.

Nomination forms must be submitted to the general secretary (returning officer) on or before Wednesday, February 10, 2016. All details in relation to requirements to be an eligible member are included in a special notice on the page opposite.

In addition to completed application forms, all candidates are asked to submit, at the same time, the following:

- Photograph
- Election manifesto.

This will allow the INMO to provide details, to every member, about who each candidate is, what they are seeking via the election, where they work etc. This really helps to make the election real, for every member, so please submit your photograph and biographical data with your nomination form.

"The Executive Council is a critically important entity. It manages the affairs of the Organisation, while also seeking to implement policies adopted at annual delegate conference. All eligible members are encouraged to come forward and strengthen this democratic exercise within the Organisation," said INMO general secretary Liam Doran.

Phil Ní Sheaghdha, INMO director of industrial relations,

## Public holiday payments over Christmas and New Year

THE HSE has advised that the provisions with regard to public holiday premium payments for the Christmas and New Year period 2015/2016 are as follows:

**St Stephen's Day**

This year St Stephen's Day (December 26) will fall on a Saturday and is a public holiday as provided for in the Organisation of Working Time Act, 1997. Public Holiday premium payments should therefore be paid to staff who work on that day. The normal Saturday premium payment will not apply.

In the case of staff who work a Monday to Friday regime, the paid day off in lieu of the public holiday will normally be granted on the following Monday (December 28).

**Staff who work a '5 over 7' roster**

In summary, staff who work a '5 over 7' roster should be granted premium payments for working over the Christmas and New Year period as follows:

**Christmas Day St Stephen's Day New Year's Day**

Friday December 25, 2015 Saturday, December 26, 2015 Friday, January 1, 2015 all public holiday premium. No public holiday premium payments are payable to staff who work on days other than December 25 and 26, 2015 and January 1, 2016.

If you require further guidance please contact the Employee Relations Advisory Services team, Tel: 01 6626966 or email: info.t@hse.ie

# National competitiveness board unnecessary – ICTU

AMONG the current areas of concern being addressed by the Irish Congress of Trade Unions is the recommendation for a national competitiveness board to be established.

The ICTU recently corresponded with Taoiseach Enda Kenny on the European Commission's recommendation on the establishment of national competitiveness boards within the European area.

The concern of the ICTU and affiliated trade unions, including the INMO, is that such boards could infringe on the autonomy of social partners in the collective bargaining and wage setting.

ICTU has drawn attention to the fact that the programme of austerity measures imposed on the citizens of the Republic of Ireland required a National Competitiveness Council and therefore there is no need for a body performing similar functions.

This is an issue of concern as the Lansdowne Road Agreement specifically states that wage setting mechanisms are to be agreed between the government and the public service trade unions. The trade unions had their first meeting on this in mid-November 2015.

The Lansdowne Road Agreement states at point 5.5 that: "The parties are agreed on the importance of achieving sustainable public pay policy that will continue to support the ongoing economic recovery over the coming years as the financial emergency legislation comes to be amended and repealed.

"The government confirms that it will engage with the representative bodies of public servants during the lifetime of this agreement in advance of it deciding on any alternative pay determination structure."

Members will be notified of all further updates on this issue.

# Talks continue on transfer of tasks

DURING the Lansdowne Road talks, the INMO, SIPTU Nursing and the IMO sought the restoration of the premium payment time and one-sixth between 6pm and 8pm to all nursing and midwifery grades.

They confirmed that savings could be found to restore this payment if certain tasks were transferred from medical doctors to nursing/midwifery staff. These tasks include:

- First dose antibiotics
- IV medication
- Nurse-led discharge
- Out-of-hours phlebotomy, which is currently the responsibility of NCHDs.

Since 2013, a number of measurement exercises have taken place. However, the employer contested the estimated savings that the trade unions arrived at, following surveys and work shadows in Beaumont, Tullamore and the Mater hospitals.

With a view to moving this forward, as part of the Lansdowne Road talks an independent process was sought to oversee the implementation of this particular issue with the understanding that the restoration of time and one-sixth remained outstanding.

That process has commenced and is being led by independent chairman, Sean McHugh, who has held a number of meetings with the employer's side, including with the Department of Public Expenditure and Reform, the Department of Health, the HSE, together with the trade unions involved – the INMO, SIPTU Nursing and the IMO.

The trade unions' position is that the tasks, if transferred, could result in savings but they can only transfer if the staffing levels within the nursing/midwifery grades allow for nurses /midwives to take on these additional roles.

The trade unions' position is also that time and one-sixth would have to be restored to all nursing grades who work between the hours of 6pm and 8pm and that the role and function of nurses/midwives, if changed in this manner, could not solely be their responsibility; medical staff would have to have an involvement as otherwise they would become deskilled. Therefore, a clear local implementation process would have to be in place in each acute hospital.

These talks are ongoing and members will be updated when a final position is arrived at, which the INMO Executive Council will then have to consider.

reports on recent ICTU negotiations and other national IR issues

# Update on shorter working year scheme and sick pay/sick leave rules

**Shorter working year**

THE HSE has announced a shorter working year scheme (governed by circular 023/2015, which is available on **www.HSE.ie**). The circular confirms that all categories of employees are encompassed by this scheme and will be eligible to apply to avail of leave in 2016.

The purpose of the shorter working year scheme is "to permit HSE employees to balance their working arrangements with outside commitments, including the school holiday periods of their children."

Under the terms of the scheme, special leave is available as a period of two, four, six, eight, 10 or 13 weeks. The leave may be taken as one continuous period or as a maximum of three separate periods, each consisting of not less than two weeks and not exceeding 13 weeks in total. The period of leave shall be unpaid special leave.

The circular goes on to state that managers are required to facilitate the implementation of this scheme and to grant applications for special leave as far as possible. While due consideration should be given to all applications, the needs of the service may require that in some cases an employee's application will be refused.

To be eligible to apply for unpaid special leave, an employee must have completed their probationary period.

Staff must apply in writing by November 30 in the year prior to the year in which it is proposed to avail of the special leave. While the period of special leave is unpaid, those participating in the scheme may apply for special administrative arrangements for the payment of part of basic salary during the period of special leave.

See the HSE website for further details. The INMO information office can also provide advice on the scheme.

**Recording of sick pay/leave**

The INMO is happy to confirm that the issue relating to the recording of sick leave has been resolved satisfactorily.

The INMO had argued constantly that the HSE was incorrectly applying the recording of sick leave. It is now confirmed that the rules in respect of the recording of sick leave are that sick leave is recorded in days not in hours.

The rules also state that if an employee is absent prior to rest days and absent immediately following rest days, that the rest days will be counted as sick leave.

However, if an employee is absent prior to rest days on sick leave but returns immediately following rest days, then the rest days cannot be recorded as sick leave.

This has now been successfully argued by the INMO and on November 2, 2015, the HSE confirmed that these arrangements are backdated to March 31, 2014, which is the date on which the sick leave changes were introduced in the public service. Therefore due to this change, members are urged to check with their HR department that all sick leave taken since March 31, 2014 has been recorded correctly.

## Latest nursing workforce figures

The INMO and other health sector unions meet health sector management bimonthly at the National Industrial Relations Joint Council (NJC). This forum is chaired by the Labour Relations Commission.

At the most recent NJC it was confirmed that there were 102,245 (whole time equivalent, WTE) employees in the public health service in Ireland. Of those, nursing makes up 34,852, consisting of:

- Nurse management – 8,205
- PHN – 1, 496
- Staff nurses – 24,149
- Other nursing – 1,002.

This represents a decrease of 111 staff nurse posts and an increase of 75 in nurse management posts since HSE figures for August 2015.

## Restoration of pension income for retired public servants

RETIRED public service employees, including nurses and midwives, are set to receive an increase in their pensions over the next three years.

The Public Service Pension Reduction (PSPR), which came into effect on January 1, 2011, imposed reductions on annual public service pensions on payments over €12,000, using a tiered set of bands and rates with a top rate of 12% on any public service pension amount over €60,000. The legislation was amended from January 1, 2012 to increase the top rate of PSPR from 12% to 20% on the portion of any public service pension amount in excess of €100,000.

The Financial Emergency Measures in the Public Interest Act 2013 also provided for additional PSPR reduction rates of 2-8% to be applied to all annual public service pensions in excess of €32,500 from July 1, 2013.

The restoration of pension income will be phased in over three years as follows:

- January 1, 2016 – return of €400 to most PSPR-impacted pensioners
- January 1, 2017 – return of €500 to most PSPR-impacted pensioners
- January 1, 2018 – return of €780 to most PSPR-impacted pensioners.

**Three-year cumulative annualised benefit of PSPR amendments**

| Gross pension | Retired before Mar 1, 2012 | Retired after Mar 1, 2012 |
|---|---|---|
| €14,000 | €120 (0.9%) | |
| €16,000 | €240 (1.5%) | |
| €18,000 | €360 (2.0%) | |
| €20,000 | €480 (2.4%) | |
| €25,000 | €810 (3.2%) | |
| €30,000 | €1,260 (4.2%) | |
| €32,000 | €1,440 (4.5%) | |
| €35,000 | €1,680 (4.8%) | €570 (1.6%) |
| €40,000 | €1,680 (4.2%) | €720 (1.8%) |
| €50,000 | €1,680 (3.4%) | €1,020 (2.0%) |

# Workplace stress – does anyone care?

## Hospitals are ignoring safety-at-work legislation, writes Dave Hughes

IT IS a cruel irony indeed that health workers, and nurses and midwives in particular, are ranked consistently as among those working in the most hazardous work environments.

The top two most frequently reported work-related health problems in Europe are musculoskeletal disorders and work-related stress.

A European Agency For Safety and Health at Work study of 2000 suggests that 50-60% of all lost working days can be attributed to work-related stress and psychosocial risks.

The UK Health and Safety Authority Survey 2009/10 estimated that in the region of 9.8 million working days were lost during that year due to work-related stress and that employees with work-related stress were absent for on average 22.6 days. The total cost of mental health disorders in Europe is estimated at €240 billion per year, €136bn of which is due to lost productivity including sick leave absenteeism. The individual costs of unhealthy work environments, which lead to either musculoskeletal injuries or psychosocial work-related stress, are immeasurable in terms of lost opportunity, pain and suffering. However, an EU report from 2009 estimates that direct medical treatment is costing €104bn.

Such is the human and business cost of occupational health and safety risks in the health workplace, that employers and trade unions in the hospital sector throughout Europe are currently engaged in a joint project to promote occupational health and safety in healthcare environments and to reduce the impact of musculoskeletal injuries and work-related stress. The INMO, as members of the European Public Service Union (EPSU), are participants in this dialogue.

The extent of occupational health risk in healthcare is not a new phenomenon. Florence Nightingale, more than 150 years ago, was well aware of the risk of musculoskeletal injury involved in patient care. She wrote that the space between beds should always be sufficient to allow the nurse/midwife to reach any part of their patient's body without having to bend.

Dr Brendan Drumm, former CEO of the Health Service Executive, described hospitals as "dangerous places". Yet in spite of the existence of health and safety legislation derived from a European Directive over 30 years ago, healthcare is still practised in a high-risk environment. This can be contrasted with the dramatic and visible health and safety improvements in areas such as transport, communications, energy and construction. You cannot, for example, enter a building site without protective clothing and a safe code pass.

With regard to workplace related-stress, European studies have identified unfavourable organisation and management in the workplace as well as a poor social context at work, including, but not limited to:

- Excessively demanding work and/or not enough time to complete tasks
- Conflicting demands and lack of clarity over a worker's roles
- A mismatch between the demands of the job and the worker's competency – underusing workers' skills can be a source of stress just as much as over stretching them
- A lack of involvement in decision making and a lack of influence over the way a job is done
- Working alone especially when dealing with members of the public and clients and/or being subject to violence from a third party, including verbal aggression, unwanted sexual attention or the threat of or actual physical violence.

Many of these factors are readily identifiable in the average emergency department throughout this country. When the ED becomes overcrowded, all rules are abandoned and occupational stress levels go through the roof.

This situation is replicated in many hospitals throughout the country when full capacity protocol or the placing of additional beds on all wards is resorted to as a first, rather than a last measure. This makes entire hospitals into virtual powder kegs of stress with falling of standards of care and concern for either patients or workers' health and safety.

One of the key INMO demands in the current ED dispute is for the effective implementation of the Safety, Health and Welfare at Work Act in all departments.

In promoting this campaign throughout the coming year, the INMO will be drawing on considerable research and expertise from across Europe and the Organisation will seek to emulate those sectors of employment that have made most effective use of the existing legislation.

The European Commission sponsored initiative by EPSU and HOSPEEM (the European Hospital and Healthcare Employers' Association) is timely in focusing on the need for greater implementation of the Directive in respect of the hospital sector.

Employers at European level seem to be prepared to take on board the words of a former EPSU president, Minke Wersäll of Sweden, when addressing the subject of occupational health and safety and workplace stress: *"No carer should be hurt while providing care."*

**– Dave Hughes, INMO deputy general secretary**

## Regional update

- THE INMO has served notice of industrial action on Beaumont Hospital following a ballot of members working in the medical and surgical directorates. An overwhelming 99% of members voted in favour of industrial action to highlight the unsafe conditions for patients. There are currently 45 vacancies across the two directorates, which members report is severely impinging on their ability to provide a safe level of care to patients and they are struggling to reach the basic care needs of patients. Industrial action in the form of a work to rule will commence on December 16, 2015. During the work to rule all essential care required by patients will continue to be provided but non-essential/administrative work will not be done.

  **– Lorraine Monaghan, IRO**

- The INMO concluded agreement with the HSE on November 2 about the opening of a new stroke unit at University Hospital Limerick. It is agreed with management that the remaining five of a total of 24 beds will not open until the agreed staffing levels are secured. The Organisation also secured, for all nurses working in this specialist unit, payment of the location allowance valued at €1,858 per annum.

- A Rights Commissioner has found in favour of an INMO member in the Mid-West who was inhibited for a period of almost 12 months from taking up a position which attracted maximum premia payments. The Rights Commissioner found that there were unacceptable delays by the HSE in the appointment of this nurse and awarded her a net settlement figure of €3,000 for the loss of premia pay.

  **– Mary Fogarty, INMO IRO**

# Action averted at Limerick maternity hospital

THE INMO suspended industrial action which was due to commence at the University Maternity Hospital, Limerick on November 27, following agreement reached on a set of proposals put forward by the Workplace Relations Commission (WRC).

Prior to this, 97.5 % of midwives confirmed their levels of frustration and concern by voting in favour of a work to rule, which would have seen midwives withdraw from all clerical administration roles to prioritise all care for pregnant women, mothers and babies.

The proposals put forward at the WRC will see an additional 30 nurses and midwives recruited to work at the hospital and this will significantly stabilise the workforce and services for mothers and pregnant women attending.

The INMO has also secured agreement that there will be a review of additional supports that are required at this hospital and a revision of the education and training supports.

Mary Fogarty, INMO IRO, said: "Our members met on November 23 to discuss these proposals. After lengthy discussion, it was agreed, by a majority of 80%, to accept the proposals and to suspend any action for a period of six months, pending a review at that time on implementation progress. All of these issues will be subject to review periodically with the Workplace Relations Commission."


*The INMO is calling on the HSE to recruit midwives immediately to ensure safe standards are reinstated at University Maternity Hospital, Limerick*

The INMO raised the need for the HSE to address the significant clinical midwifery deficits at UMH Limerick, back in January 2015 and the issue has been ongoing ever since.

UMH Limerick is the fifth busiest maternity hospital in the country. With approximately 5,000 births a year, the hospital only had a clinical midwife workforce of 112, resulting in an unacceptable midwife to birth ratio of one midwife to 44 births. The international midwifery standard is one midwife to 29.5 births so the shortfall was obviously a cause of concern to frontline midwives.

Mary Fogarty, INMO IRO, said: "It is regrettable that while the HSE publicly acknowledged that additional midwives were required, it delayed agreeing to recruit the midwives and ensure safe standards at the maternity hospital. International safe midwifery standards dictate a midwife to birth ratio of 1:29.5 and the INMO believes that these standards must be adhered to in all maternity hospitals to ensure safe care of pregnant women, mothers and babies."

# HSA called in over Croom safety issues

THE INMO has had to take extraordinary measures to secure engagement with the HSE in respect of significant health and safety issues which are impacting on the service and the physical wellbeing of nurses in the theatre department at Croom Orthopaedic Hospital.

The Organisation had to take the approach of notifying the Health and Safety Authority (HSA) of the unsafe situation in the theatre department.

This led to an independent ergonomic review that highlighted significant deficits and recommended additional CSSD operatives. The appointment of additional staff is a welcome development as it removes the requirement for nurses to undertake this additional work. Other major manual handling improvements have been recommended, including training and additional appropriate equipment to comply with safe standards in the workplace.

A two-hour work stoppage had been scheduled for November 10 to bring matters to a head. However, this was deferred pending an implementation process of all documented health and safety improvements.

The INMO remains in contact with the HSA to ensure that all safety concerns of members are addressed, as required under law by their employer.

**– Mary Fogarty, INMO IRO**

# Annual Delegate Conference 2016

## The INEC, Killarney Convention Centre
## Killarney, Co Kerry
## Wednesday to Friday, May 4-6, 2016

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

In accordance with Rules 5.9, 5.11 and 12.3.2, motions for debate at Annual Conference 2016 must be submitted to the General Secretary, no later than 12 weeks prior to Annual Delegate Conference **(Wednesday, February 10, 2016 at 5pm)**

## BRANCH/SECTION GENERAL MEETINGS

### *Each Branch/Section should hold an Annual General Meeting in order:*

**a)** To consider motions for submission to the Annual Delegate Conference 2016. Motions must be submitted to the General Secretary, on the appropriate form;

**b)** To consider any amendments or changes to the Rules of the Organisation, for submission to the Annual Delegate Conference 2016. Rule amendments/changes must be submitted to the General Secretary, on the appropriate form;

**Please note: Motions and changes/amendments to rules must be submitted to the INMO, on the appropriate form, no later than 5pm on Wednesday, February 10, 2016.**

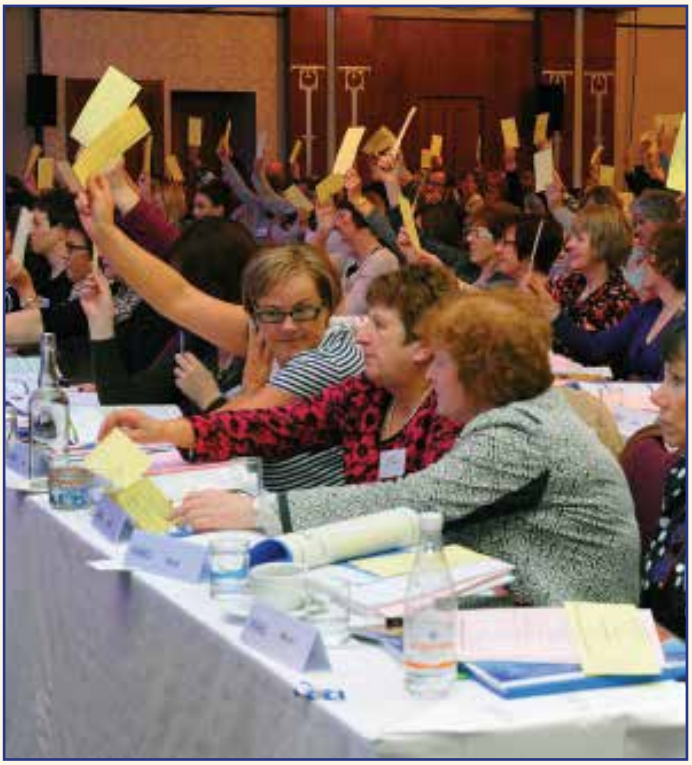
**c)** Branches to nominate delegates to attend the Annual Delegate Conference on the following basis:

| | | |
|---|---|---|
| **Membership less than 50** | - | 1 delegate |
| **Membership of 50-100** | - | 2 delegates |
| **101-200** | - | 3 delegates |
| **201-300** | - | 4 delegates |
| **301-400** | - | 5 delegates |
| **401-500** | - | 6 delegates |
| **501-700** | - | 7 delegates |
| **701-900** | - | 8 delegates |
| **901-1,000** | - | 9 delegates |
| **over 1,000** | - | 10 delegates |

For every 500 members, or part thereof over 1,000, each branch may have one further delegate

**d)** Section to nominate TWO official delegates to attend the Conference.

**Please note: Branch and Section delegate nominations must be submitted to the INMO, on the appropriate form, no later than 5pm on Wednesday, February 10, 2016.**



## HOTEL RESERVATIONS FOR ANNUAL DELEGATE CONFERENCE 2016

This year the accommodation will be provided in **The Gleneagle Hotel and The Brehon Hotel, Killarney, Co. Kerry**. Three nights B&B accommodation will be reserved for all nominated delegates, from **Wednesday, May 4, 2016 until Saturday, May 7, 2016, inclusive.**

Accommodation is available on a shared basis only. The INMO will not be responsible for any expenses incurred by delegates, other than the agreed package negotiated with the hotels. Delegates who wish to have a single room will be asked to pay the single person supplement. ***Delegates who are unable to arrive on the Wednesday evening, or who are departing earlier than the Saturday morning, May 7, 2016, must inform the hotel and Oona Sugrue. ADC Co-ordinator, as early as possible, but no later than Tuesday, May 3, 2016.***

Following your Branch/Section Annual General Meeting, when ADC delegates are nominated, Branch and Section Secretaries should reserve the required accommodation for their appointed delegates, clearly indicating the number of nights required by delegates, by sending the official INMO Booking form direct to:

**Central Reservations, The Glenagle Hotel, Muckross Road, Killarney, Co. Kerry prior to Thursday, March 31, 2016**

All reservations for both The Gleneagle and The Brehon Hotels, Killarney will be made through the Central Reservations Team. All rooms will be allocated on a first-come, first-served basis. Confirmation of hotel bookings will be made direct to the Branch/Section Secretaries, by The Reservations Team in The Gleneagle Hotel.

**For all enquiries regarding Annual Delegate Conference, please contact Oona Sugrue, INMO HQ**
Tel: 01 664 0636 Email: osugrue@inmo.ie

# Labour Court rules in favour of staff in Ard Aoibhinn services

AN ongoing dispute over the failure of Ard Aoibhinn Services in Wexford to pay increments to their staff since 2010 has resulted in the Labour Court backing the INMO/SIPTU claim that staff of the service are entitled to have their increments paid to them.

Ard Aoibhinn Services provides residential and day services to persons with an intellectual disability in Wexford town and county. Its day services are offered to pre-school children, adults and older people.

In addition, there are a number of community-based residential units offering respite and residential accommodation for people with mild to high support needs. The service employs more than 100 staff, who are represented by both the INMO and SIPTU.

The services' staff have a long-established alignment to HSE salaries, owing to previous union/management agreements.

However, since 2011, the service, which receives 90% of its funding from the HSE under Section 39 of the Health Act 2004, advised that it had received reduced funding from the HSE and therefore could not pay staff their increments. Ard Aoibhinn management has always accepted that the staff were entitled to be paid their increments, but advised that the service could not afford to do so without receiving funding for same from the HSE.

As the dispute could not be resolved at local level, or via a Labour Relations Commission Conciliation Conference in March 2015, the matter was referred to the Labour Court. A Labour Court hearing was held in September, 2015. The Court issued a Recommendation on October 27, 2015 (LCR 21067), which stated that: *"The parties are agreed that the staff associated with this claim are aligned for pay purposes with HSE staff. The parties are also agreed that the staff associated with this claim should be afforded increments in line with HSE staff to whom they are aligned.*

***Liz Curran, INMO IRO:*** *"We look forward to further engagement with management with a view to having this Recommendation implemented in full"*

*"The court has considerable sympathy with the employer who finds itself in an unsatisfactory situation influenced largely by its funding authority. The employer does not control its funding and neither does it control the pay levels of its staff. Nevertheless, having regard to the pay alignment already referred to, the court has no option but to acknowledge the entitlement of the staff concerned to increments and to recommend concession of the union claim."*

INMO IRO Liz Curran said, "We are delighted that the court's Recommendation has vindicated the INMO/SIPTU claim that our members working in Ard Aoibhinn Services are entitled to be paid their increments from 2011. We look forward now to further engagement with management of the service with a view to having this Recommendation implemented in full, so that our members are paid their owed monies as soon as possible."

# INMO welcomes funding to refurbish nursing homes

THE INMO welcomes the government initiative to commit over €300 million in capital funding to refurbish public nursing homes.

This initiative requires the Health Information and Quality Authority (HIQA) to revise its timeframe for public nursing homes to fully comply with various standards. However, the INMO believes there is no alternative to this given the pressure to maintain all available long stay/nursing home beds.

Public long-term care facilities remain an essential part of the overall health service, and the health service cannot afford to lose any further bed capacity. The concerns expressed by Nursing Homes Ireland (NHI) ignore the current situation and fail to acknowledge that closing existing public beds would be a serious error which would only cause hardship to an increased number of elderly patients.

The reality is that, without this investment and some additional time to meet HIQA standards, our health service would lose vital long term bed capacity. This would, immediately, exacerbate the existing levels of overcrowding in our emergency departments and increase the number of elderly people on trolleys or delayed in their discharge from acute hospitals.

INMO general secretary Liam Doran said: "The government's decision to invest in our public long term care facilities is both welcome and long overdue. It is acknowledged that this plan requires HIQA to extend the timeframe for adherence to infrastructural standards, but this is both logical and necessary in view of the current situation.

"The alternative, arising from a strict adherence to existing timeframes would be the closure of long-term beds leading to further increases in overcrowding in emergency departments, increased numbers of delayed discharges and, overall, a further contraction of our health service. This would be fundamentally flawed and illogical at any stage, but, at this particularly difficult time, unforgivable."

Mr Doran concluded: "It is unfortunate that Nursing Homes Ireland is considering legal action arising from this very welcome initiative. The investment, and strategic approach, is long overdue, is a common sense approach to the existing situation and, foremost of all, it seeks to improve the living environment for people in these public long-stay facilities.

"This should be welcomed by all. We would now ask the government to proceed with its capital refurbishment programme in the shortest possible timeframe".

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# Clinical Placement Co-ordinator Section to meet three times per year

THE role of the CPC and the current challenges facing CPCs were among some of the issues discussed at the second Clinical Placement Co-ordinator Section meeting, which was held in October in INMO HQ.

The group discussed issues pertaining to the role of the CPC with emphasis on current challenging and developmental topics. Minutes from this meeting will be forwarded to all those who were present. Section members are asked to forward their email address if they have not already done so to ensure they are received.

Members also discussed and confirmed an agreed schedule for further meetings and it was decided that the Section would hold meetings three times per year to coincide with the Student Allocations Liaison Officers Section meetings. This would afford both Sections the opportunity to have their individual meetings overlap when essential and synergic sharing of information and experience could occur.

The proposed motion for the INMO ADC 2016 was also discussed during the meeting. The current chair of CPC Section, Shirley English, called on members of the Section to present proposed motions at the January 2016 meeting where a consensus would be reached regarding motions for submission.

The format of future meetings was also discussed and it was agreed to have protected feedback time for members who have recently attended a CPD activity so that knowledge acquired at these activities could be disseminated amongst the Section.

The INMO CPC Section is happy to invite any member currently employed in the role of CPC to join the Section, which endeavours to act as a peer support group offering shared learning and experiences.

Simply email your contact details to: membership@inmo.ie. The next meeting will be held on January 26, 2016 when the Section looks forward to meeting members both long-standing and new.

# Radiology Nurses Section re-activated in November

**Pictured at the Radiology section meeting were (l-r):** *Claire Mahon, INMO president;Geraldine Gibson; Mary Nolan; Sharon O' Connor; Vija Punneghade; Vicky Sveydar; Sarah Higgins; Priscilla Alcos; and Susan Rutledge*

THE Radiology Nurses Section was recently re-activated following a meeting in November where it was agreed by all those in attendance that the Section was required.

During the meeting the national Section officers were elected and it was decided that meetings would be rotated around the country.

INMO president Claire Mahon and director of industrial relations Phil Ni Sheaghdha were also present at the meeting. Ms Ni Sheaghdha discussed the possibility of recognising radiology nurses as a specialist group and the various benefits this would have. On behalf of the Section, she agreed to review the possibility of this being brought forward.

It was agreed by all present that they would give a comprehensive list to Ms Ni Sheaghdha as to their roles and responsibilities and this will formulate the basis of any claim that may follow.

The next Section meeting will be held on January 16, 2016 in the INMO HQ and there will be teleconferencing facilities available for those who wish to attend but cannot travel.

# Third Level Student Health Nurses Section meets

**Pictured with the INMO general secretary Liam Doran and her colleagues, Jean Boland is presented with a small gift to thank her for her contribution to the Section over the years (l-r were):** *Jenny Scott; Patricia Brady; Liam Doran; Jean Boland; Deirdre Adamson; Alison Meagher; Joan Broderick; Laura Tully; Orlagh Fleming; Elma Clancy; and Michelle Cresswell*

THE nurses working in universities and ITs met recently in head office to hold their annual two-day workshop and Section meeting.

A number of significant events took place over the two days, one of which was the retirement of long standing member Jean Boland.

The Third Level Student Health Nurses Section also had a workshop on mindfulness and meditation for holistic nursing and midwifery care. The Workshop proved hugely successful and the group found Aparna, the facilitator, absolutely excellent. Members found it extremely beneficial for themselves, but stressed that it had also provided useful techniques that they could use professionally in their own practices for the wellbeing of the students.

Saturday's schedule included an update on contraception by Dr Deirdre Lundy, women's health expert, and also included their national Section meeting. All who attended thoroughly enjoyed the two days, both from a professional CPD point of view, and also having the opportunity to network.

# INMO Christmas fair helps to raise money for 'Sharing Fair' initiative

## 'Sharing Fair' aims to help women living in difficult situations

MORE than 40 members of the Retired Nurses and Midwives Section met recently in the INMO head office for their bi-annual conference.

**Guest speakers and talks**

Topics that were covered on the day included living with arthritis; a two-part talk delivered by Gráinne O'Leary, head of education and support services with Arthritis Ireland.

Age Action Ireland talked to members about all of the services that Age Action Ireland provide. This talk was given by Gerard Scully, senior information officer with Age Action Ireland.

Siel Bleu gave a presentation and a practical session on tailored exercise programmes for senior citizens. This session was very well received.

Members evaluated the day and gave feedback on the topics that they would like to have covered at future section events.

**Christmas fair**

Another important part of the day was the Christmas fair which took place for the duration of the morning and during lunchtime.

The 'Sharing Fair' Christmas fairies came to INMO HQ, set up their stalls and contributed greatly both to the day and to creating a lovely Christmas atmosphere.

With the Christmas music and festivities people were treated to a little retail therapy while safe in the knowledge that their support was going directly to the Sharing Fair initiative which is run by the Good Shepard Sisters.

Sharing Fair works with people in a number of countries including Thailand, Kenya and El Salvador and markets crafted items made by women often living in very difficult situations. All their projects are income generating with fair financial benefits to the workers on the products that they produce.

*The Sharing Fair team pictured at INMO HQ during the Retired Nurses and Midwives Section Christmas fair*

***Pictured (l-r) during the Section bi-annual conference were:*** *Gráinne O'Leary; Anna Winters; Mary O'Hara; and Deirdre Ronan*

# Retired Nurses and Midwives Section travel to Krakow in Poland for annual autumn trip

THE Retired Nurses and Midwives Section has existed for 10 years now and during this time members of the Section have enjoyed many different activities from interesting lectures and outings to spring and autumn breaks.

The destination of this year's autumn trip was Krakow in Poland. Members of the Section had the opportunity to learn all about the city of Krakow through a range of different activities.

First on the agenda was a walking tour of Krakow with a professional guide that included entrances to Wawel Cathedral, the Royal Tombs, Sigismund Bell and St Mary's Basilica. The Bugle call – where every hour, a bugle is played from the top of St Mary's Basilica tower – is a unique feature of Krakow, which dates back more than 700 years.

A trip to the Wielickza salt mines gave an insight in to how miners carved solid salt into ornamental chapels hundreds of metres underground.

Next up was a trip to the largest concentration camp of the Nazi regime, Auschwitz-Birkenau, which is just a short journey from Krakow. This trip left a haunting impression on everyone.

Time was also spent in the lively Rynek Glowny market square sampling local cuisine in the sunshine. The markets and the famous cloth hall have an impressive range of crafts, amber, silver jewellery and souvenirs.

Krakow is an extraordinary city to visit and was a memorable experience.

***Pictured on a recent trip to Krakow (l-r):*** *Margaret McGuinness; Frances Byrne; Mary Galvin; and Deirdre Ronan, Retired Nurses Section chairperson*

# Spotlight on Student Section

The Student Section of the INMO represents approximately 6,000 vibrant and hard-working student nurses and midwives nationally.

We work closely with Dean Flanagan, student and new graduate officer of the INMO. Dean shares our understanding that in recent years our respective professions have been severely undermined and it is indeed new entrants into the professions who continuously incur mistreatment.

The Student Section will focus on many of the main factors affecting nursing and midwifery students, including incremental credit for 36-week placement, rate of pay during the fourth-year work placement and pre-registration, post-qualification payment.

We will also be addressing any concerns or issues that are raised by the class representatives nationwide, ensuring these are addressed in a prompt manner.

The Student Section hopes that by the end of our term we will have represented our colleagues to their expectations and indeed hopefully surpass them. We encourage the nursing and midwifery students of Ireland to contact us with any queries they may have.

For any students who have yet to join the INMO, we urge you to do so and all are welcome to join us in our Student Section. To contact the Section, email the chairperson at: aoifemarthakiernan@gmail.com

## Section Officers

**Chairperson**

Aoife Kiernan

**Vice chairperson**

Stephen Woods

**Treasurer**

Bose Allen

**Secretary**

Mary Escotho

# Affiliation Form for INMO Section Membership

Name:_____

INMO membership No:_____

Home Address:_____

_____

_____

Tel (work):_____

Tel (home/mobile):_____

Email:_____

Place of employment:_____

Job title:_____

Second section option (to obtain information only):

_____

**Forward completed form to:**
Mary Cradden, membership services officer,
INMO, Whitworth Building, North Brunswick St, Dublin 7

**Tick ONE relevant Section you wish to affiliate with**

- ☐ Assistant Directors of Nursing/Midwifery/Public Health Nursing/Night Superintendents
- ☐ Care of the Older Person
- ☐ Clinical Placement Co-ordinators
- ☐ CNM/CMM
- ☐ CNS/CMS
- ☐ Community RGN Nurses
- ☐ Directors of Nursing/ Public Health Nursing
- ☐ Emergency Nurses
- ☐ GP Practice Nurses
- ☐ International Nurses
- ☐ Midwives
- ☐ National Children's Nurses
- ☐ National Rehabilitation Nurses
- ☐ Nurse/Midwife Education
- ☐ Occupational Health
- ☐ Operating Department
- ☐ Orthopaedic
- ☐ PHN
- ☐ Radiology Nurses
- ☐ Retired Nurses
- ☐ RNID
- ☐ School Nurses
- ☐ Student Allocation Liaison Officers Network
- ☐ Student Section
- ☐ Telephone Triage Nurses
- ☐ Third Level Student Health Nurses

# INMO playing ongoing role in major international projects

## ENS4Care project conclusion

In 2013 the INMO, in collaboration with the European Federation of Nurses Associations (EFN) and 23 international partners (*see Table on right*), secured European Commission funding for a two-year project entitled ENS4Care. ENS4Care is a thematic network and the main objective is the development of evidence based guidelines for the implementation of eHealth services in nursing and social care.

In addition to building on existing good practices among the participants of the Network, sharing and transferring knowledge across European regions is a core element of the project. The initiative is part of the Competitiveness and Innovation Framework Programme (CIP), ICT Policy Support Programme (PSP) funded by the European Commission.

The ENS4Care guidelines on prevention, clinical practice, advanced roles, integrated care, and nurse ePrescribing have recently been validated by an external independent panel of experts and are available at the ENS4Care website at: **www.ens4care.eu**.

Innovative, high quality, safe and cost-effective national healthcare systems are dependent upon policy-makers and stakeholders developing and implementing high-quality eHealth services.[1] ENS4Care has been designed as a response to this need with an ultimate aim of establishing a sustainable mechanism to support nursing and social care research in the field of ICT enabled integrated care.

The development of the nurse ePrescribing guidelines would not be possible without the commitment and expertise of Dr Pamela Hussey, lecturer in nursing and health informatics in the School of Nursing and Human Sciences, Dublin City University and chair of the Healthcare Informatics Society of Ireland's Nursing and Midwifery group with Anne Spencer, educational technologist, PETAL (Partners in Education, Teaching and Learning).

Two final events in Brussels in December brought this phase of the project to a conclusion: the Seventh European Innovation Summit Conference 'eHealth Services and a Highly Qualified Nursing and Social Care Workforce to Support the Health & Social Ecosystem' and the final European Commission review meeting.

## Development of WHO Strategic Directions for Nursing and Midwifery 2016-2020

Nursing and midwifery historically have been recognised within the World Health Organization (WHO). The professions have been central to decisions of governing bodies and the adoption of World Health Assembly (WHA) resolutions which have culminated in 10 WHA resolutions since 1948 that are specific to nursing and midwifery.

The International Council of Nurses (ICN) has been a collaborating partner since establishment of WHO and the INMO has been a member of ICN for the past 90 years.

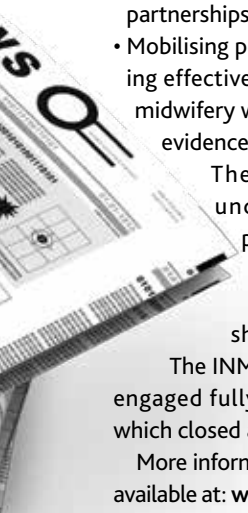
The WHO is now in the process of developing and finalising its Strategic Directions for Nursing and Midwifery (SDNM) for the period 2016-2020. The WHO draft consultation states that: "A competent, well-supported and motivated nursing and midwifery workforce can deliver quality, equitable health services and contribute to the well-being of individuals, families and communities – a basic human right".[2]

It provides a framework to implement and evaluate nursing and midwifery

developments by ensuring available, accessible, acceptable, quality and safe nursing and midwifery interventions at global, national, regional and country levels. Enhancing leadership, strengthening accountability and governance and mobilising political will for nursing and midwifery workforce is essential.

There are four thematic areas:

- Accessibility, acceptability of safe and cost-effective nursing and midwifery care based on population needs, addressing universal health coverage and the attainment of the Sustainable Development Goals
- Optimising leadership and governance accountability
- Maximising capabilities and capacities of nurses and midwives at all levels through collaborative intra and inter-professional partnerships
- Mobilising political will to invest in building effective governance for nursing and midwifery workforce actions founded on evidence.[3]



The four thematic areas are underpinned by five guiding principles for implementation and include: ethical action, relevance, ownership, partnership and quality.

The INMO on behalf of members has engaged fully in the consultation phase which closed at the end of November.

More information on the draft Strategy is available at: **www.who.int/hrh/news/2015/midwifery_nurse_SDMN_consultation/en**

## INMO to host the ICN Credentialing and Regulators Forum in 2017

The ICN Credentialing and Regulators Forum was hosted by the Emirates Nursing Association in November 2015. There were more than 60 participants from various countries including: Australia, Botswana, Canada, Denmark, Jamaica, Japan, Jordan, Kenya, Kuwait, New Zealand, Oman, Seychelles, Singapore, South Africa, Taiwan, Uganda, UK, UAE, the US and, of course, Ireland.

The Forum, on an annual basis, aims to:

- Serve as a vehicle for countries with an interest in developing dynamic regulatory processes and credentialing programs to communicate, consult, and collaborate with one another on trends, problems, solutions etc
- Promote and enable nursing's role at the forefront of healthcare and the development of contemporary regulatory and credentialing systems
- Advise ICN on developments and needs in the field of regulation, credentialing, and quality assurance.

In advance of the meeting, the INMO submitted a national environmental scan in partnership with the Nursing and Midwifery Board of Ireland, as did all other participating countries. The aim of the environmental scan was to capture key trends and issues impacting upon the credentialing and regulation in each country, including national, regional and global issues.

The major trends are captured across: regulation; health/nursing; political/government; society and technology. In addition, ICN had formally invited the INMO to present at the Forum incorporating:

- An overview of regional nursing professional, educational and regulatory collaborations in Europe including in relation to the updated Directive 2013/55/EU
- Information on what have been some challenges and also successes in the region with respect to the collaboration
- Information on impact of mobility within the region of both the Directive 2013/55/EU but also organisations working together on initiatives
- Information on any planned future initiatives.

All presentations and papers are available on the ICN website at: **www.icn.ch/what-we-do/the-credentialing-forum**.

The INMO is set to host the Forum in 2017.

*Elizabeth Adams is INMO director of professional development*

## Table: ENS4CARE Thematic Network Partners

- C3 Collaborating for Health (C3) – UK
- Danish Nurses' Organisation (DNO) – Denmark
- Helsinki Metropolia University of Applied Sciences (HMUAS) – Finland
- Irish Nurses and Midwives Organisation (INMO) – Ireland
- European Platform for Patients Organisations, Science and Industry (EPPOSI) – Belgium
- European Nursing Research Foundation (ENRF) – Belgium
- International Federation of Social Workers – Europe (IFSW-Europe) – Germany
- Northern Health and Social Care Trust (NHSCT) – UK
- Royal College of Nursing (RCN) – UK
- Consociazione Nazionale delle Associazioni Infermiere – Infermieri (CNAI) – Italy
- Ordem dos Enfermeiros (OE) – Portugal
- Nieuwe Unie'91 (NU'91) – The Netherlands
- European Institute of Women´s Health (EIWH) – Ireland
- Fundación Salud y Sociedad – Escuela de Ciencias de la Salud (FSS) – Spain
- European Union of General Practitioners (UEMO) – Belgium
- European Association Working for Carers (Eurocarers) – Luxembourg
- Association of Patients with Cancer and friends (APOZ) – Bulgaria
- European Public Health Alliance (EPHA) – Belgium
- Cittadinanzattiva Onlus (CA) – Italy
- 1.6&2.6 Million Club (1.6&2.6) – Sweden
- The European Co-ordination Committee of Radiological, Electromedical and Healthcare IT industry (COCIR) – Belgium
- Continua Health Alliance (Continua) – Belgium
- Microsoft – Belgium

*References*

*1. Sheikh A, McLean S, Cresswell K. The impact of eHealth on the quality and safety of healthcare. An updated systematic overview and synthesis of the literature. Final report for the NHS Connecting for Health Evaluation Programme (NHS CFHEP 001) London. Imperial College London; 2011*

*2.World Health Organization. Strategic Directions for Nursing and Midwifery Development 2016-2020 The Way Forward Zero Draft for Consultation. November 2015; p4*

*3. World Health Organization. Strategic Directions for Nursing and Midwifery Development 2016-2020 The Way Forward Zero Draft for Consultation. November 2015; p6*

# Quality & Safety

*A column by Maureen Flynn*

## The Health Foundation's QI Resources

THIS month I want to draw attention to The Health Foundation, an independent charity committed to bringing about better health and healthcare in the UK. The Foundation's website, **www.health.org.uk**, provides a treasure trove of resources for improving safety and quality. For example:

- Get ideas and inspiration from improvement projects. There is a categorised listing of hundreds of projects around the UK that are testing ways to improve the quality of health services
- Patient safety resource centre enables you to access resources to suit all levels of practice, from key research to national standards, implementation guidelines and case studies
- Person-centred care resource centre designed to help healthcare professionals support people to more effectively manage and make informed decisions about their own health and care
- Webinars cover topics on healthcare improvement, improvement science and health policy, with a back catalogue of recordings of previous webinars
- QualityWatch, a joint research programme from the Health Foundation and Nuffield Trust, monitoring how the quality of health and social care is changing over time
- QInitiative, led by the Health Foundation and supported and co-funded by NHS England, connecting people skilled in improvement across the UK
- Research scan, every month thousands of journals are scanned to select and summarise around 60 of the most interesting studies about healthcare improvement
- Communications toolkit for healthcare professionals working in improvement who want to understand and use communications to better plan, implement and spread their work.

### Measuring and monitoring safety

The Health Foundation published a seminal report in 2013, *The Measurement and Monitoring of Safety,* drawing together academic evidence and practical experience to produce a framework for safety measurement and monitoring (*see figure right*).

### How can we get there

A follow-up report, *Continuous Improvement of Patient Safety,* was published this month which synthesises the lessons from the Foundation's work on improving patient safety over the past decade. It advises that the journey begins with practical improvements based on what is known to work. The report presents a checklist for safety improvement, based on experiences of supporting NHS teams to improve safety. The checklist can be used by frontline teams and healthcare providers when addressing their most pressing safety problems.

Improvements to safety on the ground can only be successful with the support of senior leaders. The report sets out the three vital steps that senior leaders can take to create an environment where safety improvement can flourish:

1. Work with staff and patients to develop an organisational strategy for improving patient safety
2. Build an organisation-wide approach for creating a positive safety culture
3. Develop an approach for how safety can be better measured and monitored across the organisation.

The practice and policy of safety improvement are inextricably linked, reflecting recognition that the design of the wider system can support, and hinder, the efforts of front-line staff and senior leaders. This report sets out the Health Foundation vision for an effective system for safety improvement:

- Measurement and monitoring
- Improvement and learning
- Engagement and culture
- Strategy and accountability.

The report concludes that underpinning everything is the need to approach the work with trust, sincerity and openness. Local improvements in safety won't be successful if they are not applied faithfully, just as national improvements in safety won't be achieved if they become subverted into measures of accountability. These are the core lessons learned over the past decade; the report draws on them to make the case for why and how future improvements in safety can be realised.

### Framework for measuring and monitoring safety


### Opportunity to get involved

When you are next looking for inspiration for quality improvement, evidence or practical resources why not start by looking at The Health Foundation website.

### Further information

You can access the two Health Foundation reports described in this column at: **www.health.org.uk/publication/measurement-and-monitoring-safety** and **www.health.org.uk/publication/continuous-improvement-patient-safety**

*Maureen Flynn is director of nursing and midwifery, Quality Improvement Division, lead governance for quality and safety*

*Acknowledgement*
*A special thanks to Helen Crisp for sharing information on the work of The Health Foundation at the 5th National Patient Safety Conference held at the Aviva Stadium on November 12, 2015 and to The Health Foundation for sharing resources freely on the web*

# Q and A Bulletin Board

With INMO director of industrial relations Phil Ní Sheaghdha

## Query from member

You have previously notified us that progress had been made by the INMO in respect of the recording of sick leave. My employer recorded my rest days as part of my sick leave, despite the fact that I had returned to work immediately following my rest days. Can you confirm if this process has concluded and what is the current, agreed correct recording method?

## Reply

Yes, you are correct, the INMO has contested the manner in which the HSE recorded sick leave for those who are on a roster. As you know, the rules in respect of the recording of sick leave are that it is recorded in days not in hours. The rules also state that if an employee is absent prior to rest days and absent immediately following rest days, that the rest days will be counted as sick leave. However, if an employee is absent prior to rest days on sick leave but returns immediately following rest days, then the rest days cannot be recorded as sick leave.

This has now been successfully argued by the INMO and on November 2, 2015, the HSE confirmed that these arrangements are backdated to March 31, 2014, the date on which the sick leave changes were introduced in the public service. Therefore, you should seek a review of your sick leave record from your employer to ensure that your rest days have not been incorrectly categorised as sick leave. If you need any assistance with this please contact your INMO industrial relations officer and they will advise and assist you.

## Query from member

Having acted up for two years prior to December 2012, I am waiting confirmation of being appointed to a permanent post. I am advised that I qualify under the agreement brokered as part of the Haddington Road Agreement, yet I have not received confirmation from my employer to date. The INMO have notified us that a submission has been made to an arbitrator. Can you please advise on the current status of this process?

## Reply

Yes, you are correct, the Haddington Road Regularisation of Acting Posts process is now the subject of arbitration. The health service trade unions agreed that John Doherty be appointed to conduct this arbitration. Mr Doherty has received in excess of 800 appeals under the process. Mr Doherty has advised the trade unions and the employers that as an initial step, he is undertaking a desk top review of all appeals to both obtain an overview of all the appeals and secondly to confirm their validity as per the established criteria. In other words, do they meet the criteria for regularisation as set out in the agreement.

The outcome of this may result in a number of scenarios: Firstly, the appeal meets the criteria based on the facts provided and the appeal is therefore considered appropriate, or, secondly, the person meets all of the criteria apart from the fact that they have not been in the post for two years by December 31, 2012. In this second instance, they should be appointed in accordance with circular 17/2013, on a temporary fixed term contract basis, to the post and to the salary of that post, or, thirdly, that the appeal and the particular circumstances might not fall within the regularisation of acting process as the argument may be made that the job has changed and/or the job itself needs to be evaluated. There is an agreed job evaluation exercise for this purpose and appeals based on individual's perceived duties being above their current grade will be redirected to the job evaluation process. Finally, there will be appeals that will require a full hearing in order to validate the facts and also clarify matters that are not clear from the applicants submission/application form.

Mr Doherty hopes that he will be in a position to notify all those who have made an appeal as soon as possible and also schedule dates for the necessary hearings.

If you get correspondence of this nature, please contact us and advise us if a hearing is scheduled. It is in your interest to be represented by an INMO official at that hearing.

# Recruitment & retention round up


In a new series on the recruitment and retention of Organisation membership, **Albert Murphy** highlights some activities of interest to members

### INMO Loyalty Scheme

SO FAR so good for the INMO loyalty scheme! As readers of *WIN* will have noted, this scheme was launched in October. The scheme aims to produce substantial benefits for new members to the INMO on a range of insurance products, including free income protection for nine months.

New members who join the Organisation are invited to sign up for this scheme and will be contacted by Cornmarket subsequent to their application being approved for the INMO Membership Office.

To date, the majority of new members have opted to avail of these benefits. Now more than ever it makes sense to join the INMO. The recruitment scheme, which sees members being awarded a One4All gift card worth €20 for recruiting new members, has also proved to be a success. So therefore, do your new work colleagues a favour and ask them to join the INMO so they can avail of these benefits and you can avail of a gift card for encouraging them to join the Organisation.

### INMO briefings

Did you know that the INMO is happy to carry out short presentations on a range of subjects for members at lunch time or other suitable times? Mary Fogarty, IRO, recently organised a very successful session for more than 30 members in Ennis on the subject of fitness to practise which was delivered by Edward Mathews, INMO director of regulation and social policy. We will shortly launch a briefing on statement writing. We will circulate the details in due course and would be delighted to organise a course in your workplace.

In addition, the INMO is happy to organise the Tools for Safe Practice course or talks on the new sick pay scheme.

If you are interested in running these courses in your workplace, please contact your local IRO or Albert Murphy at email: albert.murphy@inmo.ie.

***INMO rep training course in Sligo:*** *Front row (l-r): Deepa Philips; Breda Ward; Tina Henry; Dolores Tiernan; and Grainne Hamilton*

*Back Row (l-r): Albert Murphy; Cormac Heffernan; David Hughes' Grainne O'Hara; Patricia Cullen Kiloran; Rita Keane; Trevor Lyons; and Deirdre Lynam*

### INMO rep training

As reported last month, a training course was held in Sligo for reps which proved to be very successful – *see photo above*. A reps training course was held in Cork in November. If you are interested in attending the INMO nurse/midwives representatives training courses, please contact Albert Murphy for details.

### Mapping – getting organised

Feedback from employments where mapping has been carried out signify that it is a very positive exercise for establishing strong links between the members on the ground and the Organisation. Mapping is a process whereby the representatives at workplace level effectively carry out an audit of members in the workplace in order to highlight where our members are in each workplace.

Due to the high turnover of staff it is commonplace for nurses to transfer from one employment to another and the Organisation may not have received their updated contact details.


**Maria O'Regan, Temple Street, was the lucky winner of €1,000 as part of the INMO Loyalty Scheme which is sponsored by Cornmarket. The INMO ran this draw to thank members for their continued support.** *Pictured (l-r) at the presentation were: Claire Mahon, INMO president; Maria O'Regan; Ronan Fennessy, general insurance consultant, Cornmarket; and Liam Doran, INMO general secretary*

The INMO has an 'Update Your Details' form which is available from the Membership Office and these are useful for ensuring that we have the correct details for each member including their email and contact details.

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

# Driving change in healthcare

*Martin McNamara and Eilish McAuliffe pictured recently at UCD's Belfield campus*

## **Martin McNamara** talks to Eilish McAuliffe about the benefits of health systems research and education to healthcare professionals

FOLLOWING her appointment as the inaugural professor for health systems in UCD, Martin McNamara talks to Eilish McAuliffe about her new role and why health systems training and education is an important part of nursing and midwifery.

**M:** *Eilish, congratulations on your recent appointment as the inaugural professor of health systems at UCD. I want to start by asking how do you define health systems?*

**E:** Health systems is an umbrella term that encompasses all the elements that form part of a country's healthcare delivery: the institutions, the workforce, the products and medicines, the information, the financing and governance structures and the services. These are what the WHO defines as the building blocks of a health system.

**M:** *What distinguishes health systems as an academic endeavour?*

**E:** In the academic context, health systems is about taking a more holistic perspective on all that contributes to achieving a healthy population; eg. seeing the population as part of the system and as having a role to play in improving health rather than as mere recipients of health services. It is about researching the inter-relationships between various parts of the system and understanding how change or improvement in one domain may positively or negatively influence another domain.

**M:** *What do you see as the distinctive contribution of health systems research to healthcare delivery?*

**E:** Health systems research is seen as increasingly important in unifying the worlds of research and decision-making; it connects the various approaches to research that generate knowledge to inform and strengthen health systems. It is an area that is receiving increasing attention internationally and the WHO acknowledges that the evolving field of health policy and systems research is sensitive and responsive to the knowledge needs of decision-makers, health practitioners, citizens and members of civil society.

**M:** *Health systems has only recently emerged as an academic field. I'm interested in the career trajectory that has led to your current position.*

**E:** I completed a BSc in psychology with a minor in pharmacology in UCD with the specific intention of becoming a clinical psychologist. I went on to do my clinical training at the Institute of Psychiatry in London and spent my early career working primarily in child and adolescent psychology in the NHS.

There were two 'aha' moments that led me to move away from my clinical role. The first was when I was assigned to a paediatric ward in an acute hospital in Dumfries and Galloway while working in the psychology department at the Crichton Royal Hospital. There were great expectations of this long-awaited child psychologist; I arrived on the ward and was instructed to join a ward round that was already underway. The next thing I remember is waking up on the floor with a circle of rather bemused white-coated junior doctors peering at me. I had fainted (due to an overheated ward) and had to ask myself whether I was really cut out for this work. The second moment was at a regular morning meeting in a residential unit for disturbed adolescents. Part of the therapeutic regime was to have staff and residents sit in a circle every morning and address whatever issues people chose to bring up. Sitting in one of these morning meetings listening to the discussion, I realised that the staff probably had more 'problems' than the adolescents; was it time to abscond?

You can decide which of these experiences prompted me to undertake an MBA and get involved in healthcare management, developing expertise in organisational psychology and change management! My next career move was to the University of Malawi in east Africa, a move that my fellow graduates from the MBA programme at Strathclyde University found difficult to reconcile with their typical MBA graduate expectations of being able to command high salaries. The personal benefits and the learning that ensued from my time in Africa more than compensated for any loss of salary. Anyone who has spent time working in a low-income country will attest to the richness and formative nature of the experience.

On returning to Ireland I continued my connection with Africa. In 2004, I estab-

lished the Centre for Global Health in Trinity College and remained as its director until 2014. The Centre's research activity was focused on strengthening health systems in Africa through multi-country interdisciplinary research. I balanced this with my research in the Irish health system, completing a PhD in health strategy during my time in TCD and supervising and supporting middle and senior managers and health professionals as they undertook masters level research on a broad range of management and organisational issues.

**M:** *Why should a health systems programme be located in a school of nursing and midwifery and what are the potential synergies between nursing, midwifery and health systems in terms of research and education?*

**E:** Health Systems research tends to be problem driven and therefore benefits from 'embeddedness'. Nurses and midwives are the most embedded professionals in the healthcare system, comprising the majority of the healthcare workforce and having more direct contact with patients than any other health professional.

Placing health systems research with nursing and midwifery provides a deeper understanding of problems that research can help to resolve, as well as creating greater potential to accelerate the speed at which research evidence can be made available to decision-makers and implemented to improve healthcare.

Real and lasting improvement in our health system will only happen if we manage to embed research in every aspect of healthcare practice and health services delivery. Nurses and midwives are very well placed to make this happen. It also helps that many of the current senior leaders in healthcare come from a nursing background. This helps instil a belief amongst more junior nurses and midwives that they can really be the drivers of system improvement.

The College structure in UCD helps to promote interdisciplinarity and there is great potential to develop programmes of research and teaching across the schools in our College and beyond.

**M:** *You were formerly based in a medical school. Do you notice any changes when compared to your current location?*

**E:** I am a strong believer in interdisciplinary research and teaching and everything I do speaks to this. Because of this I don't feel defined by the school I am in. Many of my international collaborations are with schools of public health. I also work with colleagues in business schools and within the social sciences. As long as my school enables me to achieve my goals, I am happy.

As a general observation, I would say that medical schools are less embracing of change, there tends to be a strong drive to retain the status quo. Of course, that could also be said of many institutions with a long history!

**M:** *What impact do you think health systems research and education can have on health professional education?*

**E:** In my opinion, health professionals in this country receive excellent technical training. Against this they receive insufficient education about the health system and how to work within this system to maximise their impact on patient care. It is not enough to be a good nurse, you must also understand other professionals' roles and contributions, you must be able to work as part of a team, see beyond the boundaries of your specialty, ward or hospital, question how things are done and strive to find better ways of delivering care and improving health.

Placing well-intentioned people in a dysfunctional system will not improve that system and it may even do harm. We must give health professionals the evidence and expertise to create functioning systems that are efficient and effective. If we don't do this, we will constantly be restructuring, reconfiguring and reforming to little effect. Teaching health professionals how to understand, analyse and improve the systems they work in is where health systems academics can make a real contribution.

**M:** *I totally agree. System blindness characterised by a lack of understanding and appreciation of others' roles in the system is a major issue that needs to be addressed. As educators, where might we begin?*

**E:** We should start at the undergraduate level with introductory courses in systems thinking and the healthcare environment. In UCD we are developing an elective that aims to do just that and it will be offered to students from across the university.

At the postgraduate level, it is about giving people the knowledge and tools to challenge how things are done, to test different ways of organising and leading healthcare teams and services and to be bold and innovative, using the best evidence available to them and building new bodies of evidence as they go. We need to move away from narrowly defined career progression pathways and expose people to flexible learning experiences that give health professionals the scope to discover where they can make the best contribution.

Not all health professionals make good leaders, not all want to be leaders. Some may be more effective in purely clinical roles, others may be good mentors, have a passion for quality improvement and so on. With this in mind, what we are doing here in UCD is creating a flexible modular structure that provides several masters level pathways for healthcare professionals. All of our health systems programmes will be interdisciplinary, as it makes no sense to train people for systems roles in disciplinary silos.

**M:** *Again, I strongly agree. For me, the purpose of academic nursing and midwifery is to strengthen the disciplines so that they can make a distinctive contribution in diverse interdisciplinary contexts. What about the potential impact of health systems research on health professionals' education and wider formation?*

**E:** Health systems research by its nature must be interdisciplinary. One thing I have learnt from my experience in the Centre for Global Health over the past 10 years is that interdisciplinary research is fraught with difficulties. It takes time to understand and appreciate the contributions of other disciplines, to traverse the language differences, to bring together the different bodies of literature and then there is the thorny issue of where to publish: single-discipline journals or more interdisciplinary ones. Now that the latter are climbing up the impact-factor scale this is less of an issue.

On the plus side, this type of research is richer for the variety of perspectives it brings to bear on problems and it is intensely rewarding, as there are always new challenges that bring new learning.

Health systems research can be difficult to explain. One misperception is that research needs to be about the whole system for it to be considered health systems research but, of course, it would be impossible to orchestrate a research project that accounts for every aspect of a health system.

**M:** *What might be a more useful characterisation of health systems research?*

**E:** A more accurate reflection is one where the research question emerges from a systems problem and the researcher focuses in on one or two leverage points to

explore and understand that problem.

**M:** *Can you give a specific example from your own research?*

**E:** A project I am about to start working on; 'Co-Lead: Collective Leadership and Safety Cultures' is a five-year project that starts from the problem of healthcare errors and risks to patient safety. Recent concerns about quality and patient safety have raised issues about leadership, governance, poor working relationships in teams and lack of clarity in accountability and reporting relationships. One major contributory factor is failure to invest in leadership development and the lack of an evidence base to support a consistent approach to the training and development of leaders and teams. This research programme will draw on emerging theories of collective leadership.

**M:** *How do you define collective leadership in this context?*

**E:** Collective leadership is not the role of a formal leader but refers to the interaction of team members to lead the team by sharing leadership responsibilities. It is not a characteristic of an individual person; rather, it involves the relational process of an entire team, group, or organisation. In contrast to traditional approaches that focus on the development of the individual as a leader, the approach in this programme will be on developing the team as a dynamic leadership entity.

Rather than starting from a top-down, competency framework-driven curriculum targeted at the individual as a leader, development will be informed through a bottom-up, service needs-driven, co-designed curriculum targeted at team members as co-leaders. This represents a radical shift from current practice and an entirely necessary one if the hospital groups are to function effectively as networked structures. The programme will implement leadership development interventions for groups of leaders at different levels within the hospital groups and test the impact of these interventions on staff performance and patient safety.

The overall aim is to support quality and safety cultures through the development of a new model of healthcare leadership that is associated with effective team performance. It is essentially about addressing the practical problem of improving patient safety, but doing so within a rigorous research framework that allows us to test a new model of leadership. This reflects another distinctive feature of health system research: active engagement with the system not only to inform the research question but also to pave the pathway for implementation and scale-up or dissemination of the findings. So in Co-Lead, for example, the Ireland East Hospital Group and the HSE are partners in the research. The King's Fund in the UK is another important partner as they are doing complementary research in the NHS and it provides a good opportunity to share learning across both systems.

**M:** *Thank you Eilish. You provide a compelling case for health systems education and research and their contribution in supporting healthcare professionals to strengthen health systems.*

*Martin McNamara is the dean of nursing and head of school at the UCD School of Nursing, Midwifery and Health Systems, UCD*

# Health needs of refugees – are we prepared?

## In part two of an article on responding to the needs of migrants and refugees, **PJ Boyle** discusses their care within the Irish health services

AS THE reception centre is the first phase of direct provision accommodation, voluntary health assessment is offered to all newly-arrived residents – asylum seekers/refugees and programme refugees, including victims of human trafficking. Consequently the population remains transitory and the service is demand and needs led. Now located at Balseskin Refugee Reception Centre in Dublin, the refugee health screening team provides health and social care support from the medical centre on-site to more than 320 residents.

The interdisciplinary health screening team works as part of HSE (Dublin North City) primary care and social inclusion services. The team is made up of a clinical nurse specialist (CNS – asylum seekers health assessment), two nurse-midwives, a medical doctor (area medical officer), a visiting PHN and clerical staff. In addition, there are two HSE childcare staff who provide preschool education, parent support and play therapy. The team works in partnership with psychologists from the HSE Specialist Psychology Service for Refugees and Asylum Seekers who are based in the medical centre. The team also works closely with the visiting GP service for the referral and management of acute and chronic conditions for residents on site. The HSE also recently approved the positions of a primary care social worker and community mental health nurse.

Health assessments are private and confidential and separate to the asylum process. They are undertaken during residency at the centre and clients are given a personalised hand-held record of their assessment and any results. Pending outcomes and disclosures during the health assessment, referrals to specialist services are arranged if necessary, for example maternity, paediatrics, infectious diseases, public health. The team has provided health screening assessment to thousands of residents since its inception and has undertaken a number of work-based research studies to date.[1,2,3]

### 'Public health' in context of migrant health

Although the service was established with a focus on communicable disease screening, such as TB, hepatitis and HIV, over the past 15 years it has evolved significantly. By responding to the health and social care needs of refugees and asylum seekers, the team has amassed specialist experience on migrant health, transcultural nursing and cultural competence development. Health screening comprises public health assessment, vulnerability assessment and a broader psychosocial evaluation of the immediate health and wellbeing needs of people on arrival.

Although some newly arrived refugees and asylum seekers may have specific health issues pre-departure from their country of origin, the majority are generally healthy – both physically and psychologically. Likewise the refugee population is not a homogeneous group. Their presenting health issues reflect a microcosm of global health. Our experience is not limited to the provision of voluntary public health or communicable disease screening. However, in addition to their refugee experience, some people may also have a serious illness requiring different nursing support and interventions.

Over the years our nursing and midwifery practice has supported many people, including children with chronic illness, life-limiting conditions, palliative care and serious mental health problems. This work involves close liaison with healthcare services and professionals in acute hospitals, maternity services, community/primary care and psychiatric/mental health services. Many of these services may not be familiar with the living circumstances of refugees and the barriers associated with accessing equitable care when required.

The new guidelines for migrant health screening in Ireland from the HSE/HPSC offers an opportunity to deliver on best professional interdisciplinary and inter-agency practice in public health – *see* **www.hpsc.ie**. However, gaps remain and there is room for improvement in health services for refugees and migrants. The delivery of practice in accordance with these guidelines will require significant commitment and financial resourcing, including staffing, education and training in primary care, public health and population health. Establishing a single interdisciplinary unit in the HSE to plan and implement migrant health services, across the organisation and relevant agencies, may prove more valuable and cost effective than the current fragmented system.

### Engaging with clients and others

A key component of working with asylum seekers and refugees is forming partnerships with community-based organisations with expertise in community integration and primary healthcare. Practicalities may impact on the provision of care, such as communication/language

barriers, cultural differences in understanding causes of ill-health and treatments, and health-seeking behaviour, lack of resources such as interpreters/mediators. We work from a specialist knowledge base of transcultural nursing and cultural competence, including application of explanatory health models. We can share this information with other services, agencies and professionals.

Using this community development approach enables a richer engagement and ownership by service users to finding their own solutions to their needs. Balseskin clinic staff liaises with many such services, such as the Community Mothers Programme, HIV Ireland, the Cross Care Migrant Project and Jesuit Refugee Service. Our vision of nursing extends beyond narrow definitions of public health to include other important social determinants relevant to the migrant health context.

In addition, professional education is a key component of our work. We contribute to formal multidisciplinary undergraduate and postgraduate programmes in nursing, medicine and psychology, including participation in many international conferences and symposia on migration and health.

## Future of migrant health work

Despite examples of effective migrant health programmes across Europe, there remains cause for concern. There seems to be a number of contradictions to Europe's approach to migrant health. Healthcare organisations and professionals are becoming increasingly compromised professionally and ethically in their practice. In some EU states healthcare staff must consider the 'migrant status' of people before determining their level of access to care and treatment. This is an unfair and challenging position for any healthcare professional. Such expectations may be interpreted as a collusion by healthcare professionals with stringent and damaging migration policies that can deny people their fundamental human rights. For further information on such developments see **www.eupha.org** and **www.ecre.org**

In an effort to address such issues, in April 2014 at the European Association of Public Health Conference on Migrant and Ethnic Minority Health in Granada, Spain, participants drafted the 'Granada Declaration' to highlight concerns of healthcare professionals to the Council of Europe (see **www.epha.org/a/6023**).

Although clinical knowledge and project management are important, fundamental in responding to migrant and refugee health needs is humanitarianism and social justice. In March this year the University of Limerick hosted the RESTORE Migrant Health Conference addressing issues beyond language and cultural barriers, including the promotion of professional migrant health education for healthcare staff. Ireland has participated in a number of international studies and conferences investigating such issues.

In Ireland the HSE National Intercultural Health Strategy 2007-2012 (under review) has contributed significantly to the migrant health sector. Although not all its recommendations have been implemented, work is ongoing in several areas, including health screening, language and communication. The HSE National Intercultural Governance Committee works with other HSE directorates, statutory bodies and NGOs, to advance the recommendations.

The nursing profession contributes significantly to this organisational process and to the wider HSE organisation on issues of migrant and intercultural health, including policy development and education. Nursing scientific literature provides many useful resources, including specialist texts in transcultural nursing and cultural competence.

The International Council of Nurses position statement on the treatment of migrants, refugees and displaced people outlines the professional and ethical obligations of nurses internationally in responding to the needs of migrants and refugees. See also the European Transcultural Nurses Association **www.europeantranculturalnurses.eu**, the Irish Transcultural Nurses Network **www.tnn.ie** and the Partnership for Health Equity website **www.healthequity.ie**

## Help in times of need

As Ireland prepares a response to the European refugee crisis, where do you position yourself and how prepared do you feel? It is important for us not to lose sight of the value of helping each other in times of need. As a nurse who has worked exclusively with asylum seekers and refugees, I continue to ask myself – is it not simply the case that we are all individual human beings deserving of respect and dignity when we need care? We need to ask ourselves if the assigning of a political, social or administrative label to a person negatively affects us and the quality of care and relationship between the nurse and the patient, and, if so, why?

| HSE refugee clinic Balseskin 2014 | |
|---|---|
| Total number of asylum seekers accommodated (2014) | 1,358 |
| Total invited for health screening assessment (2014) | 1,217 |
| Total number attended health screening assessment (2014) | 981 (81%) |
| Reviews/recalls/emergencies (2014) | 2,141 |
| Total No (multidisciplinary) (2014) | 2,711 |
| Grand total of attendances (2014) | 5,833 |
| Health screening Jan-April 2015 | 639/786 |
| Reviews/recalls Jan-April 2015 | 804 |

**Top eight countries of origin of asylum seekers in 2014:**
Pakistan, Nigeria, Bangladesh, DRC, Zimbabwe, Albania, Algeria, Malawi

**Cohorts accommodated:** asylum seekers, convention refugees, programme refugees, permanent medical resettlement cases (UNHCR evacuees), victims of human trafficking, pending deportees

**Staff at HSE :** Staff at HSE Medical Centre, Balseskin: PJ Boyle, CNS; Dr Maureen Brennan, AMO; Kay Murphy, nurse/midwife; Liliana Moralés, psychologist; Ann Maria O'Brien, nurse/midwife; Elaine Upton and Lorraine O' Connor, medical secretaries


*PJ Boyle, who holds a doctorate of professional studies (Health), is a clinical nurse specialist (asylum seekers health assessment) at the HSE Medical Unit, Balseskin Refugee Reception Centre, Dublin, Email: pj.boyle@hse.ie*

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# A shortened experience of motherhood

## In the second article in a two-part series, **Denise McGuinness** provides insight into the world of bereaved mothers

THE development of maternal-foetal attachment from an early stage in pregnancy has been described in the literature.[1,2,3] Psychoanalyst, Daniel Stern describes how the baby has a long prenatal history as the baby grows and develops in the mother's uterus; subsequently, the baby undergoes a parallel development in the mother's mind.[4] Birth is the meeting place for the baby that is in her arms and in her mind.

In a study[5] exploring the experiences of mothers as they suppress lactation following late miscarriage, stillbirth or neonatal death, mothers were attached to and grieved the loss of their babies. They valued their pregnancy, holding their baby and bonding with their baby. The care bereaved mothers receive during this time can be as lasting and important as any other memory of the pregnancy or the baby's brief life.[6]

### Mothers and grief

Normal grief is associated with common experiences of shock, anger, sadness, anxiety, guilt and numbness.[7] Mothers in the study described these feelings and behaviours. Perinatal loss is considered to be one of the hardest losses to come to terms with. In the study, two mothers described these feelings and also self-directed blame following the loss of their baby.

Prior to her interview, Amelia said: *"He was given to me to look after," "I made bad decisions,"* she felt responsible for the loss of her baby.

Another interviewee, Ash stated: *"You just blame yourself for small things, maybe I should have gotten to the hospital earlier." (Ash 22+1/40 P3)*

### State of being

Shock, numbness and helplessness are common feelings following a sudden death. Amelia described this feeling of helplessness, being unable to make any decisions. She felt broken. The hospital care she felt was very good as they provided direction with what to do next:

*"Obviously you're broken and you're not capable of... you don't know what to do, you know what you're supposed to be doing and the hospital was really good at guiding you as to what the next step was." (Amelia 38/40 P3)*

Anne described a restless hyperactivity following the loss of her baby and then following the funeral everything became more real:

*"You are still kind of in business mode. You have been doing so much stuff and it's not until after that everything hits you." (Anna 24+6/40 P2)*

### Unviable baby

Helen discovered at her routine 20-week scan that her pregnancy was unviable. She explained that she knew for more time in her pregnancy, than not, that her baby would not survive following birth. Pregnancy changes a mother's body in many ways; physically, emotionally and spiritually, this experience is a very challenging time for mothers with an unviable pregnancy. Helen made a decision to leave work and committed to enjoying the short time she had with her baby.

The couple received counselling from the bereavement midwives. The community midwives provided support and midwifery care during the pregnancy, birth and following the birth. Helen attended her GP during the pregnancy and found her to be a great support. Helen also appreciated the honest communication with one of their doctors at the hospital.

*"We found out at 20 weeks and after that we met with the bereavement midwives over the weeks and months leading up to Tom's birth. The doctor, he was always very honest with us, he always told how it was and you know if things had changed." (Helen 42/40 P1)*

During the pregnancy Helen and her husband had time to prepare for their baby's funeral and they wanted it to be a special occasion with family and close friends:

*"It was something we could do for Tom (pseudonym)."*

### Family bonding

Some mothers had other young children to consider. It was a painful experience for mothers to first cope with the loss of their baby and then to prepare and support their other children with their loss.

Cora prepared for the situation; she asked the midwife to take her baby out of the room before the children arrived. She then had an opportunity to talk with her children, comfort them and prepare them to meet their new baby brother. The children subsequently held their brother. Cora

recalled how she prepared the children:

*"I let them see me, we hugged and I made sure that they were okay, once they were comfortable I asked them did they want to see him and then I brought him back in and they got to hold him and they were very, very good." (Cora 27+4/40 P3)*

Sarah spent a few hours with her baby after she died. Her husband wanted their toddler to see her new sister also. Sarah described:

*"My husband wanted my little girl to see Amy even though at that time she would have only been 13 or 14 months because we wanted to have a photo. But practically that was hard work because my toddler was running riot, she was running everywhere." (Sarah 26+6/40 P2)*

Some mothers brought their baby home for a night before the funeral. This journey home for the family with the baby was managed in different ways. Amy reported:

*"He slept in the bed between us. We took him ourselves to Glasnevin and a friend of my husband had written a poem just after he found out that Tom was born and that was read at the funeral." (Helen, 42/40 P1)*

Cora and her family went shopping and bought their baby an outfit that he could wear going home from the hospital. This ritual involved the children and created family memories as they moved forward:

*"Myself, John (husband's pseudonym) and the two girls went shopping. We bought Ronan (pseudonym) an outfit and we brought it up to the hospital for him, the midwives were going to dress him." (Cora 27+4 P3)*

Consideration of the impact of the baby's death on their other children was prioritised by mothers. For some mothers bringing the baby home was a very important event in the family's life.

## Holding a baby that has died

The discourse on whether a mother should hold her baby following late miscarriage, stillbirth or neonatal death is ongoing in the literature and in clinical practice. In more recent years mothers are encouraged to hold and spend time with their baby that has died. It is suggested that touching the baby's hands and feet can help the mother realise that her baby is now separate from her and this may help the grieving process. Sinead described the transition from being in labour to seeing her baby. Being face-to-face with her baby made the whole experience very real and she became upset:

*"When you're going through the labour pains it's all about you at that time but suddenly they bring this tiny little baby up to you and then it really hit home that this was the little baby and I got upset. I wept and I agreed then to have the blessing at that point… yes please I do want to have her blessed. I was very grateful for that. I was really appreciative of that." (Sinead 23/40 P2)*

With support from the bereavement midwives and chaplain Sinead looked at and touched her baby:

*"I would definitely encourage any mum who was going to go through this to see their baby, definitely, it's the only chance you will ever get to see that child and if you don't I think you will regret it. You will always wonder what did they look like and I should have held her. It was the right thing to do." (Sinead 23/40 P2)*

Cora's baby lived for approximately 30 minutes:

*"I still can't and I'd love to be able to remember holding Ronan (pseudonym) because seemingly I held him while he was alive." (Cora 27+4/40 P3)*

From the accounts of the experiences of the bereaved mothers in this study, holding their babies did not appear to cause unnecessary distress or harm but rather was viewed as a positive experience during a very difficult time.

## Discussion

The psychological transition to the role of a mother and motherhood begins during pregnancy.[8] The development of maternal-foetal attachment from an early stage in pregnancy has been described in the literature.[1,2,3] The theory of attachment guided the study, namely Bowlby's influential work on attachment[9,10] and Ainsworth's[11] description of attachment as a specific emotional bond between an infant and caregiver.

It was important for mothers in this study[5,12] to have their motherhood validated by holding their baby. While an earlier study by Hughes[13] suggested that it may be harmful for a mother to hold her stillborn baby, more recently, it is recognised that it may be important for mothers to hold their baby, providing love, warmth and time with their baby. The literature has identified that mothers value and benefit from contact with their baby, particularly when they are supported to do so.[14,15,16]

Current clinical guidelines suggest that decision making around holding a baby that has died should be a parental decision made with an experienced practitioner.[17] The role of healthcare professionals in encouraging parents to see and hold their stillborn baby is paramount. Kingdon et al[16] offer the opinion that parental choice not to see their baby or uncertainty should be continuously revisited in the hours after birth as the opportunity for contact is fleeting and final.

Newer grief theories guided the understanding of memory making following the loss of a baby. These new models place emphasis on holding on to and developing continuing bonds with the deceased. Parenting and caring for the baby that has died is recognised to produce positive memories by supporting the grieving process; it provides an opportunity to bond with the baby and forms a sense of identity for the baby.[18] Mementoes are a tangible reminder of a baby's short life and mothering. The literature describes the importance of mementoes to families[19,20,21,22] by creating a bond and sense of identity of the baby[18] that may aid the grieving process. Radestad et al[23] describe the significance of creating memories in the form of photographs, baby clothes and moulds of the baby's hands and feet.

Bereavement theory guided the understanding of a mother's grief in the short time period following the loss of a baby. The bereaved mothers strongly emphasised feeling traumatised in the early days following the loss of their baby, with feelings of helplessness described. Grief symptoms of shock, anger, emptiness, helplessness and loneliness are described in the grief literature.[24,7,25] Perinatal grief is a unique grief; it is a prospective mourning, relinquishing hopes, dreams and fantasies about the child that never was. The findings of this study have provided a useful insight for professionals involved in the care of bereaved mothers following the loss of a baby.

It is important for bereaved mothers to have their motherhood acknowledged and validated and to receive compassionate and empathic care from nurses and midwives. The support of health professionals is paramount at the time of a baby's death as this may influence how a bereaved mother copes with the baby's death and the memories surrounding the birth and death years later.[6,26,27,28]

*Denise McGuinness is a clinical midwife specialist (lactation) at the National Maternity Hospital, Dublin and a clinical tutor in midwifery at the School of Nursing and Midwifery, Trinity College Dublin*

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*References on request from nursing@medmedia.ie*

*(Quote McGuinness D, WIN 2015; 23(10): 55-56*

# Clinical handover:
## Clear communication protects all

**Deirdre Munro** discusses the importance of handover in midwifery

### Identify

Clinical handover refers to the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.[1]

In November 2014, the National Clinical Effectiveness Committee (NCEC) published 'Communication (Clinical Handover) in Maternity Services', National Clinical Guideline No.5. This guideline is intended for use by all healthcare staff involved in clinical handovers in maternity services in Ireland.

### Situation

The NCEC is a ministerial committee; its role is to prioritise and quality assure national clinical guidelines. These guidelines recommended by the NCEC for implementation provide robust evidence-based approaches to underpin or define models of care as appropriate. Implementation of clinical guidelines can improve health outcomes, reduce variations in practice and improve the quality of clinical decisions.

### Background

Following a tragic maternal death at University College Hospital Galway in 2012, in which poor communication was identified as a contributory factor, the HSE established the National Implementation Support Group to act on the recommendations of the reports of the coroner, HIQA and the HSE. A communication sub-group and guideline development group was also established to develop a national clinical guideline with recommendations on communication (clinical handover). This group was chaired by Eilish Croke and project managed by Celine Conroy. In developing the clinical guidelines, the sub-group was supported by Prof Gerard Fealy and a team of researchers at UCD. The team provided the evidence base for the guideline through a systematic review of literature on clinical handover,[2] expert consultation and an examination of current clinical handover practices in maternity services in Ireland.[3]

### Assessment

National Clinical Guideline No.5 describes the essential elements for timely, accurate, complete, unambiguous and focused communication of information in maternity services in Ireland.[1] It relates to both urgent and routine conditions of a patient including: professional consultations; such as team-to-team and one professional to another, deterioration of a patient's condition and transition of care; as at change of shift, escalation to a higher level of care and communicating with patients or relatives.

### Recommendations

The recommendations contained in Guideline No. 5 include all communication (clinical handover) between healthcare staff in maternity services to be conducted using a structured communication tool, promoting standardisation of practice and minimising variability, thereby reducing the risk for patients. Recommendations relate to organisational, conduct content and risk rating elements of clinical handover.

*Organisational*

- Recognise clinical handover as a clinical risk activity
- Participation should take priority except in emergencies
- Review existing clinical handover guidance with stakeholders
- Develop a local policy in compliance with national clinical guideline
- Audit clinical handover practice by relevant quality and safety committee
- Provide staff with education and training for the clinical handover policy
- Mandatory for staff orientation and ongoing staff in-service education
- Promote a culture of mutual respect between professionals.

*Conduct*

The patient should be involved in the clinical handover process, considering their preferences while meeting the requirements of confidentiality.

- Ensure all staff have access to relevant, accurate, up-to-date information during clinical handover
- Consider electronic patient records and

diagnostic data as a solution to provide relevant accurate up-to-date information
- Implement multidisciplinary clinical handover where possible, include junior and senior staff
- Shift handover should include a discussion of operational issues, including identification of factors that may impact clinical care
- *ALL* patients should be discussed at shift clinical handover
- Clinical handover should be conducted in an area with minimal distractions/ interruptions
- The organisation should ensure mandatory protected time be designated for shift clinical handovers
- Clinical handovers should specify staff attendance, roles and responsibilities at clinical handover
- Clinical handover should be conducted verbally, face-to-face, supported with relevant documentation
- Taped handover must NOT be used in any circumstance.

*Content*
- Clinical Handover should be conducted using ISBAR$_3$ communication tool (Identify, Situation, Background, Assessment, Recommendation, Read-back, Risk)
- ISBAR$_3$ may be available in written format but preferably electronically
- The ISBAR tool should be used when communicating information in relation to a critically ill or deteriorating patient

**Risk rating**
- The safety pause should be utilised during shift clinical handover to provide an opportunity to clarify and discuss any aspect of a patient's care
- Radiology QA guidelines should be implemented in all locations for the management of critical, urgent, clinically significant and unexpected radiological findings
- Laboratories should have policies and assurance processes in place for clinical handover of critical results.

**Read-back**
- Read-back is by the recipient of clinical handover to confirm and clarify clinical handover information is received and confirms responsibility

**Summary**

The National Clinical Guideline No. 5 recommends that higher education institutions providing preparatory professional education and continuing education and professional development should incorporate clinical handover within curricula. The Guideline also recommends the establishment of a national communication (clinical handover) group to support implementation of this important guideline. The HSE and all healthcare organisations are responsible for disseminating and implementing the guideline, including education using the recommended communication tools.

The service user is at the centre of healthcare. Clinical handover is every healthcare organisation's responsibility. All healthcare staff are accountable and responsible within their professional scope of practice for adhering to Guideline No. 5 and for maintaining competence when communicating through clinical handover.

*Deirdre Munro was midwife researcher on the national communication project UCD. Currently INMO Executive Council member. Project co-ordinator QID, Corporate HSE*

*Special thanks to Prof Gerard Fealy and the UCD team, Eilish Croke and Celine Conroy, Communication (Clinical Handover) sub-group, GDG HSE*

*References*

*1. Communication (Clinical Handover) in Maternity Services. National Clinical Guideline no 5. Department of Health/ NCEC/ Patient Safety First. Nov 2014. http://health.gov.ie/wp-content/uploads/2014/11/National-Clinical-Guideline-No.-5-Clinical-Handover-Nov20141.pdf*

*2. Fealy GM and Riordan F (2014) Communication and Clinical Handover Practices: A Systematic Review (Systematic review conducted on behalf of the National Clinical Effectiveness Committee), Dublin: HSE/UCD*

*3. Fealy GM, Munro D, Riordan F, McNamara M (2014) Clinical Handover Practices in Maternity Services in Ireland (National review of clinical handover practices conducted on behalf of the National Clinical Effectiveness Committee), Dublin: HSE/UCD*

# On the ground with the president

## All Ireland Chief Nursing Officers conference

ON BEHALF of the Organisation, I attended the All Ireland Chief Nursing Officers conference in the Titanic Centre in Belfast. The theme of the conference was 'leading and shaping the nursing and midwifery agenda — an all-Ireland approach'. The conference was hosted by Dr Siobhan O'Halloran, chief nursing officer (CNO) at the Department of Health and Charlotte McArdle, CNO for Northern Ireland.

Leo Varadkar addressed the conference and thanked nurses and midwives for their contribution to the health service. He also acknowledged the challenge in recruiting nurses and midwives, but advised that progress was being made. He stressed his ongoing support for the work of the 'Taskforce on Staffing' and 'Skill mix for Nursing', chaired by Dr O'Halloran, in developing a framework to determine the safe staffing and skill mix requirements for the nursing workforce in general and specialist medical and surgical care settings. He also announced that he had approved the taskforce's interim report on the framework. An extensive pilot is to be funded and run next year.

I want to mention the CNOs' award for 'Excellence in Cross Border Nursing' which was presented to Anne Gallen and Alan Cory Finn for establishing the Cross Border Senior Nurses and Midwives Forum. This award recognises innovation and excellence in patient care within the border region or on an all-island basis.

## Happy Christmas

IT IS hard to believe that Christma is upon us and 2016 is just around the corner. I would like to take thi opportunity to extend my warme wishes for the festive season. Mar of you will be working, providing excellent care on the frontline to our loved ones, but I do hope that you will get to take some time out for yourselves to be with your families and loved ones. I thank all INMO reps, committees, Branch and Section officers who work on a voluntary basis on behalf of the organisation. This work is greatly appreciated, as is your commitment to the INMO. I look forward to meeting you at your AGMs in the new year. Happy Christmas and new year.

## European Federation of Nursing Assembly (EFN)

ELIZABETH Adams, INMO director of professional development, Dean Flanagan, INMO student and new graduate officer, and I attended the European Federation of Nursing Assembly in the Royal College of Nursing in London. At the general assembly we discussed key political issues related to the three main political institutions: European Commission, Council and European Parliament, including a discussion on the sustainability of the European Nursing Research Foundation, developed when EFN started co-ordinating the EU thematic network 'ENS4Care'.

I sit on the EFN workforce committee. During our meeting we evaluated the EU strategy on 'EU workforce for health' and agreed on two position statements on 'recruitment and retention', and 'dementia and the workforce needed in the community to cope with the challenges of chronic diseases'. Furthermore, the entire general assembly, representing 34 member States, adopted the EFN Position Paper on 'Principles Underpinning the Development of Health Care Assistants', providing clear guidance for the EU in its political discussions surrounding 'mutual recognition' and 'workforce for health'. It is time researchers and policy-makers start acknowledging the EFN's concerns and solutions.

## Social policy

AS YOU are aware we have been in involved in a number of campaigns in relation to violence against women. A number of initiatives have been launched in November to end violence against women. Man-up launched a video in conjunction with Cathal Pendred UFC fighter which can be found at www.manup.ie

Our general secretary Liam Doran was one of the guest speakers at White Ribbon ambassadors' reception event recently. I am immensely proud of our Organisation's involvement in these important issues on social change and gender equality. I would encourage you to participate in events in your local area.

We continue to be involved in the Turn off the Red Light Campaign and hope to see the government introduce the criminalisation of the purchase of sexual services into the Sexual Offences Bill in the coming weeks.

## Branch and section meetings

I RECENTLY attended a number of branch and section meetings. It is great to see so much activity and to see new sections being established and old ones re-energised. These are important events and I would encourage you all to look at upcoming events and participate. Details of meetings can be found on page 72.

## Get in touch

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

Claire

# Placement advice and tips

## **Dean Flanagan** discusses the details of the new Student Section meeting and offers first year students tips for their first placement

### New Student Section meeting

THE new INMO Student Section *(see page 26),* which represents approximately 6,000 student nurses and midwives across the country, held its inaugural meeting in Dublin recently. The meeting was held in November and coincided with the class rep meeting, which took place on the same day.

During the meeting, which was attended by more than 40 people, nursing and midwifery students from across most of Ireland's third-level institutes put their names forward for election onto the new Section.

The Student Section is a great opportunity for students to decide what they want on the agenda for the coming year. I work very closely with the Section and look forward to collaborating with the new chairperson Aoife Kiernan who studies at NUIG. It is also fantastic that the head of department in NUIG, Catherine Comiskey has pledged to support Aoife in any way possible in light of the ongoing difficulties facing student nurses and midwives.

The other Section officers elected were as follows: Stephen Woods, vice chairperson; Bose Allan, treasurer; and Mary Escotho, secretary.

### Workshop with Canadian nursing and midwifery students

The Canadian Nursing Students' Association hosts their national conference in January every year and they have invited Irish students to join them virtually as 'global guests' for their keynote speakers presentations on January 28, 2016. This will be the first webcam conference organised for students to interact with each other from across the world.

The 2016 conference will focus on transformation and the changing landscape of the nursing and midwifery professions. If you are interested in this please contact me by email to: dean.flanagan@inmo.ie as places will be limited. To view the full programme visit: **www.aeic.ca/english/conferences/national**

**Pictured at INMO HQ attending the first meeting of the new INMO Student Section were (l-r):** *Claire Minton; Eddie Flynn; Mary Escoto, secretary, Student Section; Bose Allen, treasurer, Student Section; Dean Flanagan, student and new graduate officer; Aoife Kiernan, chairperson, Student Section; Tara Collins; Cliodhna Beirne; Fiona Conlon Dunne; Alicia Wallace; and Darren Ó Cearúill, student representative, Executive Council*

### Placement time has arrived

I want to wish all the first years the best of luck in undertaking their first placements and I really hope you enjoy them as much I did.

Here are just some tips to make note of as you begin your placements:

- *Get organised:* Being organised can help make your student years a success. To save time, make folders for your assignment briefs, timetables and documents. On placement, maximise every learning opportunity by organising your time to include all the experiences open to you
- *Access support and ensure you maintain regular contact with your CPCs and mentors:* They are there to help. They are experienced nurses and can answer questions you're unsure about or just offer to listen. Access support sooner rather than later, don't let something small become major (this was the biggest fear I had on placement)
- *Look after yourself:* It seems really simple but how can you care for others if you are not looking after yourself? Eat regular meals and drink plenty of water because being well hydrated aids concentration. Establish a good sleep pattern and try to exercise
- *Talk to family and friends*: 'Second-year blues' may actually arrive in your first or third year and they come without warning. It's that time in your course when you wonder whether you can really do this? The answer is yes, you are already doing it. I got through these doubts by talking to my family and friends, seeking the advice of my tutor and taking some time for myself
- *Plan your time:* This sounds so simple but can mean the difference between 3am panic writing and actually enjoying the assignments. I used to try to keep assignment dates in my diary and then work out how many words per day I needed to do to complete the assignment by the deadline.

*Dean Flanagan is student and new graduate officer at the INMO*

# INMO KILKENNY BRANCH

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## Branch Officers

**Chairperson**

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**Treasurer**

*Margaret Murphy*
*Margaret.Brennan Murphy@hse.ie*

**Secretary**

*Sheila Swain*
*sheila.swain@hse.ie*

**Vice Chairperson**

*Fran Hayes*

**IRO**

*Liz Curran*
*liz.curran@inmo.ie*

### Branch workplaces and areas covered

- St Luke's General Hospital
- Kilcreene Regional Orthopaedic Hospital
- St Colomba's Hospital
- Castlecomer District Hospital
- St Patrick's Centre
- Aut Even Hospital
- Public health nurses and community RGNs

### Latest news

The Kilkenny Branch of the INMO meets twice or three times per year. The venue for these meetings has been rotating between Kilcreene Regional Orthopaedic Hospital and St Luke's General Hospital to allow for flexibility of attendance. Local reps and our IRO are meeting regularly to discuss issues pertaining to their own areas.

The main issues of concern relate to staffing levels and ongoing overcrowding and lack of recognition on the appeals process for Acting Category 3 status.

St Luke's Hospital has undergone major capital project development on a new ED, day services facility, oncology unit, hepatology and MAU which will be operational over a phased period between November 2015 and February 2016. There is in-house enthusiasm to ensure adequate staffing is agreed and adhered too.

INMO members have attended safe practice workshops with our IRO on industrial relations matters and have been active at local and national demonstrations on issues of concern in support of our colleagues.

## Industrial relations update

Liz Curran is the IRO for the Kilkenny Branch.

Local issues

**St Luke's Hospital, Kilkenny**

- A number of services are planned to move into the new building in the coming weeks, including the accident and emergency department, MAU, oncology services, endoscopy and hepatology services. Additional nurse staffing levels for services in the new building have been agreed, however, discussions with the INMO continue regarding the proposed revised opening hours of the MAU in the new building. In the maternity department, shift leaders have been appointed and additional midwives have been appointed to the department.

**St Patrick's Centre, Kilkenny**

- Ongoing uncertainty prevails in this service regarding the future management of the service further to various HIQA reports. Discussions are ongoing with regard to same and discussions have commenced regarding the implementation of the report on moving on from congregated settings. A number of industrial relations claims have been served to management and are awaiting a response.

**Aut Even Hospital**

- The INMO has sought discussions with management regarding nurse staffing levels and nurse management posts in this service.

**Kilcreene Hospital**

- INMO compensation for loss of earnings claim has now been resolved and all members eligible for increased payments have received their due monies.

**Castlecomer District Hospital**

- Claims for payments of location allowance to members in this hospital are ongoing.

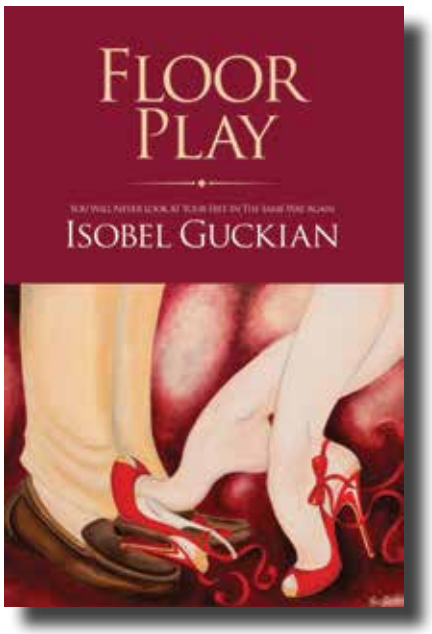
# Make the new year all about your feet

THE first book launched in Europe on foot health for the general audience since 1845, Isobel Guckian's *Floor Play – You will never look at your feet in the same way again* is the product of many years' clinical experience.

The author trained as a general nurse at the Mater Hospital Dublin, later obtaining a degree in podiatry from the University of Cardiff. She is a council member of the Society of Chiropodists and Podiatrists in Ireland.

Her book aims to serve as a practical guide to the most common foot complaints and focuses on problems such as dry skin, cracked heels, verrucae, ingrowing toenails, fallen arches and Achilles tendon complications. It also looks at broader issues such as children's feet, sports injuries and foot health in diabetes, among others.

However, as is suggested by the cover, Ms Guckian starts the book on a less serious note with a description of an evening get-together between friends, which ends up with foot massage and – perhaps to the reader's surprise – an episode of toe sucking. This description will certainly catch the reader's attention, and is aimed to highlight how much we




neglect our feet – regarding general foot health as well as a potential 'erotic organ' as Ms Guckian describes it.

However, this is by no means a book of 'fifty shades of toe-sucking', rather it draws attention to our feet and how we should probably think of them a lot more than we do.

Along with the rather unusual introduction to a book on a health topic, Ms Guckian also includes a lot of small 'did you know' boxes along the way. Once again, these are entertaining and highlight some facts that you may not have been aware of.

As for specific foot problems, having recently suffered from a double Morton's neuroma (which incidentally the author would prefer to call Durlacher's neuritis) in my left foot – due in my case to high-impact sports rather than wearing high heels – I was already aware that I *should* take better care of my feet. However, being aware of it and acting on it are two different things. With the simple advice at the start of this book, I will make a greater effort this time, and it is now part of my new year's resolution.

The book could certainly act as a great resource for those studying foot-focused specialties, but it is mainly aimed at the general audience to promote greater appreciation of the importance of foot care.

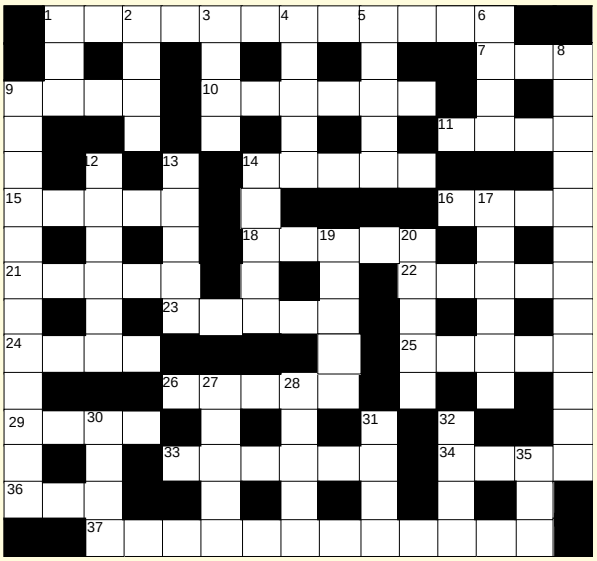
The book can be purchased online at **www.bodyrightphysio.ie**

**– Sonja Storm**

*Floor play – You will never look at your feet the same way again, is published by Barrett Business Communications*
*ISBN 978-1-908417-68-8*

# Crossword Competition

WIN A €30 BOOK TOKEN



**Across**
1 Tend to your mental health when the ceiling is set low! (4,4,4)
7 Painting, sculpture etc (3)
9 Hatchets (4)
10 Get some jewellery from a Celt? OK (6)
11 Dam (4)
14 Fewest or smallest (5)
15 The 'two' in a deck of cards (5)
16 Stand here at darts and dispel the echo (4)
18 Blood-vessels (5)
21 Bar of precious metal (5)
22 Shinbone (5)
23 It's hell being a shade different (5)
24 Part of the window my father wore? (4)
25 Avarice (5)
26 Ingrained dirt (5)
29 Points a weapon at its target (4)
33 It has a diameter and circumference (6)
34 Damage (4)
36 Snakelike fish (3)
37 Would Confucius, Plato and Aristotle exemplify the Magi? (5,4,3)

**Down**
1 Blend (3)
2 The 'N' of ENT (4)
3 Christmas (4)
4 Male relative (5)
5 Pays attention to (5)
6 Fruit found in the calendar (4)
8 The confused Yank hated rum as traditional Christmas fare (6,3,3)
9 Naval caddies are upset to find an abundance of riches here (8,4)
12 A mushroom, for example (6)
13 The Royal County (5)
14 Extremely angry (5)
17 Spider's creation (6)
19 Publish, bring forth (5)
20 On which to perform a show (5)
27 You might lose her in this major European river (5)
28 Tropical bird (5)
30 Grain used in brewing (4)
31 Vegetables that grow in pods (4)
32 One's pal is much confused (4)
35 Sprint (3)

Name: .....
Address: .....
.....
.....

The prize will go to the first correct entry opened.
Closing date: Tuesday, January 19, 2016
Post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin

Solutions to November crossword

Across: 1. Son 3. Transcribed 8. Gander 9. Sympathy 10. Inter 11. Deals 13. Brain 15. Consort 16. Example 20. Satyr 21. Triad 23. Clash 24. Pakistan 25. Figaro 26. Approximate 27. Tit

Down
1. Significant 2. Nineteen 3. Their 4. Nosegay 5. Roped 6. Betray 7. DIY 12. Strep throat 13. Birds 14. Nixer 17. Pheasant 18. Sternum 19. Link up 22. Disco 23. Crime 24. Pea

**The winner of the November crossword is: Colette Gibbons Louisburgh Co Mayo**

# First 1,000 days' nutrition has lifelong influence

THE first 1,000 days of life – from conception to two years of age – has been identified as a unique 'window of opportunity' for nutrition, which can have a major long-term impact on health.

Speaking at a medical seminar on this topic in Dublin, Dr Emily Oken of Harvard Medical School in the US, who is an expert in this field, said that studies show that nutrition in early life 'has a lifelong influence on the health of an individual'. Her research has pinpointed the first trimester during pregnancy as the most sensitive period of development. At this stage, the baby is most sensitive to environmental exposures, such as poor nutrient intake and excess weight gain by the mother.

"The nutrition a baby receives in the womb during the first trimester in particular, has a lasting effect on their cognitive development and risk of obesity, type 2 diabetes, heart disease and stroke in later life," she said.

Dr Oken is currently involved in an ongoing study into the benefits of maternal oily fish consumption on the cognitive development of offspring.

"Our research shows that moderate fish consumption during pregnancy showed no detrimental effects on the offspring and can actually benefit their language and visual motor skills in the early years of life," she explained.

Also speaking at the seminar, Prof Michael Turner, the national lead for the HSE clinical programme in obstetrics and gynaecology, pointed out that the increasing rate of obesity in Ireland was having a severe impact on contemporary obstetrics.

"We now know that a woman's pre-pregnancy weight is far more influential than weight gained during pregnancy on her offspring and contributes to her chance of gestational diabetes, incidents of which have increased in Ireland three-fold in the last six years.

"This is largely due to the fact that one in six women in Ireland are obese before they conceive and there is better screening compliance among obstetricians and GPs. Gestational diabetes results in maternal and foetal complications and the need for obstetric intervention, all of which increase the cost," he explained.

Dr Oken and Prof Turner made their comments at the annual First 1,000 Days seminar, in association with the Irish Nutrition and Dietetic Institute. It is part of a programme aimed at encouraging behavioural change in the way nutrition is approached in Ireland.

Attendees at the seminar, which took place in Dublin's Convention Centre, were told that while the impact of good nutrition on children's physical and cognitive health is well acknowledged, expectant parents and new parents need more advice and support.

# Dealing with domestic violence

A VIDEO, made by White Ribbon Ireland and the INMO, highlights the issue of domestic violence in Ireland through the experiences of nurses dealing with victims of domestic violence. The video was launched at the White Ribbon annual event on November 25 in the Rotunda Hospital and was followed by '16 days of action against violence against women'.

INMO general secretary Liam Doran represented the INMO on the day and White Ribbon Ireland thanked him as well as Claire Mahon and Naomi O'Donovan for their excellent contributions.

The video is testament to the psychological and physical toll that violence against women has on the victim, survivors, our communities and our country as a whole. It aims to highlight how endemic the problem is in Irish society and how healthcare professionals, including nurses, have an undeniable voice in this as they have a unique view from the frontline. It is hoped that this video will reinforce a zero-tolerance approach to violence against women in our society.

See **www.inmo.ie** for more details.

# Study finds midwife-led maternity care is safe and offers value for money

A RECENT study has found that midwife-led maternity care is €182 cheaper per woman than consultant-led care and is as safe an option for expectant mothers.

The study, which was carried out by the School of Nursing and Midwifery and the School of Medicine in Trinity College, found that the average cost of caring for a woman in midwife-led units was €2,598 compared to €2,780 in consultant-led units.

The research, which involved 1,635 low-risk women cared for in the HSE Dublin North-East region between 2004 and 2009, looked at the mean difference in clinician salaries, cost of care based on manager's data, known costs of postnatal bed days and costs of key interventions.

Findings from the study will have significant implications for future policy makers and funders of maternity care and highlights the need to incorporate more midwife-led units into maternity care in Ireland.

**Masters of care:** *Pictured (l-r) are Joanne Doyle, Sinéad Moran, Eilín Ní Mhurchu and Cathy Keighery, four nurses from the Irish charity Jack and Jill Foundation who have received their masters degree in children and young people's palliative care and complex care. This brings to five the total number of Jack and Jill specialist children's liaison nurses at masters level. The core group of children's liaison nurses at Jack and Jill manage 1,000 nurses and carers*

# Nursing home upgrades delayed until 2021

## ALONE unhappy with government decision to delay closures and upgrades

ALONE, a charity that works with older people who are homeless, socially isolated or living in deprivation, has recently expressed their frustration over the government's decision to push out the deadline for nursing homes closures and upgrades to 2021.

According to CEO of Alone, Sean Moynihan: "This government has largely ignored the warnings and failed to adequately invest in our public nursing homes. In September, there was an announcement of €450 million in the government capital spend in nursing homes, however now it is being reported as €300 million. Even with this investment, it won't be enough to tackle the challenges of 2021 when we will have 240,000 additional over 65s compared with when the problems were first identified in 2009."

"It took the Fair Deal review three years to be published, another 18 months for a plan to be developed and now the implementation of the upgrades is being pushed out to 2021, 12 years later. This investment needs to be fast-tracked as a matter of urgency," said Mr Moynihan.

Mr Moynihan continued: "ALONE is also concerned about the over reliance on private nursing homes. Our public nursing homes are a cornerstone of our health system. There is a danger that we are moving to a more and more privatised system. We cannot be wholly reliant on the private sector for the care of our most vulnerable people."

"Enda Kenny previously stated that he wanted to make Ireland a great country to grow old in, so far he has failed to invest in this notion. We need to plan for the future and invest in alternatives. Of late, we have been hearing from vulnerable older persons that it is virtually impossible to get home help at the moment. This is not good enough, home help hours are vital to keep people active in their communities for a fraction of the cost of nursing home care. Investment in primary health care is desperately needed to stop the current problem from running out of control," added Mr Moynihan.

# 2015 IARN annual conference held in Galway

THE annual conference of the Irish Association of Radiology Nurses (IARN) was held in Galway on October 10.

This year's event was hosted by Galway University Hospital. The conference was very well organised and informative and the Irish Association of Radiology Nurses would like to give a special thanks to Sarah Higgins and all those in Galway for their hard work.

Informative presentations were given by Prof Peter McCarthy, consultant radiologist University Hospital Galway (UHG); Smitha Sukumaran, RGN, St Vincent's Hospital, Dublin; Dr Jeeban Das, SpR,UHG; Stephen McNulty, radiographer, UHG; Dr Patrick Navin, SpR, UHG; and Dr Gerry O'Sullivan, consultant radiologist, UHG.

The conference provided members with a fantastic opportunity to update themselves on current and emerging interventional radiology practices as well as to discuss issues arising out of an increased demand for services in tandem with little or no resource improvement.

Next year's meeting will be hosted by the Mater Hospital in Dublin. Further details will be published in WIN in due course.

For further information, or to join IARN, please contact Sharon O'Connor by email at: soconnor@mater.ie

# MedMedia – 20 years of publishing *WIN*

2015 saw the 20th anniversary of MedMedia publishing *WIN – World of Irish Nursing and Midwifery*.

*WIN* publisher Geraldine Meagan said: "We are delighted to have been part of such a longstanding and successful relationship with the INMO as publishers of *WIN*, which is such an integral part of the Organisation's communication strategy. We are looking forward to working together for many more years to come."

# INMO member receives prestigious UCD Alumni Award

*University College Dublin celebrated its outstanding alumni at the UCD Foundation Day Alumni Awards 2015 recently. President of UCD, Prof Andrew J Deeks presented awards to 15 notable alumni who have achieved excellence in their field and whose professional achievements are a source of inspiration to students.*

*INMO member Virginia Pye, director of public health nursing for HSE Longford/Westmeath, was presented with the Nursing, Midwifery & Health Systems award. A spokesperson for UCD said: "Ms Pye is an innovative leader in the area of child welfare and health services. One of her greatest achievements was in 2014 when the HSE launched the Child and Family Needs Assessment Framework for Public Health for public health nurses working in the Midlands".*

*Virginia Pye is pictured above with Martin McNamara, dean of nursing and head of school at the UCD School of Nursing and Midwifery and Health Systems*

## December

**Wednesday 16**
RNID Section. 11am-1pm. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

## January

**Saturday 9**
PHN Section. 11-1pm. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

**Tuesday 12**
Care of the Older Person Section. 11am. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

**Saturday 16**
Radiology Nurses Section. 12pm-2pm. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

**Wednesday 20**
Telephone Triage Nurses Section AGM. 11am. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

**Saturday 23**
Operating Department Nurses Section AGM. 11.30am. Tallaght Hospital. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

**Saturday 23**
GP Practice Nurses Section AGM. 11am. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

**Saturday 23**
CNM/CMM Section AGM. 11am-1pm. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

**Tuesday 26**
Student Allocation Liaison officers group. 12pm-3pm. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

**Tuesday 26**
Clinical Placement Co-ordinators Section. 11am-1pm. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

**Thursday 28**
Retired Nurses and Midwives Section AGM. 11am. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

## February

**Friday 5**
Nurse/Midwife Education Section AGM. 11.30am. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

## March

**Tuesday 1**
Care of the Older Person Section annual conference. Clayton Hotel, Galway. Log onto **www.inmoprofessional.ie** to book your place. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

**Saturday 5**
INMO International Nurses Section Conference and Culturefest. INMO HQ, Dublin. Registration at 8.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

## Notice for Sections

- All Sections must ensure that they have organised their AGMs by February 13, 2016. Contact jean.carroll@inmo.ie or Tel: 01 6640648

## Condolence

- The INMO extends its deepest sympathy to the family and work colleagues of the late Kevina O'Callaghan who was a valued member of staff at Ennis General Hospital. May she rest in peace.


## INMO Membership Fees 2015

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

## Obituary

- It was with great sadness that the INMO community learned of the sudden death of their colleague Jacqui Ellis. Jacqui worked as a clinical nurse specialist/team leader in children's palliative care with the Laura Lynn Children's Outreach Service and previously worked as a clinical nurse specialist with the Louth/Meath palliative care team based in Our Lady of Lourdes Hospital, Drogheda.

She was a member of the INMO since May 2002 and was extremely active in the Drogheda Branch, holding the position of treasurer for four years. She attended Branch meetings and always made a calm, rational and intelligent contribution.

Jacqui was an exceptional person, who devoted herself to her patients; she was the essence of care and understanding. The INMO Drogheda Branch, her friends and colleagues extend their deepest sympathies to Jacqui's partner Dave, her mum Agnes, brother Geoff and his partner Mandy, all her extended family, friends and work colleagues on their enormous loss.