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WIN

INMO

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

World of Irish Nursing & Midwifery

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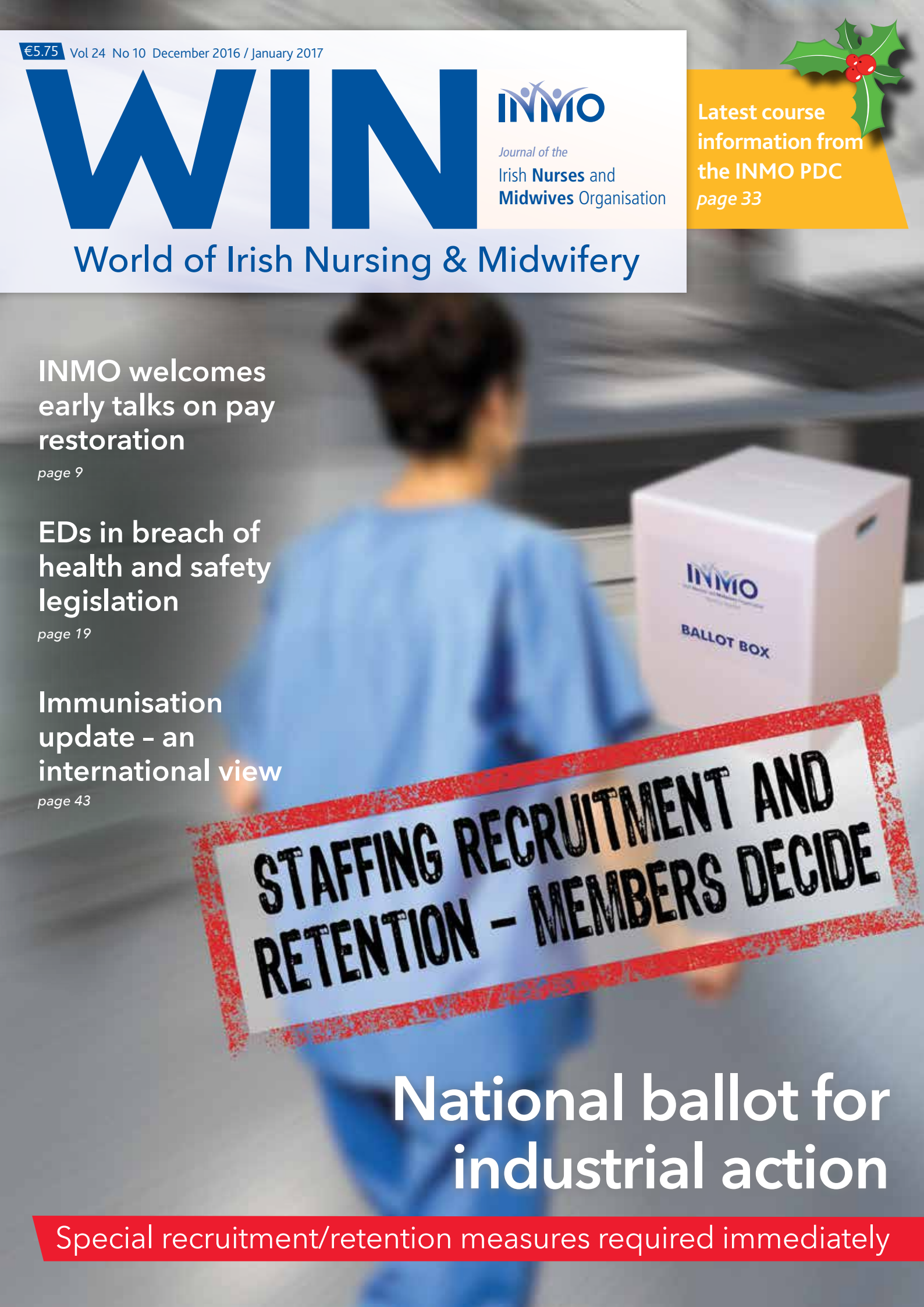

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In each we trust

AS YOU receive this issue of *WIN* you will be aware of developments and actions on a number of fronts in relation to pay restoration, staffing, recruitment and retention.

In relation to pay restoration, the strategy of our Executive Council is to ensure that the INMO is centrally involved, with all other public service unions, in demanding the acceleration of pay recovery in the context of the improving economy and recent developments following a Labour Court Recommendation regarding Gardaí.

As a result of this collective approach, the government is now entering discussions on the critical issue of pay restoration. These discussions must be completed by the end of January. The INMO is clear, as are other public service unions, that these discussions must deliver positive movement on earlier pay restoration for nurses, midwives and all public servants.

Separately, again arising from the strategy adopted by our Executive Council, the INMO has almost completed a national ballot of all members in the public health service seeking a mandate for industrial action. This campaign is in pursuance of special measures to address the staffing/recruitment/retention crisis that continues to grow.

The intent behind this strategy is to secure special/targeted initiatives that will both attract additional and retain existing nurses and midwives in the face of intolerable work pressures. If these measures are not brought forward then any industrial action will be shaped to contract services to a level appropriate to the available staffing.

It is now clear, from the statements of the Minister and health employers, that all relevant parties accept we have a serious and growing recruitment/retention problem in nursing and midwifery. Soft words and good intentions are no longer enough in recognising the extent of the problem however. What is required is substantial and meaningful action on a number of levels that will have the twin effect of recruiting additional nurses and midwives into the Irish public health service and retaining existing staff.

The cornerstone of these strategies is unity of purpose through, if necessary, collective action. In other words we must adopt the policy of 'IN EACH WE TRUST'. We must move on from simply talking about the problem and take ownership, if required, of all measures necessary to ensure all members can practise safely in an acceptable working environment that respects their professionalism while they deliver safe care to patients/clients.

If the current working environment was not bad enough, in recent weeks we had the sad débâcle of legal opinion, circulated throughout the HSE, that patients should be treated as trespassers and nurses could use "reasonable force" to remove them from a bed. This Organisation, quite correctly, rejected this approach and advised members to ignore any such instruction and to continue to act – as nurses and midwives always do – in the interests of the patient.

The saddest thing about this whole episode was that anyone working in our health service could feel that such a policy should not only be written up but also distributed to senior managers across the health system. Yes, it has been withdrawn and, yes, an apology was issued, but why did it ever see the light of day in the first place?

In the face of all of these challenges our collective strength is, as I have said, through collective action and unity, personified by the principle 'IN EACH WE TRUST'. Therefore, support the strategies, adopted by the Executive Council and let us support each other, through whatever processes and actions are necessary, to secure progress on these issues. If we trust and support each other then these difficulties can, and will, be overcome.

Finally, may I wish you, your family and your friends a happy, peaceful and restful Christmas. I hope 2017 brings you good health, peace of mind and happiness both in your professional and personal life.

Liam Doran
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

Nollaig shona daoibh go léir!

IT IS difficult to believe that it's that time of the year again! I would like to take this opportunity on behalf of the Executive Council to wish you, your family and loved ones a very happy Christmas and a New Year that will bring the hope and respect that our professions deserve.

Respect for our clinical decision making

IT IS on the theme of respect for our clinical decision making as nurses and midwives that I will dwell for this month's piece. The blatant lack of respect shown to nurses and midwives has been evident over the past number of years. Initially this was insidious and covert, but now it is manifesting overtly in memos. I am referring to the memo which described patients as 'trespassers' and said minimum force could be used 'by nurses' to remove them. The memo leaked to RTE in November disturbs and angers me in that non-clinicians have arrogantly decided that they have a greater understanding of the role of the nurse and midwife. This demonstration of utter contempt toward the professional role of nurses and midwives, and the blatant dismissal of the requirement for our profession to uphold the *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives*, is appalling and despicable.

However, this latest diktat from the HSE by these non-clinicians who categorically informed the INMO, when we raised the issue in mid-October, that it had been withdrawn, was in essence a ruse, as the memo remained in the system and was raised by members of the Executive Council at the November meeting. This is, to say the least, appalling but confirms the 'broken promises model' that currently permeates the HSE.

In an interview with RTE in November, our general secretary, Liam Doran, reiterated that this was a clear demonstration of how the HSE had lost its soul. As president, I would go a step further and state that they have lost their minds. The utter madness of this memo oversteps any rationality in the context of a care setting. What is more concerning is that if this is the only 'creative thinking' that the HSE can come up with – nurses and midwives as 'bouncers' to deal with overcrowding – then the system is beyond repair. I acknowledge that Tony O'Brien, director general of the HSE, apologised to patients as was just and correct. However, I note that no apology has been offered to nurses and midwives. Why is this? Please be reassured I, for one, will not tolerate this prevailing attitude from the HSE any longer.

European Federation of Nurses general meetings

OCTOBER saw my first trip abroad to represent the INMO at European level. I was delighted to be accompanied by Elizabeth Adams, INMO director of professional development who was a great support to me. At the meeting Elizabeth was elected first vice president of EFN and I know you will join me in extending congratulations and wishing her every success. *(see also page 10)*. The EFN is influential on the formulation of European policy so it is vital that we are actively involved (I am on the Workforce Committee). This was illustrated by the packed agenda which included recruitment and retention, WHO global Workforce Strategy, antimicrobial resistance, value of health systems, governance and EU projects submissions. The next meeting of the general assembly is in Malta on March 30-31, 2017 and I will keep you posted re further developments.

Oireachtas Health Reform Committee

I WAS honoured and privileged to accompany Dave Hughes, INMO deputy general secretary and Edward Mathews, director of social policy and regulation, as the INMO delegation which met with the Special Oireachtas Committee on the Future of Healthcare on October 26, 2016. I presented the opening statement in which the INMO called for a radical transformation, of our current two-tiered health system, so that it is single tiered, guaranteeing equality of treatment to all and funded through general progressive taxation.

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

Quote of the month

"The harder the conflict, the more glorious the triumph"
–Thomas Paine

Report from the Executive Council

THE Executive Council met on November 7-8. The priority agenda item was the national campaign giving cognisance to the feedback received from members who attended the 12 regional consultation meetings where you outlined your anger and frustrations at the working conditions and staffing levels being experienced by nurses and midwives across the country.

It was unanimously decided to commence a nationwide ballot of members, which would run from November 24 to December 14.

The ballot which you are all actively participating in includes a work to rule and one-day work stoppages in protest at your current working environment and the abject failure of government and management to recruit and retain nursing/midwifery staff.

The approach adopted by the Executive Council is two tiered:

- Tier 1 – Staying within the parameters of LRA and applying pressure in association with other public service unions through ICTU's Public Services Committee to accelerate the restoration of our pay
- Tier 2 – Industrial action to include one-day work stoppages and WTR in order to get immediate action by government to agree to implement special recruitment/retention initiatives for all nurses and midwives

As your president, I urge you to vote and stay informed through the many locally organised meetings. This way you have a say in the survival of nursing and midwifery in Ireland.

Get in touch

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

National ballot in protest at staffing/ recruitment/retention crisis

Members urged to make every effort to vote by December 14

THE INMO Executive Council at its meeting on November 8 took the decision to commence a nationwide ballot of members in protest at their current working environment and the failure of management to recruit/retain nursing/midwifery staff.

This followed a review of the outcome of 12 regional consultation meetings with members and other workplace meetings, together with detailed correspondence from members relating to the pay, working conditions and staffing currently being experienced throughout the country.

From all of the consultative meetings, individual Executive members reported extreme anger from nurses and midwives in the frontline. The meetings were given multiple examples of:

- Chronic persistent overcrowding with no additional staff
- Excessive working hours (unpaid)
- Repeated episodes of missed care, in acute, care of the elderly and disability services, with up to 30 patients being left under the sole care of third year students
- Community nursing services unable to fulfil statutory functions and which are held together purely by nurses carrying excessive workloads and having to work extended unpaid additional hours.

The situation was such that the Executive Council formed the view that the health, safety and welfare of staff, and patients, is compromised on a daily basis.

Based on reports, the Executive Council also found that the government, the HSE and all health employers have not recognised the need to recruit and retain additional numbers of nurses and midwives in order to provide safe care. The current efforts to recruit have failed as they simply cannot compete with either overseas recruitment markets or the private hospital sector in Ireland.

The Executive Council determined that special recruitment and retention incentives are therefore essential if the public health service is to succeed in attracting the nursing/midwifery staffing levels required to ensure safe care.

In making its decision the Executive Council also noted that the health service continues to have 3,800 fewer nursing/midwifery posts than it had in 2009. It was against this stark, unsafe and unsustainable background that the Executive Council decided that the current appalling conditions for patients, and the utter disrespect by employers for nurses and midwives, must cease.

Campaign of action

The Organisation has therefore commenced a ballot of members for a campaign of industrial action which will include a series of one day work stoppages and a work to rule.

This industrial action, if mandated, will seek to secure:

- Incentives aimed at enhancing the ability of health employers to recruit and retain nursing/midwifery staff
- Secure adequate staffing levels or to curtail services to a level necessary to provide safe care and a safe working environment for members.

In this regard members' attention is drawn to the special 'Questions and Answers' sheet in this issue of *WIN (see page 11-12)* which has been produced as part of the information process related to this national campaign.

Pay restoration

The INMO Executive Council also confirmed its commitment to the Lansdowne Road Agreement but demanded immediate public service wide engagement, with government, to accelerate the pay restoration process.

In the context of this public sector wide issue, please see *opposite page* for coverage of this critical issue.

Speaking after the Council decision INMO president Martina Harkin-Kelly said: "Our members have spoken and have clearly indicated they can no longer endure the working environment and will no longer accept having their professional judgement disrespected or ignored by management.

"Nursing and midwifery is in crisis and our health services are failing to meet the needs of patients. This action is absolutely necessary, and justified, in the interests of patients and our members. Accepted worldwide evidence demonstrates that patients are safest and mortality rates lower when there are sufficient nurses and midwives working in positive environments providing their care".

INMO general secretary Liam Doran said: "The level of anger within our membership was palpable at the recent meetings. This action seeks to have government and management come forward with special initiatives that will attract and retain the required number of nurses and midwives to staff our service safely and expand it to meet ever increasing demand.

"In addition we will, in conjunction with our public service union colleagues, participate in early discussions, with government, which must deliver an acceleration of the restoration of pay and other conditions of employment which were cut in recent years".

Workplace information meetings and balloting

As you receive this journal all of the workplace information meetings, and balloting arrangements, at your own individual workplace will have taken place. It is hoped that members will have attended such meetings and cast their ballot. However, if you have not already done so members are urged to make every effort to cast their ballot before the closing date of **Wednesday, December 14, 2016.**

Details on workplace meetings, and balloting arrangements, for individual workplaces can be found on the INMO website **(www.inmo.ie)** or through our social media platforms.

In addition, members may cast their ballots in all INMO offices (Dublin, Cork, Galway and Limerick), from 8.30am-6.30pm on Tuesday and Wednesday, December 13 and 14, 2016.

The Executive Council is calling on all members to make every effort to participate in this democratic process and to vote in favour of the action. This will indicate that nurses and midwives have had enough of their current working environment and the staffing crisis must be addressed with special recruitment/retention initiatives.

INMO welcomes Minister's invitation to new talks on pay restoration

THE INMO has welcomed the announcement by the Minister for Public Expenditure and Reform Paschal Donohoe that he would be inviting the public service unions, who are party to the Lansdowne Road Agreement (LRA), to talks.

These talks, which the Minister said would conclude before the end of January, will seek to address anomalies arising from the recent Labour Court recommendation in relation to the Garda dispute.

In his statement, the Minister reiterated the government's support for the LRA and the collective approach to public service pay issues. He emphasised that the priorities for government in the upcoming discussions will be to:

- Secure the continued implementation of the LRA
- Maintain the productivity, industrial peace and stability provided by the LRA
- Ensure that issues of mutual concern to the parties are addressed in a fair and reasonable way and in a manner that safeguards existing government expenditure commitments and the broader fiscal position.

The ICTU Public Services Committee, of which the INMO is a member, has also welcomed this development and the INMO will be active participants in these talks.

The INMO, consistent with all public service unions, has clearly indicated that the new talks must result in the acceleration of pay restoration due to members following the series of cuts of recent years.

The Public Services Committee of the Irish Congress of Trade Unions, which comprises 20 public service unions including the INMO, took a unanimous decision at a special meeting in Belfast recently that all public servants must benefit from the acceleration of pay restoration required following the cuts of the past seven years.

Against this background the unions, including the INMO, have all made individual statements clearly indicating that the current pay proposals contained within the LRA, which provide for a €1,000 increase from September 1, 2017 with the agreement expiring in September 2018, are no longer acceptable, satisfactory, fair or equitable. In addition, the unions involved have indicated that as this is a collective agreement affecting all public service unions, then any campaign seeking acceleration in the absence of a positive development from government, is best progressed through a collective approach with any action being clearly co-ordinated.

Pay Commission to examine labour market realities

THE Public Service Pay Commission (PSPC), established recently by the government to undertake preliminary work on future public service pay negotiations, is expected to deliver its initial report in spring 2017, according to Minister for Public Expenditure and Reform Paschal Donohoe.

"This report will provide inputs on how the unwinding of FEMPI legislation can be best managed in the context of the national finances," according to the Minister. "It will also have regard to any particular labour market challenges the Commission identifies and to other conditions of service of public servants, including tenure and pension."

The Minister confirmed that once the PSPC's report is issued, the government intends to initiate negotiations on a successor collective agreement ahead of Budget 2018 considerations. "These negotiations will deal with the full range of issues including productivity, reform and the issue of affordable increases in pay," the Minister said.

The ICTU Public Services Committee, together with INMO general secretary Liam Doran, are scheduled to meet with the PSPC on December 12, 2016 to determine what submissions/engagement the commission intends to seek from public service unions.

At this meeting, the INMO will be seeking clarity from the PSPC on how it intends to meet its specific term of reference to examine 'labour market challenges' pertaining to individual grades/groups within the public service. The Organisation intends to ascertain what submission it can make to provide the necessary detail on the recruitment/retention crisis facing nursing and midwifery currently.

The ICTU Public Services Committee said it expects the PSPC's report to inform the parties to the Lansdowne Road Agreement (LRA) on how the unwinding of the FEMPI legislation, which introduced pay cuts and the pension levy, can be best addressed during negotiations on a successor to the agreement.

INMO general secretary Liam Doran: *"The INMO looks forward to engaging with the commission on the critical issue of the labour market realities facing nursing and midwifery"*

INMO general secretary Liam Doran said: "The INMO looks forward to engaging with the Pay Commission as it undertakes its work to provide a framework for direct engagement, between the government and public service unions, on public service pay in the medium term. In particular we look forward to engaging with the commission on the critical issue of the labour market realities with regard to nursing and midwifery, and how, at this time, the terms and conditions, offered to nurses/midwives working in the public health service, are simply not competitive when compared to the private health sector or overseas destinations.

"In addition we believe that the PSPC affords the INMO the opportunity to present our outstanding claim, for parity with all other allied health professionals, and to have it the subject of independent scrutiny as part of the commission's work. However, the commission does not offer an opportunity, in the short-term, to address the immediate issues which have arisen, following recent developments, regarding public sector pay. This is why the INMO and other unions are continuing to work to seek accelerated restoration of pay under the LRA".

INMO delegation leaves Minister in no doubt about of level of discontent

PRIOR to its decision to hold a national ballot, the INMO Executive Council had already sought a direct meeting with the Minister for Health as part of the strategy to address the severe staffing crisis.

Minister Simon Harris met with an INMO delegation of INMO president Martina Harkin-Kelly, first vice president Mary Leahy and members of the INMO management team, on November 17, 2016. In a robust exchange the president and the INMO delegation left the Minister in no doubt about the level of disillusionment and frustration felt by a nursing and midwifery workforce close to breaking point.

At the meeting the INMO also advised the Minister of the crisis that continues to grow with regard to staffing levels and the failure to recruit/retain nursing and midwifery staff.

The Organisation demanded that the Minister ensures adequate funding for several critical issues including:

- The 1,000 additional nursing/midwifery posts announced in the budget
- Special measures to assist with recruitment/retention against the reality of the health service continuing to lose nurses and midwives
- Delivery of the agreed initiatives to fill all vacant nursing/midwifery posts in emergency departments and other specialist areas
- The continued implementation of the recommendations from the Taskforce of Medical/Surgical staffing
- Delivery of the additional midwifery posts provided for as part of implementing the National Maternity Strategy.

The Minister undertook to have his department respond, in writing, outlining the status of all ongoing work in relation to these matters. The INMO followed up the meeting by putting in writing to the Minister the issues about which a response had been promised and was now awaited. The Organisation also reminded the Minister that what is being sought is the implementation of stated policies. It also stated that delay in progressing these initiatives was exacerbating the current staffing crisis.

In the context of the Organisation's decision to commence a ballot, seeking special recruitment/retention initiatives within nursing and midwifery, the Minister acknowledged that there was a real problem in relation to nurse/midwife recruitment. However, he said that this could only be resolved in the context of a collective engagement within the broad parameters of the Lansdowne Road Agreement.

In replying to this the INMO reaffirmed that nurses and midwives are completely demoralised due to intolerable workloads and the persistent disrespect being shown to them. The Organisation confirmed that, in the absence of real and tangible initiatives, it would, following ballot and mandate, take industrial action to protect the health and safety of members.

It was agreed that contacts between the Minister, the Department of Health and the INMO would continue.

New Executive Council member

ANNE HARNEY has been nominated to fill the vacant clinical seat on the INMO Executive Council, following the resignation of Deirdre Munro. Anne works as a CNM2 in St Hilda's Services, Athlone, for which she has been an INMO rep since 2006. She was serving her second term on the Standing Orders Committee before joining the Executive Council. Anne has been a lifelong member of the INMO since her time in Jervis Street Hospital, where she did her general nurse training. You can read more about Anne when she features on the Executive Council Focus page in the coming months *(see page 28)*.

EFN elects Elizabeth Adams vice president

INMO director of professional development Elizabeth Adams was elected as vice president of the European Federation of Nurses Associations (EFN) at its General Assembly recently.

Ms Adams was elected to this key role by the 35 European member countries.

Established in 1971, EFN represents over three million nurses across 35 European countries represented by national nursing associations. EFN is the independent voice of the nursing profession at European level. The INMO has been a member of EFN since its inception.

EFN is an important organisation representing nurses and nursing concerns across Europe. There are a number of significant projects and policy developments that the INMO is central to, due to being a proactive member of EFN.

Issues concerning health, patient care, workforce, mobility of health professionals, education, technology and health funding continue to be central to the European Union (EU) debate and the culmination of these debates result in legislation which all member states have to implement.

INMO general secretary Liam Doran said: "The INMO is very pleased at the election of Elizabeth Adams as vice president of EFN. With the INMO holding this influential position, the Organisation is leading and representing 35 EU countries' national nursing associations, to strengthen and drive the EU political agenda to enhance the health for the population of Europe, protect quality and safety, and to represent and protect the working environments for nurses.

Elizabeth Adams elected as vice president of European Federation of Nurses Associations (EFN)

Prof Dr Máximo A González Jurado, president of the Spanish General Nursing Council, hosted the 104th EFN, General Assembly on October 20-21, in Madrid. With over 70 representatives meeting, several strategic issues concerning nursing across Europe were discussed.

November trolley figures worst on record

THE INMO's latest trolley watch survey for the year to the end of November confirms a minimal (1%) improvement in the number of admitted patients on trolleys in 2016.

In the first 11 months of 2016, 85,731 patients had been admitted for inpatient care but were left on trolleys as no beds were available, compared to 86,864 in 2015.

However, the figures also confirm that the level of overcrowding in November, which saw 9,306 admitted patients on trolleys, was the worst on record for the month of November since counting began. The level of overcrowding was 26% greater than in November 2015 and 99% higher than the level of overcrowding recorded in November 2006 (see *Table*).

Analysis for the first 11 months of 2016 compared with 2015 shows:

- Overall figures for the 11 months reduced by 1%
- Numbers in the East reduced by 21%, eg. Connolly Hospital down 48%, St James's 33% and Beaumont 26%
- Numbers in rural hospitals rose by 10% with South Tipperary up 162%, MRH, Tullamore 75% and University Hospital, Waterford 54%.

Analysis for November 2016 compared with 2015 shows:

- Overall figures increased 26%
- Numbers in the East reduced by 15% – Connolly 41%, Tallaght 36% and Beaumont 35%
- Numbers in rural hospitals rose by 49% – South Tipperary 252%, Mercy, Cork 201% and Letterkenny General 161%.

Overall, these figures are very disappointing as they confirm that all measures taken to date have not reduced the overall numbers of admitted patients waiting on trolleys.

The marked deterioration in November may be partly due to the closure of 180 beds across the system for infection control reasons. The INMO believes that this scenario was not surprising as ward overcrowding compromises best practice in infection control.

INMO general secretary Liam Doran said: "These figures are hugely disappointing and confirm that our health service cannot cope with demand. The situation is further exacerbated due to the crisis in nurse recruitment, with many EDs and inpatient wards grossly understaffed – there are over 120 vacant posts compared to 85 in the first quarter of this year.

"The INMO notes recent initiatives to fill these posts, however the reality is that current terms and conditions in the public health service are not competitive. This only serves to confirm the need for special initiatives to attract and retain nursing staff and these must be brought forward without delay."

Table. INMO trolley and ward watch analysis (November 2006 – November 2016)

Hospital	Nov 2006	Nov 2007	Nov 2008	Nov 2009	Nov 2010	Nov 2011	Nov 2012	Nov 2013	Nov 2014	Nov 2015	Nov 2016
Beaumont Hospital	513	602	725	814	676	710	421	661	729	586	383
Connolly Hospital, Blanchardstown	237	219	260	231	423	292	276	425	514	443	261
Mater Misericordiae University Hospital	359	504	537	440	354	375	252	266	450	464	404
Naas General Hospital	280	144	239	366	387	192	160	104	315	108	256
St Columcille's Hospital	38	91	246	216	237	172	167	42	n/a	n/a	n/a
St James's Hospital	55	87	351	201	121	112	89	62	231	178	309
St Vincent's University Hospital	369	581	570	495	593	546	322	63	250	464	379
Tallaght Hospital	329	326	570	463	607	181	135	245	375	459	293
Eastern	**2,180**	**2,554**	**3,498**	**3,226**	**3,398**	**2,580**	**1,822**	**1,868**	**2,864**	**2,702**	**2,285**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	15	0	47
Cavan General Hospital	203	154	144	254	330	369	170	79	32	172	13
Cork University Hospital	188	478	480	383	635	479	339	361	329	424	648
Letterkenny General Hospital	308	6	25	25	26	81	68	209	47	184	481
Louth County Hospital	33	0	1	5	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo General Hospital	289	129	94	100	113	37	108	18	198	108	213
Mercy University Hospital, Cork	107	97	123	79	198	168	217	308	236	141	424
Mid Western Regional Hospital, Ennis	109	51	32	4	76	1	47	0	n/a	10	1
Midland Regional Hospital, Mullingar	16	4	26	36	160	388	196	175	245	305	444
Midland Regional Hospital, Portlaoise	42	45	25	21	75	261	13	73	94	251	258
Midland Regional Hospital, Tullamore	3	1	29	0	117	190	77	65	272	248	399
Monaghan General Hospital	12	23	17	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nenagh General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	4	1
Our Lady of Lourdes Hospital, Drogheda	348	276	414	56	350	709	533	248	584	578	607
Our Lady's Hospital, Navan	105	65	118	47	9	116	108	53	45	101	59
Portiuncula Hospital	8	11	14	125	52	132	109	21	121	56	144
Roscommon County Hospital	80	117	76	52	87	n/a	n/a	n/a	n/a	n/a	n/a
Sligo Regional Hospital	30	72	59	100	111	164	274	32	223	204	107
South Tipperary General Hospital	60	157	3	53	3	121	188	251	153	193	680
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	50	109	67	86	96	339	360
University Hospital Galway	115	292	369	323	416	846	330	411	536	480	594
University Hospital Kerry	42	21	52	38	71	45	57	36	128	92	208
University Hospital Limerick	239	169	245	300	331	393	347	399	556	542	789
University Hospital Waterford	n/a	n/a	43	35	141	112	160	234	153	251	412
Wexford General Hospital	154	23	63	161	250	207	139	39	197	22	132
Country total	**2,491**	**2,191**	**2,452**	**2,197**	**3,601**	**4,928**	**3,547**	**3,098**	**4,260**	**4,705**	**7,021**
NATIONAL TOTAL	**4,671**	**4,745**	**5,950**	**5,423**	**6,999**	**7,508**	**5,369**	**4,966**	**7,124**	**7,407**	**9,306**

Comparison with total figure only:
Increase between 2015 and 2016: 26%
Increase between 2014 and 2016: 31%
Increase between 2013 and 2016: 87%
Increase between 2012 and 2016: 73%
Increase between 2011 and 2016: 24%
Increase between 2010 and 2016: 33%
Increase between 2009 and 2016: 72%
Increase between 2008 and 2016: 56%
Increase between 2007 and 2016: 96%
Increase between 2006 and 2016: 99%

Dave Hughes, INMO deputy general secretary, explains why nurses and midwives are voting on industrial action

Need to blow the whistle on an unaccountable health service

FOLLOWING 12 regional consultative meetings with members, the INMO Executive Council took the decision to recommend a programme of industrial action to its membership.

The INMO argues that the health service has 3,800 fewer nurses and midwives than were employed in the public health service in 2009, yet the demand for services has grown. Has the adage 'more with less' been taken to its extreme in the health service and is it a case now of too few to provide a safe service?

The INMO has been counting trolleys in emergency departments and on hospital wards for the past 12 years to demonstrate the inability of our hospitals to provide humane, timely care to the most ill patients waiting for a bed. Politicians and most members of the public have reassured themselves that once admitted to the system, the care was second to none. Having listened to the testimony of those who attended the INMO consultation meetings and read the emails of fatigued nurses and midwives coming off gruelling shifts, it's clear that for many, such consolation is misplaced and for others its wide of the mark.

In a major regional hospital once described as a centre of excellence, a consultant surgeon allegedly amputated two toes from a patient in a ward so frustrated was he at the constant cancellation of planned surgery due to staff shortages and overcrowding.

Another instructed nurses to take four patients to the front door where he picked them up in his private car and transported them to a private facility to operate on them. Nurses were called again to send the pool nurse out to escort those same patients back from that private hospital at the expense of the public hospital in the middle of the night. Two third-year and two second-year unpaid students were left in charge of almost 30 patients for an entire shift with only the oversight of one clinical nurse manager.

Midwives recounted how they could not go home at the end of shifts as there was no replacement coming on duty and numerous others recounted their heartbreak at holding the hands of patients or their relatives in their final hours without the dignity or the privacy they deserved.

Can it be right that nurses and midwives leave their place of work in tears and fear coming back the next day to face the same or worse in our now dysfunctional health service where the abnormal has become normal for so many in the professions?

To add insult to injury, legal advice was recently issued in an attempt to have nurses treat discharged patients as trespassers and use force to eject them from hospitals.

So, to a large degree a yes vote from our members will be a huge exercise in whistle blowing on an unaccountable health system to which our political masters are content to entrust our health and welfare without any recognisable governance system.

The INMO hopes to prompt the HSE and the government to offer a package comparable to that offered by private hospitals and foreign recruiters which will attract the numbers which all parties accept are necessary to safely staff our services.

For those who place cost over care, just ponder the fact that the HSE now spends €1 million a week or €52m a year for agency staff to cover a fraction of the now vacant posts. Agency fees and VAT charges mean a cost of 1.5 times that of directly employed staff.

Richmond Building transformation on track

Work is continuing apace on the new INMO Education and Event Centre, which is expected to be completed early in the new year. Pictured (above) fire proofing of ceiling between floors; (right) installing pipes for heating; and (inset) cleaned attic in east wing in preparation for air conditioning units

IR update by Phil Ní Sheaghdha, INMO director of industrial relations

Safeguarding vulnerable adults policy

THE INMO and other health service unions have raised a number of concerns about the manner in which the Safeguarding Vulnerable Adults Policy has been approached by the HSE.

The INMO has raised these concerns at a number of meetings, particularly matters that would bestow additional responsibility on already overworked, overstretched nursing/midwifery grades.

The HSE did commit to taking these concerns back to the policy group and reverting to the INMO and other unions on September 22, 2016.

However, the HSE cancelled this meeting and, despite three requests for rescheduling, the unions have not been offered a rescheduled date. Therefore, the INMO and other health service unions are now referring the matter as a grievance to the Workplace Relations Commission.

In the meantime, the previous advice issued stands, which is that nurses and midwives should not engage in training on the Safeguarding Policy until full negotiation and dialogue has concluded, as it is likely the policy currently in place will be altered and until this time there is no point in engaging in training.

Concerns in respect of any alleged abuse or safety issues should be raised to line managers.

Peer vaccination issue raises concerns about staffing

THE HSE has commenced a programme of peer vaccinations. This requires nurses/midwives to volunteer and be available to vaccinate other HSE employees.

Discussions were not held with the INMO prior to this development and the Organisation has raised a number of issues with the HSE in respect of this. The main concerns are the implications for staffing levels.

One meeting has been held and we are awaiting a second meeting when management is due to revert in respect of the concerns we raised.

In the meantime, the INMO is requesting that nurses or midwives do not volunteer for this programme at this time. This is to ensure that any negotiations will allow for the concerns about staffing and expansion of roles to be taken into account, prior to nurses/midwives expanding current role.

Mayo midwives take action at severe staff shortages

MEMBERS of the INMO in the maternity unit, the labour ward and maternity OPD of Mayo University Hospital, Castlebar have unanimously balloted in favour of industrial action, up to and including a full withdrawal of labour, due to severe staff shortages.

As we went to press members were planning a lunchtime protest at the hospital on December 5, followed by a work to rule to commence on December 7. During the work to rule members will withdraw from clerical and support duties to focus on, and prioritise, direct midwifery care. If no progress is made members will proceed to a full withdrawal of labour.

The action is to be taken in pursuit of the INMO's claims for the maternity ward, labour ward and maternity OPD at Mayo University Hospital to deal comprehensively with the understaffing, lack of key specialist roles and lack of robust governance structures within the departments. The Organisation is calling for:

- An independent review of staffing in the maternity unit
- Appointment of a director and assistant director of midwifery and CMM3
- The appointment of an advanced midwife practitioner, a clinical facilitator for maternity services, a lactation consultant, a bereavement CMS and a CMS sonographer
- The immediate appointment of dedicated ward clerks and porters to support the midwifery service
- The immediate replacement of staff on all forms of leave and proper rostering of staff for each shift
- A review of transfers from the maternity unit to other locations
- A follow up framework on risk assessments.

The decision by INMO members to commence industrial action is based on their concerns in relation to patient safety and their ability to provide safe care. The INMO has engaged with management on this issue on an ongoing basis and highlighted members' concerns which, to date, have not been adequately addressed.

INMO IRO Anne Burke said: "Midwives are disillusioned with the HSE and its failure to act in a timely fashion and put in place robust governance and safe staffing arrangements. Our members have nothing personally to gain by speaking out except to secure a safe, quality and appropriately staffed maternity service for mothers and babies. It is of real concern to frontline midwives that ongoing clinical risks at the hospital due to a shortage of staff are left unaddressed.

"Earlier this year the INMO welcomed the launch of Ireland's first National Maternity Strategy which was to lead to a positive transformation of maternity services in Ireland, with much improved staffing levels. A subsequent report on midwifery manpower, published by the Office of Nursing and Midwifery in the HSE, clearly stated that services, when implementing the Maternity Strategy, should move to a midwife to birth ratio of 1 : 29.5. An additional 450 midwives is required to achieve this ratio in the next four years. The strategy needs to be implemented as a matter of urgency in Mayo University Hospital where there is a severe shortage of midwives, in order to provide safe care.

"Members are extremely concerned about patient safety and are frustrated at management's inadequate response to their claims. Members also highlighted their concerns over maintaining their professional registration and believe that working in this environment is having a detrimental effect on their health. They have been left with no other option but to take this course of action."

INMO condemns gross overcrowding

THE INMO has condemned the gross overcrowding in University Hospital Limerick and the compromised ability of its members working there to provide acceptable and safe care to all patients within the hospital.

The level of overcrowding – which hit the highest ever level of 66 admitted patients waiting on trolleys and in extra beds on wards at one stage last month – is unprecedented and is a serious crisis.

INMO members do not accept that the hospital management is robustly managing all of the available bed capacity to meet the demands of emergency patients who are deemed to need admission.

It is incumbent on the management team as the employer and in governing the hospital to ensure that the hospital is safe for staff and patients. According to the INMO, this is not the case, which is increasingly worrying for members as the clinical care of patients is compromised and there are high levels of stress being experienced by nurses/midwives daily. In recent weeks members of the nursing staff have left work in tears at the unmanageable workloads and are extremely concerned regarding the outcomes for patients and their professional practice.

INMO IRO Mary Fogarty said: "Many initiatives have been put in place in other hospitals throughout the country where they have experienced gross overcrowding with some improvements. However, the past six to 12 months has seen a significant deterioration at University Hospital Limerick. Despite the Workplace Relations Commission (WRC) proposals from February 2016 and, meeting locally with hospital management, the situation at UHL has significantly deteriorated."

The INMO has balloted nurses on all wards, with 97% in favour of industrial action of which management has been notified. Our members have not yet activated the industrial action however we have detailed to management a claim for staffing levels and other measures on individual hospital wards. A meeting to address these matters with the chief director of nursing is scheduled for early January.

Galway ED in total breach of health and safety legislation

THE emergency department at University Hospital Galway is in crisis, according to the INMO.

On one day recently (November 9) trolley figures revealed that 38 patients were on trolleys within the confines of the emergency department itself, with 14 extra patients on already full wards. In addition, there were a further 25 patients in the ED who had been waiting up to eight hours to be assessed by a doctor due to the lack of cubicles to examine them. Trolleys were backed up on both sides of the corridor around the department making access, privacy and dignity impossible. There were just four nurses to look after the 38 admitted patients in the ED.

Some elective surgeries were cancelled as it was anticipated that only 20 patients were fit for discharge in the entire hospital that day. In addition, there were a further 10 patients being accommodated in the surgical day ward which meant that day surgeries had to be cancelled. The fire officer and the Health and Safety Authority were contacted.

INMO IRO Anne Burke said: "Access to and egress from the department was completely compromised. There was no room to physically assess any more ED patients who turned up at the hospital. Meanwhile, there is a 75-bed single occupancy unit ready to be opened at the hospital but no funding has been approved by the HSE to staff this area.

"Taoiseach Enda Kenny said in a statement recently that the hospital is 'not fit for purpose' but nothing has been done to alleviate the pressure within the ED. Patients deserve safe care in proper beds, on a properly staffed ward, not on trolleys in public areas. Likewise our members deserve a safe place to work. The conditions that our members are working in are in complete breach of health and safety legislation.

"The INMO invited the Taoiseach who visited Galway city that day to do a walkabout in the ED to see, first-hand, the conditions both nurses and patients are experiencing." Unfortunately he did not accept the invitation.

Members draw:
The winner of the Annual Cornmarket draw for €1,000 is Jean Spillane who works in the Midland Regional Hospital, Tullamore. Jean will be presented with her cheque in HQ before Christmas.
Pictured at the draw were (l-r): Dave Hughes, INMO deputy general secretary; Anne Harney, Executive Council member, who drew the winning ticket; Martina Harkin-Kelly, INMO president; and Mary Cradden, INMO membership officer

Dialysis unit underfunded

INMO members working in the dialysis unit at the University Hospital Limerick have not agreed to move to a new dialysis unit as the HSE has not secured any funding for the new service and a range of industrial relations issues are unresolved.

The HSE scheduled the new unit to open on November 14 before initiating any engagement with the INMO on the proposed transfer. At the request of the union engagement commenced in late October with management not being in a position to resolve all issues in the short timeframe. Specific outstanding issues relate to allocation of funding from the Department of Health, patient safety issues related to infection control, inpatient bed availability at night, overall staffing levels and the availability of staff parking for the 10.30am shift. It is agreed that the move will initially be based on the present level of service but there is significant pressure to expand the service due to demand.

– Mary Fogarty, INMO IRO

Protest at Dungarvan Community Hospital:
"INMO members feel they have no option but to concentrate on core nursing care roles to ensure their focus is on delivering quality and safe care to their patients at the hospital"

Members commence work to rule in Dungarvan

Action due to management's failure to curb admissions in face of staff shortages

A WORK to rule is ongoing at Dungarvan Community Hospital, Waterford since November 21 due to management's refusal to curb admissions in the face of ongoing severe staff shortages.

Prior to this action, INMO members held a lunchtime protest to highlight the problem and were supported at this by councillors from Fine Gael, Sinn Féin and Labour.

During the work to rule nurses are setting aside non-nursing roles in order to maximise patient care requirements.

This 146-bed care of the older person facility currently has 12 vacant whole time equivalent (WTE) nurse positions and this is further compounded by approximately seven vacant posts arising from absences including maternity leave, which are not being replaced.

Calls by members to curtail admissions to this HSE-run facility until such time as nursing levels improve were not acted on by management.

INMO IRO Mary Power said: "INMO members feel that they have no option but to concentrate on core nursing care roles to ensure their focus is on delivering quality and safe care to their patients at the hospital.

"This shortage of nursing staff has been ongoing for quite some time and while we have met management on many occasions, the HSE has failed to recruit enough nurses for Dungarvan Community Hospital to meet the service needs.

"The work-to-rule action will enhance the actual nursing care for patients as it will allow nurses to prioritise patient care by ceasing non-urgent clerical/support work."

Despite further engagement with management since the commencement of the work to rule, there has been no change in their position. "Management is unwilling to reduce the level of admissions to the facility to meet the 17.5% deficit in nursing staffing levels," said Ms Power.

Public holiday payments over holiday period

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

- Sunday, December 25 – Sunday premium
- Monday, December 26 – public holiday premium
- Tuesday, December 27 – public holiday premium
- Sunday, January 1 – Sunday premium
- Monday, January 2 – public holiday premium.

Monday to Friday roster

Employees who work a Monday to Friday attendance regime will normally receive a paid day off on Tuesday December 27 and Monday January 2 in lieu of the two public holidays which fall on a Sunday.

No public holiday premium payment is payable to those working on days other than Monday 26 and Tuesday 27, December 2016 and on Monday, January 2, 2017.

INMO Information Office

World news

Nurses and midwives in action around the world

Global
- Nurse staffing levels are the 'surprise' key to stroke survival, finds study

Australia
- Hospital workers 'treated like punching bags' – one attacked every hour in Victoria
- Emergency workers unite to keep Shellharbour Hospital public

Brazil
- Aracaju nurses resume strike on the 8th

Canada
- Never mind the evidence! An expert unpacks Alberta's unending experiment in health care staffing
- Nurses want province to clearly define violence as workplace hazard

Dominican Republic
- TB outbreak affects patients of Cabral y Báez. Nurses could walk

Ghana
- Nurses, midwives to strike on November 14

Kenya
- Harmonise our pay or we will call a nationwide strike, says nurses' union

Nigeria
- Oyo teaching hospital nurses strike over unpaid salaries

Spain
- New demonstrations in healthcare due to lack of staff

UK
- Hospital staffing must be priority – Ogmore AM
- Concerned nurses can blow the whistle by app
- Musgrave Park Hospital elderly ward to close as nurses 'redeployed to ease staff shortage'

United States
- Desert Regional dangerously understaffed, nurses say
- D.C. parents wary over plans to reduce school nursing hours

Third Level Student Health Nurses Section

Pauline Carbery RIP

OUR beautiful friend and colleague Pauline Carbery passed away on October 5 this year. Firstly, we want to offer Pauline's husband Paddy, and sons Evin and Alex, our deepest sympathy for the loss of this amazing lady.

Pauline was the founder of the Student Health Centre in Maynooth University in 1990. She set a high standard of nursing care for all students throughout the next 24 years until she resigned due to illness in 2014.

Pauline was a valued secretary of the Third Level Student Health Nurses Section for many years and she encouraged all of our members to always strive for the wellbeing of students.

She was a beacon of light and energy to everyone who met her, as well as being good fun. She fought against her illness with the same dignity and grace with which approached everything in life.

From the moment you met her you just felt she was special and how right we were. We hope she's flying with the angels.

Third Level Student Health Nurses Section

Engaging seminar at INMO HQ

THE Directors and Assistant Directors of Nursing, Midwifery and Public Health Sections met recently at INMO HQ for an afternoon seminar, at which members had the opportunity to hear from senior INMO officials on current matters.

General secretary, Liam Doran delivered a national overview of strategic and operational opportunities and challenges for directors and assistant directors, which included staffing, recruitment and retention, the Lansdowne Road Agreement, recent developments on HSE management structures, and community health organisation management structures, among other issues.

There were also opportunities for members to raise queries and discuss pertinent issues among themselves.

Edward Mathews, director of regulation and social policy, spoke on the fitness to practise process and issues arising for senior nurse/midwife managers. He explained the nine grounds for complaint, ranging from professional misconduct to the breach of the Misuse of Drugs Act. He discussed the fitness to practise process and the two stages of preliminary proceedings committee and fitness to practise hearings and all that they encompass, both from a reporting perspective to acting as witness, to supporting a nurse/midwife going through the process.

Clockwise from top left at the seminar: Edward Mathews, INMO director of regulation and social policy; Dave Hughes, INMO deputy general secretary; and Liam Doran, INMO general secretary

Dave Hughes, deputy general secretary spoke on the art of negotiation and the operation of the grievance and disciplinary procedures, which again led to many questions and discussion points arising from the floor.

With more than 40 members in attendance, the seminar featured lively engagement and discussion throughout.

International nurses visit Leinster House

Visiting Government Buildings: *The International Nurses Section pictured on their trip to Leinster House holding their copies of the 1916 Proclamation*

THE International Nurses Section recently organised a tour of government buildings for its members with the aim of raising awareness of where and how State matters are debated.

The Section also wanted to promote social inclusion, as most of its members have become Irish citizens through naturalisation.

Speaking on the visit, Ibukun Oyedele, chairperson of the Section, said the tour of Leinster House would be "a memorable event for a long time".

The tour was arranged by the Section officers in collaboration with the Minister for Justice and Equality Frances Fitzgerald and was a great experience for all those who attended.

Technology supporting healthcare

Elizabeth Adams discusses a recent health informatics conference and the ever-increasing role tech plays in healthcare

THE 21st annual Health Informatics Society of Ireland (HISI) Conference and Scientific Symposium was held in the Aviva Stadium in Dublin on November 16-17. The theme of the conference was 'Digital Patient: Empowerment through Technology' and the national and international audience was welcomed by Mary Cleary, deputy chief executive officer, HISI and Irish Computer Society (**www.ics.ie**).

The plenary session included Richard Corbridge, HSE chief information officer (CIO), who has responsibility for implementing the National eHealth Strategy. Mr Corbridge set the scene for the national and international audience on what had been achieved over the past 702 days, describing the task to hand as "devising a digital fabric for Ireland". His presentation provided an update on the deployment of the electronic health record (EHR), underpinned by the implementation of the individual health identifier (IHI).

A core aspect of this initial development for 2017 includes the deployment of eReferral from general practitioner to hospital and eDischarge via of Healthlink. The focus of the Office of the CIO is to ensure that technology supports healthcare efficiently and effectively throughout the entire health and social care service in Ireland. The core of the eHealth Ireland strategy is to bring improved population wellbeing, health service efficiencies and economic opportunities to the island of Ireland through the use of technology enabled health and social care provision.

Further information on the eHealth Ireland Strategy and the Knowledge and Information Strategy is available at: **www.ehealthireland.ie**

The Health Informatics Society of Ireland Nursing and Midwifery (HISINM) group is part of HISI. HISINM was originally established in 1996 with a view to promote the practice and knowledge of nursing and midwifery informatics in Ireland. Paula Kavanagh, HSE North West nursing and midwifery development officer, and Jackie Kirrane, clinical informatics leader at the Galway Clinic, are currently the joint chairs of the group, further information is available at: **http://hisinm.ie**

Since its inception, HISINM has provided leadership, networking and educational opportunities for nurses and midwives with an interest in informatics in Ireland. Dr Pamela Hussey from DCU School of Nursing and Human Sciences, who is a long-standing member and former chair of the HISINM group established Ireland's first accredited International Classification for Nursing Practice (ICNP), Research and Development Centre. On day two of the conference she presented an update on the progress of ICNP Centre's first year of development.

In the presentation entitled 'Integrated + Contemporary + Nursing + Personhood = ICNP', Dr Hussey stressed the need for integration of nursing data within shared patient records. Reported earlier this year in *WIN*, the ICNP has been a project of the International Council of Nurses since 1990. The ICNP is a reference terminology for nursing that supports standardised nursing documentation globally. It provides a dictionary of terms and expressive relationships that nurses can use to describe and report their practice in a systematic way. The resulting information is used reliably to support care and effective decision-making, and inform nursing education, research and health policy. It can improve communication between nurses and other health professionals, thus facilitating safe and improved quality of nursing care for patients.

The vision of the ICNP programme is to have nursing data readily available and used in healthcare information systems worldwide. Dr Pamela Hussey and Dr Anne Matthews, head of school and an associate professor at the DCU School of Nursing and Health Sciences, secured institutional commitment and INMO support to establish the first national ICNP Research and Development Centre.

In presenting the work of the Centre, Dr Hussey stated that: "The concepts and terms we include in our health and social care systems will shape our health and social care services well into the future, impact on citizens wellbeing and inform policy and funding – we have a duty to ensure sustainability is embedded throughout the entire process. We need to ensure co-creation and co-design of the resources is optimised from the outset".

She described the ICNP Centre value proposition as one that will impact existing fragmented health services at national enterprise level and strike a balance with powerful and affluent groups that focus on over-medicalised models of care. In this way ehealth records can be configured to represent the nurse or midwife practitioner and the service user using an holistic model of care as appropriate. Since receiving ICN accreditation in early 2016 the DCU ICNP Centre has:

- Established a number of working groups to focus on advancing the uptake and use of ICNP in Ireland
- Provided education and training on nursing informatics and its impact on chronic disease management
- Created a research cluster for mapping of ICNP terms and development of catalogues with existing partners in care of older person , intellectual disability and public health services
- Instigated discourse on the use of ICNP equivalences tables with SnomedCT with national clinical programme objectives through the integrated services framework in the office of the chief information officer and published an interim report on eHealth Ireland website
- Disseminated information on research activity both internationally and nationally through the revised website
- Promoted harmonisation with other standards based concepts and terminology groups.

Further information is available at: **www.dcu.ie/snhs/icnpusergroup.shtml** and a link to the report on eHealth Ireland is: **www.ehealthireland.ie/Our-Team/Enterprise-Architecture/** entitled 'Data Development for Health and Social Care Interim Report'.

European Oncology Nursing Society Conference

The European Oncology Nurses Society Conference was held in Dublin in the Aviva Stadium on October 17-18. The European Oncology Nursing Society is a pan-European organisation dedicated to the support and development of cancer nurses.

Introduced by Pauline Kehoe, president of the Irish Association of Nurses in Oncology, the Minister for Health Simon Harris opened the conference and indicated that the new national cancer strategy for Ireland would be launched soon. More than 500 oncology nurses from all over Europe and beyond gathered to network with nurse leaders and colleagues from around the world and benefit from a packed scientific and educational programme.

The overall theme of the conference was: balancing health care needs in a changing context – a close examination of the physical and psychosocial care needs of patients and their families in the context of demographic change and constant advances in diagnosis and treatment.

The INMO was an invited speaker at two sessions. One presentation was delivered on behalf of the European Federation of Nurses Associations and the second a workshop was in partnership with the Danish Nurses Association:

- Psychological Health and Wellbeing in Nurses – European Policy – Influencing Nursing Practice. Presentation on behalf of the European Federation of Nurses Associations
- Recognition and roles of nurses in cancer care – Advanced and changing roles in future cancer nursing. Workshop delivered in partnership with the Danish Nurses Association.

Cancer nurses and other key members of the multiprofessional team discussed the care needs of patients and their families and the challenges that nurses face in providing comprehensive care in a fast-changing world. Further information is available at: **www.cancernurse.eu/**

The International Council of Nurses Congress 2017

The International Council of Nurses (ICN) 2017 Congress will be held in Barcelona, Spain from May 27 to June 1, 2017.

The ICN has worked in partnership with Prof Dr Máximo A González Jurado, President of the Spanish General Nursing Council, and his team to deliver one of the largest dynamic and innovative Congresses for nursing globally. The theme is nurses at the forefront transforming care.

Details of the scientific programme and themes to be addressed can be accessed at **www.icncongress.com**. The plenary sessions will be dedicated to exploring the theme, with particular focus on the sustainable development goals, human resources for health, universal health coverage and safe staffing. Featured main sessions will offer the most recent expertise on patient-centred health care, evolving scopes of practice, climate change, infectious as well as non-communicable diseases, mental health, migration, human rights, patient safety, policy, technology, leadership, education and history.

Themes for abstract submissions (concurrent sessions, symposia and posters) will address these issues plus developments in healthcare systems, health promotion, nursing workforce, disasters and regulation.

The Congress will also be the venue for ICN Network meetings.

Elizabeth Adams is INMO director of professional development

Barcelona
ICN Congress 2017
27 May-1 June, Barcelona, Spain

Financial assistance available to INMO members for ICN Congress in Barcelona, Spain

The ICN 26th Quadrennial Congress will showcase the key role nursing plays in equity and access to healthcare. The Congress will permit access to, and dissemination of, nursing knowledge and leadership across specialities, cultures and countries. The three ICN pillars – professional practice, regulation and socio-economic welfare – will frame the Congress sessions and programmes.

The INMO will be formally represented at the ICN 26th Quadrennial Congress in Spain, in May 2017, by the President of the Organisation, Martina Harkin-Kelly, and the Director of Professional Development, Elizabeth Adams.

In keeping with past practice, the Executive Council will provide some financial assistance, subject to criteria laid down by the Executive Council, for those who may wish to travel to this worldwide gathering of nurses sharing the latest information, research and expertise on nursing and issues of concern to nursing.

The criteria, as determined by the Executive Council, for a member to be eligible to access this financial assistance are:

- The applicant must be fully paid up and have been in membership for at least three years
- The applicant should have attended at least one annual delegate conference and/or have been active in local branch/workplace Organisation activities
- Each applicant, before final sign off, must be the subject of support from a local rep/branch/section officer to confirm their involvement in the INMO's day-to-day activities

(Please note the maximum amount any one member can obtain, under this special initiative, is €1,000 with the total fund being €10,000).

To avail of a reduced rate of €525 early registration is available from now until February 17, 2017. Members who are interested in attending and who wish to find out more about the financial assistance, subject to the stated criteria, should contact the General Secretary's office by email (michaela.ruane@inmo.ie) before Friday, January 27, 2017. Further information can be found at: **www.icn.ch**

Q and A Bulletin Board

With INMO director of industrial relations Phil Ní Sheaghdha

Query from member

I work part-time and have been advised that I cannot get overtime payment, is this correct?

Reply

No this is not the case, part-time employees can earn overtime as follows:

In accordance with the Agreement on Flexible Working in the Health Service, nurses and midwives who work reduced hours are entitled to earn overtime payments for additional hours worked in certain circumstances. The following are some examples:

- A nurse or midwife working in a department or unit with a three or four-shift cycle would be eligible for overtime payment were they to work a full normal shift and were then requested to work additional hours outside the span of the shift
- A nurse or midwife working mornings only (8am to 1pm) in a department or unit where the normal shift is 8am to 4pm would be paid at flat time if requested by their employer to work from 1pm to 4pm. If asked to work from 1pm to 6pm (having started at 8am) the hours from 4pm to 6pm would attract payment at overtime rates. (This would apply whether or not the nurse or midwife had actually worked the hours 1pm to 4pm.) In circumstances where a 12-hour shift applies payment would be at flat time in respect of any additional hours worked with the span of the shift
- A nurse or midwife working a 'week-on/week-off' arrangement would be eligible for overtime payment if requested by their employer to work on their rostered days off, ie. to work in excess of the full time hours for the grade. They would be eligible for payment at flat time if requested by their employer to work their usual hours or a normal shift during their 'week off'.

Query from member

I am working in the private sector and was out on sick leave however I had to take unpaid sick leave due to my illness. I have asked my employer what my annual leave entitlement is for that period of unpaid sick leave and was advised I would be entitled to annual leave for my paid sick leave but not for my unpaid sick leave. Is this correct?

Reply

Employees are entitled to accrue statutory annual leave while on periods of unpaid certified sick leave as per changes to the Organisation of Working Time Act, which is effective from August 1, 2015.

Employees who cannot, due to their illness, take annual leave during the leave year in which it accrued, or during the normal carry-over period of six months, will be able to carry over such leave for a period of 15 months after the end of the leave year in question.

Additionally, employees who leave their employment within 15 months after the end of the leave year in which they accrued statutory annual leave while on sick leave are entitled to payment in lieu of any annual leave not taken.

Know your rights and entitlements

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

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

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

Introducing Executive Council members

Helen Butler

Director of nursing and midwifery, St Luke's Hospital, Kilkenny

I am currently serving my second term on Executive Council and have been an active member of the INMO as both a hospital representative and at branch level since 1987. I began employment in St Luke's General Hospital, Kilkenny, as a temporary staff nurse in the 1980s and have worked in several roles in the intervening period including CNM1, CNM2, discharge planner, assistant director of nursing and currently as director of nursing and midwifery, a post which I've held for the past 26 years.

The main issue that I will focus on is to ensure that nurses and midwives, as the best placed professionals to do so, decide on the optimum number of nurses/midwives and healthcare assistants that are required to deliver safe care to all patients in all settings.

Nursing and midwifery must be at the centre of the solutions required to ensure our health services recover from years of austerity and cutbacks. I believe that nurses and midwives have to stand together as professionals and fight for safe staffing levels.

It is vital that special measures are put in place to bring nursing and midwifery colleagues who have gone to work abroad back to Ireland and to keep them here, working in our health system.

I will work hard with my Executive Council colleagues to ensure that this is achieved, while also focusing on pay restoration for our members.

Email: butlerhelen42@gmail.com

Ailish Byrne

Senior staff nurse, Laois

I am serving my second term on the INMO Executive Council in the RNID seat. I am a senior staff nurse in a respite service in Laois under Muiriosa Foundation. I qualified as a registered nurse in intellectual disability in this organisation. I worked in a variety of settings as an RNID before later qualifying as an RGN in Tralee General Hospital and spent the next eight years mainly working on surgical wards. I have been a member of the INMO from the start of my nursing career and a union representative for the past 14 years. I am also the chairperson of the RNID Section.

Mortality is almost four times greater in those with intellectual disability than the general population and 11 times higher in females. The Tilda study by Trinity College points clearly towards multimorbidity of this older population. On the other end of the spectrum, the number of children born with intellectual disability is increasing, as are their complex needs. Many families are in crisis. It is vital that the correct, suitably qualified personnel have key roles to play in the lives of persons with intellectual disabilities.

My main aim is to ensure that the critical role of RNIDs is fully recognised and used in a variety of different settings to promote lifelong health and best outcomes for people with intellectual disabilities. I will continue to ensure that RNIDs are at the helm of service reforms and partnering with mainstream health and social services.

I will also advocate for all nurses and midwives to be provided with a safe place to work with appropriate pay, as well as ensuring that they are a valued member of our health service.

Email: ailish.brennan@yahoo.ie

Tommy Caulfield

CNM1, Portiuncula University Hospital, Ballinasloe, Co Galway

I was nominated to fill one of the vacant positions on the Executive Council following the resignation of two members. I attended my first meeting in September 2016.

I trained in Portiuncula Hospital Ballinasloe in 1994 and worked for many years in the theatre department in what is now called Portiuncula University Hospital, Ballinasloe. I started working in the central decontamination unit four years ago. I have a postgraduate higher diploma in perioperative nursing from NUI Galway and a certificate in sterile services technology from Tallaght IT.

I have been an INMO representative since 1997 and served as chairperson and vice chairperson of the Ballinasloe Branch. I have extensive experience in disputes, both at local and national level, including attending the LRC.

I take up my position on the Executive Council at a critical time in our professions, as we demand acceleration of pay restoration to try to stem the crisis in frontline staffing, the chronic overcrowding of our hospitals, unpaid working hours and unsafe conditions for both nurses, midwives and patients. We also have a major problem with the lack of respect from management, leading to the departure of nurses and midwives from the public health service.

Finally, I would like to say that I intend to work hard at national and local level to advocate for nurses and midwives to have our professions respected and our pay restored.

Email: tommy.caulfield@yahoo.com

Strengthening the INMO at local level

INMO organiser **Albert Murphy** focuses on advanced rep training courses and upcoming courses in 2017

AN ADVANCED nurse rep training course, which was the first course to be held under the revised format, took place in INMO HQ on November 10 and 11, 2016.

The importance of meetings was among the topics discussed during these two rep training days. A presentation was given by Colette Mullin, INMO information and research executive, on the principles of natural justice and fair procedures in employment. A session on social media and basic media skills was facilitated by Dean Flanagan, IRO and media assistant, Freda Hughes. Attendees also took part in an advanced negotiating skills session, which was given by INMO deputy general secretary, Dave Hughes.

In addition, there were sessions on how to build a stronger INMO and on democracy within the INMO. The feedback from the course participants was very positive and we look forward to having further advanced nurse rep training courses in 2017.

Also in November two basic rep training courses took place in Kilkenny and Galway, which were well attended. Over 2015 and 2016, the INMO has intensified the training for local reps and is committed to ensuring that all of our reps receive support.

In the context of the campaign on staffing and pay restoration, it is now more important than ever we have reps on the ground who will help organise and assist this campaign. If you wish to become involved please contact your local IRO who will help you in this regard.

2017 training programmes

Following the December meeting of the Executive Council, it is expected that the programme for nurse and midwife rep training will be finalised and made available to members. If you are interested in participating in these courses once advertised, please contact Martina Dunne at email: martina.dunne@inmo.ie or Tel: 01 6640624.

Pictured at the advanced nurse rep training course at HQ, which took place in November were *(back, l-r): Deborah Fitzpatrick; Liam Conway; Bernie Lucey; Annette Simpson; (front, l-r) Albert Murphy, INMO industrial relations officer and organiser; Clodagh Cardiff; Aisling O'Neill; Aidan Wilson; Eilish Horkan; and Dave Hughes, INMO deputy general secretary*

Some participants at the training course in INMO HQ were (l-r): *Catherine Rotte-Murray; Aidan Wilson; and Liam Conway*

Master class: *An advanced negotiating skills session was given by Dave Hughes, INMO deputy general secretary, at the recent training course in INMO HQ*

Pictured at the Galway basic rep training course were (l-r): *Ann Burke; Karen McGowan; Pauline Canny; Ann Tully; Patricia Cullen-Killoran; Priscilla Alcos; Joan Brennan; Niamh McKeon; and Mags Walsh*

Filipino Nurses Association Ireland

INMO director of regulation and social policy Edward Mathews addressed the bi-annual Filipino Nurses Association Ireland summit, which was held in Dun Laoghaire, Dublin on November 3.

Mr Mathews gave the keynote address and also gave a presentation on the staffing challenges which face the Irish health system. The Filipino Nurses Association is a chapter of the Worldwide Filipino Nurses Association of Ireland and is a support for Filipino nurses for social, cultural and education perspectives.

The conference was well attended by both delegates and a number of INMO activists.

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

Quality & Safety

A column by Maureen Flynn

Quality and safety committees

QUALITY and safety committees, sometimes referred to as clinical governance, perform an essential role in our health services by providing a multidisciplinary forum to consider, monitor and improve the quality and safety of care we provide. Here we examine guidance for the establishment and operation of quality and safety committees.

For effective governance, it is important that there is division of duties between oversight roles, management and implementation roles. This is realised through the establishment of separate local, executive and board committees for quality and safety. The number and level of the committee(s) will be informed by the context and size of and nature of the service *(see Table)*.

For smaller services where there are limited personnel, quality and safety can be incorporated as a standing agenda item of the management team meeting, thus avoiding the requirement to establish a separate local committee.

Quality and safety committee operation

The committees provide much needed space to stand back and consider the quality and safety of care we provide, to monitor this on a routine basis, and to provide respectful challenge and act to improve care. Quality and safety committees address issues such as:

- How do we know what good care is?
- How do we know we are getting better?
- Do we have the appropriate measures?
- Have we confidence in the relevant data?
- Do we know where you stand relative to the best?
- How do we demonstrate that we are a learning organisation?
- How do we keep in touch with the reality of service delivery?
- How do we ensure we hear the voices of patients, families, service users and staff?

Table: Quality and safety committee levels

Local quality and safety committee *Aim:* To develop, deliver, champion, implement and evaluate a quality and safety programme for the service area	Supports delivery of quality safe services at local or service level, is multidisciplinary comprising staff whose roles are concerned with establishing, developing and implementing quality and safety systems within the local service. It focuses on driving the implementation of improvements and safeguards in quality and safety. Where in place, the chair of the committee is operationally responsible to the executive management team and reports on progress to the executive quality and safety committee.
Executive quality and safety committee *Aim:* To develop, deliver, implement and evaluate a comprehensive quality and safety programme with associated structures, processes, standards and oversight which are the vehicle for improving quality and safety	Manages quality and safety on behalf of the executive management team, is multidisciplinary, roles are directly concerned with establishing, developing and implementing quality and safety structures, processes, standards and oversight across the service. It focuses on driving the implementation of service-wide improvements and safeguards in quality and safety. The committee is accountable to the senior accountable officer and reports on progress to the executive/senior management team
Board quality and safety committee *Aim:* To drive quality improvement and provide a level of assurance to the Board that there are appropriate and effective systems in place that cover all aspects of quality and safety	Oversees management of quality and safety across the service on behalf of the Board. For voluntary services of the HSE (and in the future, Trust Boards for groups of hospitals/community services), the governance of quality and safety is a function of the Board. A board committee comprising non-executive and executive members would normally be established. The board quality and safety committee operates on behalf of and reports directly to the Board

Guidance for quality and safety committees

To help this process, the HSE quality improvement division has just updated guidance and produced a step-by-step guide with terms of reference, agenda, minutes and report templates to assist staff who wish to establish or review their quality and safety committees.

The guidance and checklist for prioritising measures of quality are provided ready for adaptation to the specific context of each of our services and are valuable tools for all of us to improve the care that we deliver.

Further information

Go to **www.hse.ie/eng/about/Who/qualityandpatientsafety/Clinical_Governance/Q-S-Committee** to download the guidance document or contact Karen Reynolds, quality improvement division governance for quality and safety facilitator, at email: karen.reynolds@hse.ie or Tel: 086 8394929 for more information.

Maureen Flynn is the director of nursing and midwifery ONMSD, lead governance and staff engagement for quality HSE Quality Improvement Division

Acknowledgement
A special thanks to the many staff and teams across the health system who have used the original document (published in 2013), shared their experiences and made suggestions for strengthening the revised document during the consultation processes

Immunisation – an international view

In the latest clinical update in this continuing professional development series, **Gerry Morrow** examines different diseases which are preventable by immunisation

THE World Health Organization describes immunisation as "the process where a person is made immune or resistant to an infectious disease, by the administration of a vaccine. Vaccines stimulate the body's own immune system to protect the person against subsequent infection or disease".

Immunisation is a proven tool for controlling and eliminating life-threatening infectious diseases worldwide. It is estimated to prevent up to three million deaths each year.

This topic is designed to support primary healthcare professionals:

- To understand the range of diseases that can be prevented with immunisation
- To immunise all children who require protection from infectious disease
- To educate and inform parents, carers, and older children of the benefits of immunisation.

Diseases prevented by immunisation

Diphtheria

Diphtheria is an acute infectious disease caused by toxigenic strains of *Corynebacterium diphtheriae* and *C. ulcerans*. It causes a grey, thick, fibrinous membrane (pseudomembrane) to affect the upper respiratory tract.

Classical diphtheria presents with pharyngitis, fever, swollen cervical lymph glands and oedema of the soft tissues ('bull neck' appearance). The pseudomembrane can cause death due to respiratory obstruction.

Diphtheria, which affects the skin, appears as vesicles become ulcerated and covered with a hard, bluish-grey, raised membrane, usually on the limbs. Diphtheria toxin can also cause heart failure and paralysis by affecting the heart muscle, nervous and adrenal tissues.

The best evidence to support the efficacy of diphtheria-containing vaccines is that the disease has been virtually eradicated in many countries since immunisation began.

For example, there were no notifications for diphtheria in England and Wales in 2014, and no deaths. This compares with 61,000 cases of diphtheria in the UK in 1940, with 3,283 deaths.

In the US, there were 206,000 cases of diphtheria in 1921 and 15,520 deaths. There were no cases of diphtheria in the US in the years 2004-2008. However, it is still prevalent in some countries, and death rates are highest in the under five age group, where 20% of those affected with diphtheria are likely to die.

Haemophilus influenzae

Haemophilus influenzae can cause serious disease, especially in young children.

The most common presentations of invasive disease are meningitis (60%), epiglottitis (15%) and bacteraemia without an obvious focus (10%).

Before vaccination, it is estimated that in 2008 globally 203,000 children under five years died due to Hib (*Haemophilus influenzae* type b) .

Hib is estimated to cause 2% of all cause-child mortality under five and 4% of non-neonatal mortality. There is now a national immunisation schedule in 68 countries worldwide. As a direct result of this, the all-cause pneumonia death estimates by WHO declined from 1.8 million in 2000 to 1.2 million in 2008.

Measles

Measles is an acute viral infection with features that include fatigue, common cold symptoms, conjunctivitis, cough, red spots in the mouth (Koplik spots), red rash and fever. Complications include ear infections, pneumonia, diarrhoea, seizures and, rarely, post infectious encephalitis (which occurs at around one week after the onset of the rash). Historical evidence shows that the measles vaccine is effective. As uptake of the vaccine has increased, the incidence of measles has fallen correspondingly.

Before the measles vaccine was introduced in the UK in 1968, there were up to 800,000 each year with peaks every two years. When the combined measles, mumps and rubella (MMR) vaccine was introduced in 1988 and coverage exceeded 90%, notifications fell substantially.

Meningococcal infection

Meningococcal infection commonly presents as meningitis or septicaemia, or both, and is caused by *Neisseria meningitidis*.

Less commonly, meningococcal infection may present with pneumonia, myocarditis, endocarditis, pericarditis, arthritis, conjunctivitis, urethritis, pharyngitis or cervicitis.

The best evidence on the effectiveness of the meningococcal group C vaccine (MenC) is a huge fall in the number of cases of meningitis after the vaccine was introduced in the UK in 1999. Since this time, the incidence has decreased by 97%. Similar results have been seen in Canada and Australia.

Pertussis

Pertussis (whooping cough) is a bacterial infection caused by *Bordetella pertussis*. Following an initial common cold-type stage, an irritating cough gradually becomes a paroxysmal cough, usually within one to two weeks. The paroxysms are often followed by the characteristic 'whoop'.

Severe complications and deaths are most common in babies less than six months of age. Possible complications include pneumonia or cerebral hypoxia resulting in brain damage. Repeated post-tussive vomiting may lead to weight loss.

Historical evidence has shown that the pertussis vaccine is effective. In 2008, about 82% of all infants worldwide received three doses of pertussis vaccine. The WHO estimates that, in 2008, global vaccination against pertussis averted about 687,000 deaths.

Pneumococcal disease

Pneumococcal disease can present as sinusitis, ear infection, pneumonia, bacteraemia or meningitis. It is a major cause of morbidity and mortality, especially in the very young, the elderly, and in people with a suppressed immune system. The pneumococcal vaccine can prevent about 50-70% of cases of pneumococcal infections.

Poliomyelitis

Poliomyelitis is a viral infection which attacks the nervous system. Early infection is often not apparent but symptoms can range in severity from a fever to meningitis or paralysis. Acute disease may present with fever, fatigue, headache and vomiting, often with stiffness of the neck and back (with or without paralysis).

Historical evidence has shown the poliomyelitis vaccine to be effective. Today, the disease is on the verge of worldwide eradication, with only isolated cases still occurring in a few countries.

With the introduction of a vaccine worldwide, the number of cases has decreased dramatically. The WHO reports a reduction in the number of children affected by polio from 1,000 per day in 1988 to five per day in 2006. The WHO now lists many countries which have eliminated polio infection entirely.

Rotavirus

Rotavirus infection causes a highly contagious gastroenteritis that usually lasts from three to eight days. People with rotavirus usually present with a fever, severe diarrhoea, vomiting and stomach cramps. Rotavirus infection can lead to dehydration. Most infections occur in children between one month and four years of age.

By January 2015, rotavirus vaccination had been implemented in national vaccination programmes in 75 countries worldwide. As a direct result there has been a more than 90% reduction of rotavirus hospitalisations in these countries.

Smallpox

Smallpox was officially eradicated in 1980. This is testament to the success of an international collaboration across the world, which was in no small part due to immunisation.

Tetanus

Tetanus is an acute infectious disease caused by tetanus toxin. Typical symptoms are muscle rigidity with painful contractions of the muscles. The muscle stiffness often involves the jaw (lockjaw) and neck, and then becomes more widespread.

Tetanus spores are present in soil and can be transmitted through any small wound. Therefore, tetanus can never be eradicated.

The best evidence for the efficacy of the tetanus vaccine is the decline in the prevalence of the disease since immunisation was introduced. By the year 2000, 135 countries had eliminated neonatal tetanus and annual deaths from tetanus had dropped by 75% worldwide.

Other illnesses

Other illnesses which can prevented by immunisation worldwide include:

- Cholera
- Hepatitis A and B
- Human papilloma virus
- Influenza
- Japanese encephalitis
- Mumps and rubella (as part of the MMR vaccine)
- Rabies
- Tuberculosis
- Typhoid fever
- Yellow fever
- Varicella.

Advice for parents

Healthcare practitioners should discuss the following with parents of children who need immunisation:

- Explain the benefits of immunisation to parents, in particular emphasising that it helps prevent serious illness in children, especially potentially severe diseases such as meningitis and tetanus
- Explore any concerns that the parent may have, taking time to present the facts
- Reassure that vaccinations are safe. Pain, swelling and reddening at the site of injection are the most common side-effects, other effects are rare and usually only cause a mild fever
- Advise parents not to routinely give paracetamol or ibuprofen to prevent fever. However, if pain or fever is problematic after the child has been immunised then paracetamol or ibuprofen may be used.

How to administer vaccines in a child

- Obtain consent from a person with parental responsibility
- Ensure that there are no contraindications to the vaccine
- Ensure that the parent or carer has been fully informed about the immunisation
- Discuss possible adverse reactions with the parent or carer and make them aware of how to treat them
- Check that the vaccine is correct, has been stored appropriately and has not expired.

When administering the immunisation:

- Wash the site with soap and water if it is visibly dirty
- Most vaccines are given by intramuscular (IM) injection (if the child has a bleeding disorder, use the subcutaneous (SC) route for vaccines normally given by the intramuscular route as this reduces the risk of bleeding). Do not give immunisations into the buttock
- Use a 25mm 23-gauge (blue) or 25-gauge (orange) needle for IM administration (a 16mm 25-gauge needle may be appropriate for pre-term or very small infants)
- Give IM and SC immunisations into the anterolateral aspect of the thigh. If an additional vaccine is required on the same day, use separate legs if possible, or inject at sites at least 2.5cm apart
- Rotavirus vaccine is given orally. To administer an oral vaccine, seat the child in a reclining position and administer the entire contents of the oral applicator into the child's mouth (towards the inner cheek). If a baby spits out or regurgitates most of the vaccine, another single dose can be given (at the same visit)
- Record the date of administration, vaccine and product name, batch number, expiry date, dose administered, and site of administration for each vaccine.

If the child is anxious or nervous, several measures can be tried, including adopting a calm, sympathetic approach, giving patient explanations (to the child and the parent), preparing and administering the vaccine out of sight of the child, and using distraction techniques.

Observe the child after vaccination to detect immediate adverse reactions. Ensure any bleeding has stopped and check the child has no symptoms of allergy before they leave.

Severe allergy (anaphylaxis) is extremely rare and usually becomes apparent within minutes. By the time the site has been checked for bleeding and documentation has been completed, most reactions will have become apparent.

Make a final assessment of the child before they leave the premises.

Gerry Morrow is medical editor and medical director at Clarity Informatics

Bibliography

1. Andre FE et al Vaccination greatly reduces disease, disability, death and inequity worldwide Available from: http://www.who.int/bulletin/volumes/86/2/07-040089/en/

2. Ali A et al. Global practices of meningococcal vaccine use and impact on invasive disease Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4083163/

3. UNICEF and World Health Organisation. State of the world's vaccines and immunization. Third Edition. Available from: http://www.unicef.org/immunization/files/SOWVI_full_report_english_LR1.pdf

4. World Health Organization Myths and Facts about vaccination Available from: http://www.who.int/features/qa/84/en/index.html

CPD Quiz

There may be more than one correct answer to the multiple choice questions listed here. The correct answers *(given below in the inverted text)* are those deemed most appropriate by the authors in the context of this CPD article.

1. Diseases which can be prevented by immunisation include:

A) Diabetes
B) Measles
C) Yellow fever
D) Zika virus

2. Diseases which have been completely eradicated by immunisation include:

A) Chicken pox
B) Cholera
C) Zika virus
D) Smallpox

3. The best side for administering a vaccine in a child is:

A) The buttocks
B) The lower arm
C) The anterolateral aspect of the thigh
D) The calf

2. Worldwide immunisation has reduced deaths from which of the following disease?

A) Diphtheria
B) Tetanus
C) Meningococcus
D) All of the above

After reading this article you may wish to reflect on what you have learned, how this might be applied to your own work and to make a note of this in your portfolio.

Clarity informatics

For further information and resources: **www.clarity.co.uk**

Answers: Question 1 = B and C; Question 2: D; Question 3: C Question 4: D

INMO Campaign of Action

Ann Keating reports on INMO activities reported in the media recently, including the Organisation's Campaign of Action, overcrowding, agency spend and that HSE memo

THE INMO press conference on November 8 was well covered in the media. Under the headline **Hospital beds could close if nurses back industrial action,** *The Irish Times* (November 9) reported "Hospital beds face closure while some community services could be restricted if nurses and midwives back industrial action in a forthcoming ballot. The Irish Nurses and Midwives Organisation (INMO) is to ballot its 37,000 members for industrial action in protest over their working conditions and staffing levels. The INMO is also to seek an acceleration of pay restoration. The INMO, which announced the move yesterday, is seeking the introduction of new incentives to recruit and retain nurses and midwives and to secure adequate staffing levels."

INMO general secretary Liam Doran said: "If the ballot was carried, the initial work to rule would involve matching the level of services on offer to the number of staff available... This could involve nurses taking control of their working environment by taking beds out of the hospital system or curtailing community services..." It continued: "The INMO did not specify the level of financial incentives which it would be seeking... Mr Doran said it is not just about recruiting staff. It is about retaining existing staff as well."

The *Irish Examiner* (November 9) also covered the story – **Nurses to be balloted for industrial action**. "While the union stressed last night its main focus is on ensuring the recruitment and retention of nurses as the system has 3,800 nurses less now than in 2009, it added pointedly that a key element of the demand is 'accelerated restoration' of recession-era pay cuts... The ballot is being commenced, and if our members endorse the action it will be entirely geared towards two things – getting from the employer special recruitment and retention of staff incentives. If they don't do this, we will take beds out of the system and curtail community services so that they match available staff."

Overcrowding

The *Donegal Democrat* (November 17) ran a headline – **Overcrowding 'not sustainable' at LUH**. INMO IRO Maura Hickey said: "The volume of overcrowding at Letterkenny University Hospital is unsustainable. The INMO had reported there were 45 patients waiting for beds at LUH on Wednesday morning. They said the Emergency Department National Escalation Policy had been applied, with management opening three escalation areas to house some patients and others nursed in treatment rooms or ward corridors... the hospital has seen a 10% increase in emergency department attendances since January."

Ms Hickey said: "More bed capacity in acute and continuing care, and extra home help and home care must be provided immediately to ease this crisis. She said patients' "loss of dignity, privacy and access to care in an appropriate environment cannot be forgotten and should be the HSE's priority."

INMO condemns overcrowding at UHL was a headline in *The Clare Champion* (November 11). The INMO "has condemned the gross overcrowding at UHL and the compromised ability of nurses to provide acceptable and safe care to all patients there. The nursing union has described the placement of 66 patients on trolleys and extra beds on wards this week as 'unprecedented' and a 'serious crisis'.

INMO IRO Mary Fogarty said: "The INMO has balloted nurses on all of the wards, with 97% in favour of industrial action of which management has been notified."

Dungarvan Community Hospital

The *Dungarvan Observer* (November 18) reported on the INMO's lunchtime protest and work to rule due to staff shortages at Dungarvan Community Hospital – **Nurses hold lunchtime protest at Dungarvan Community Hospital.** INMO IRO Mary Power said: "INMO members feel that they have no option but to concentrate on core nursing care roles to ensure their focus is on delivering quality and safe care to their patients at the hospital... this action will enhance the actual nursing care for patients as it will allow nurses to prioritise the patient care by ceasing non-urgent clerical/support work."

Agency spend

The *Sunday Independent* (November 6) reported: **€25,000 an hour spent employing expensive agency hospital staff.** "Last year, the HSE was forced to spend more than €207m on a range of agency staff to fill vacancies in acute hospitals... Liam Doran said 'it's utter madness' but that the HSE is continuing to pay inflated rates to agency staff. Every hospital is now relying on agencies as a stop gap measure – yet it's at least 28% more than the cost of employing particular nurses."

HSE memo

Union and minister lash HSE for memo was a headline in the *Irish Examiner* (November 10) which reported that: "A controversial memo advising nurses of their right to remove 'trespassing' public patients from acute hospital beds when others are more in need has been withdrawn... The memo outlines how a patient's right to be on a hospital premises 'is merely a licence and once that has been abused, the nurse is also legally entitled to remove the person as a trespasser, using minimum force to do so'. Mr Doran, who described the memo as 'madness, immoral, bizarre and unbelievable', said the HSE had 'lost its soul' and that the memo was disrespectful towards nurses."

Ann Keating is INMO media relations officer
Email: ann.keating@inmo.ie

McAuley Place in Naas (above left) and a group of volunteers from Irish Dog Foods alongside McAuley Place residents and staff after a successful volunteer day (above right)

Keep walking on walls

We need to demand effective, robust, age-positive policies on housing and care, writes **Margharita Solon**

HOW exactly should we support our older members of society? This is a question I have been asking for more than 15 years. During that time I've come up with some surprising answers, one of which is literally concrete: the Nás na Ríogh Housing Association, known as McAuley Place, which, according to President Higgins, ought to be a model for all such undertakings in Ireland. This complex provides 53 individual independent living apartments for older people from in and around Naas and is a realisation of the philosophy behind this project.

It was not just my experience as a nurse caring for older people that brought me to question how we, as a society, interact with them, it was my everyday experience of seeing how older relatives and friends were treated. How often do we lose patience with an older driver, thinking they shouldn't be driving at their age? Get weary of hearing the same stories over and over? Or rush to put the kettle on because we don't have the time to wait while someone shuffles slowly to the sink?

How often do we ask ourselves, does it have to be like this? Not often enough, I believe. And I do understand why – to ask these questions is to face our own ageing, and that, in our youth-fixated society, is very difficult to do. But that person who is holding you up in the queue is you – not now, but someday.

This was my starting point for McAuley Place, asking where I would like to be when I get to the stage where I can no longer be as independent as I once was. I wondered about the environment I would like to live in, the kinds of things I would like to do. Crucially, I realised that to achieve the old age we desire, we need to act now.

The question is not what you want to be when you get older, but where? Is it somewhere with nondescript walls with the same posters or prints to look at day after day? Is it somewhere where the armchairs are too low and the seats too soft for you to get in and out of easily? To ask these questions is not to imply criticism of current practice, and indeed many positive changes are already taking place. There is now a focus on 'ageing in place' but I worry that unless this is defined carefully, it may end up incubating older people for long-term care. I suggest that a more effective approach would be to provide for 'naturally ageing in the right place' and that the right place is in the community. Community is at the heart of my vision, but it is a community of 'interest', not of age. I am very proud of the fact that when you walk into McAuley Place, you are not instantly confronted with age: the people in the lobby looking at the original art on the walls, the people coming in and out of the tea rooms, the staff going about their business are from all generations, and the interiors suggest boutique hotel rather than institution. In fact, the aim of McAuley Place was to bring older people to the heart of a vibrant community, the focus being not on the older people but on the community.

Social prescribing essentially encapsulates what I have been advocating for years – basing the care of older people on non-medical sources of support, allowing them to age naturally in a non-medical environment.

To see a garden through our window; to hear children playing; to smell the oils we are painting with; to taste the soup we are making – these stimulations are just as necessary at 84 as at 48. To have stories to tell, you have to be out there, engaged, exploring, but the world won't let you take any chances if it considers you 'old'. It's not just our senses that need to be kept alert, our body has to be constantly invigorated.

Keeping physically and mentally active to stave off the worst effects of ageing is not a new concept. But how can we enable older people with reduced mobility to do this naturally in their own environment?

To create effective environments, we need to rethink two things, our attitudes to older people and our policies on housing. I feel that there is a need for a cyclical housing system, whereby the needs of people at different stages in their lives are taken into account, all the while maintaining a sense of community.

We need to ensure that current health, housing and government policy acknowledges, indeed encourages, that state of affairs through a cohesive and coherent approach. And there are good economic reasons for doing so; at present, the cost of keeping an older person in care is around €1,000 a week, in McAuley Place, the weekly rent is around one-tenth of that amount. It is only if we engage with our own ageing, that we will be able to control its impact more positively, and see it as a privilege rather than a burden. We need to ask ourselves, what is old? What makes us feel old? What will prevent us from feeling old? We now need actively to demand, create and ensure effective, age-positive policies on housing and care, not just for our parents and relatives, but for ourselves. We need to keep walking on walls.

McAuley Place is currently seeking volunteers, and those with a nursing background are particularly welcome.

Further information is available from Catherine O'Sullivan, by email: catherine@mcauleyplace.ie, Tel: 045 897833 or visit **www.mcauleyplace.ie**

Margharita Solon is vice chairperson of Nás na Ríogh Housing Association, McAuley Place, Naas and a graduate of the Mater Hospital School of Nursing, Dublin

Key benefits of colostrum

WOMEN have produced and fed their babies with colostrum since the beginning of time. Colostrum is produced by mammals before birth and is intended for feeding the infant. It is produced by mammary glands in the breasts of mammals and is not only shown to protect infants from illnesses but it also aids long-term health.[1]

Colostrum is a yellow fluid, resembling blood in composition, that contains more than 60 components.[2] It is high in carbohydrate, protein and antibodies, but is low in fat as newborn babies find fat difficult to digest.[3] Colostrum provides babies with passive immunity in the form of lactobacillus bifidus, lactoferrin, lysozyme and secretory IgA.[2]

Breastfeeding

'Colostrum – Every Drop Counts' is a global initiative by Prof Khashu et al 2016 and it highlights the unique properties of colostrum and its benefits to babies, parents, families, communities and populations.

The World Health Organisation (WHO) describes colostrum as the 'perfect food for newborns and recommends initiating feeding within the first hour after birth'.[5]

Colostrum helps to protect babies from a range of diseases, including respiratory infections, diarrhoea and it also offers protection against obesity.

Breastfeeding also has many benefits for mothers, partners, communities and the environment.[6] Globally, only 38% of infants are breastfed and sub-optimal breastfeeding contributes to 800,000 infant deaths each year.[3]

The WHO identifies breastfeeding as 'the normal way of providing young infants with the nutrients they need for healthy growth and development. Virtually all mothers can breastfeed, provided they have accurate information, support of their family, healthcare system and society at large.

Exclusive breastfeeding is recommended up to six months of age, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond'.

Breastfeeding habits and benefits are hugely impacted by global marketing of formula by lucrative companies often reporting benefits over breastfeeding. The International Code of Marketing of Breastmilk Substitutes is an international health policy, adopted by the World Health Assembly of the WHO in 1981. The Code recommends restrictions on the marketing of breastmilk substitutes, such as infant formula, to ensure that mothers are not discouraged from breastfeeding and that substitutes are used safely if needed.

Since 1981, 84 countries have enacted legislation, yet only 37 countries (19% of those reporting) have passed laws reflecting 'all of the recommendations'.[5]

The *Lancet*-review *'Breastfeeding in the 21st century'* reported the importance of breastfeeding in low-income and middle-income countries as well recognised, however, less consensus exists about its importance in high-income countries.

Local context

Ireland has extremely low levels of breastfeeding. The 'Growing Up in Ireland Study 2015' showed that 49.5% of Irish mother's initiated breast feeding compared to 88.1% of non-Irish mothers living in Ireland who report to have breastfed at least one of their children.[6] The Irish government spent €100,000 nationally on the promotion of breastfeeding in 2015.[7]

The alarmingly low rates of breastfeeding among the Irish population initiated a study in 2005 entitled 'Breastfeeding in Ireland - A five-year strategic action plan'. This aimed to promote breastfeeding as normal and the preferred choice for families in Ireland and to change attitudes on a national basis.

In 2015, a Kerry public health nursing initiative opted to action this national plan by encouraging primary care team members to utilise antenatal visits to educate new mothers on the benefits of colostrum, including skin-to-skin contact between a mother and baby after birth. Breastfeeding workshops were established to support mothers to learn about the benefits of colostrum and breastfeeding for mother, baby, partner and environment.[8]

In Limerick, approximately four out of every 10 babies are being breastfed and 45% are exclusively breastfeeding on discharge home.[9,10]

Breastfeeding initiative's in Limerick include:

- The Baby Friendly Health Initiative
- World café breastfeeding event (multi-agency)
- Friends of Breastfeeding breastfeeding challenge, which aims to have as many babies latched on simultaneously across locations in Ireland. Limerick accounted for 17 babies of a total 392
- Cuidiu breastfeeding support group, Maternity Hospital Limerick
- The Friends of Breastfeeding Mum2Mum group meet in Bruff Community Café, Co Limerick
- Midwife/lactation consultant-led clinic, Maternity Hospital Limerick.

The UL midwifery class discovered the unique benefits and protection of colostrum and questioned why the international marketing code laws are not all passed.

In class we discussed that bovine colostrum (known as beestings) is highly valued in Irish farming and veterinary communities. It is also used as a dietary supplement by children and adults to stimulate immune systems, treat diarrhoea, colitis and infections. Athletes use colostrum to improve stamina and burn fat.[1] The UL midwifery class suggest 'human colostrum' needs to be more valued for every baby in Ireland and globally.

This article was written collaboratively by first-year midwifery students in the University of Limerick

Acknowledgement
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References on request quote WIN December 24(9): 51

Clarification
The Midwifery Matters article 'Pathway to respectful care' published last month (WIN 2016, Nov: 24(9):52) was based on an article in the 'Lancet Maternal Health Series', and not a midwifery series as stated

Children and surgery – role of the nurse

Nurses can be central to improved outcomes for children undergoing surgery and parents who support them, writes **Kathleen Healy**

GOING to the hospital for surgery can be an unfamiliar and daunting experience for most people and can evoke feelings of anxiety and stress. In particular, it can be a potentially threatening experience for children and their parents. However, having access to relevant information in advance of admission in order to assist in preparing for this event can be of benefit and have positive results in terms of reducing anxiety for both children and parents. Taking this into consideration, a research study was undertaken to explore the information needs of parents of children admitted for day surgery.

The literature reviewed explored the historical experiences of children in hospital and the involvement, or lack thereof, of parents in caring for their children during a hospital admission. The benefits of same-day surgery were considered, in particular the shorter period of separation between parent and child, resulting in less behavioural changes in children.

Interventions used to prepare children and their parents for the hospital and surgical experience were discussed and these included use of a child-orientated book,[1] a Saturday Morning Club[2] a child life specialist,[3] and therapeutic play.[4] Preparation of parents was recognised as a fundamental ingredient in ensuring more positive outcomes for the child.

Survey

A cross-sectional, descriptive, correlation survey design was used to establish what the information needs of parents were in terms of the procedures which occurred in the operating room, and how this information may best be provided.

A sample of convenience and non-probability (n = 120) were given a self-administered, structured questionnaire developed specifically for this study.

Table 1: Items pertaining to operating room procedures

- Fasting time
- Questions in the perioperative nursing care plan
- Dress code operating room staff
- Dress code for child in operating room
- Dress code for parent in operating room
- Journey to operating room department
- Waiting times
- Equipment used in operating room
- Operating department environment
- Parental participation in operating room
- Recovery room
- Pain relief

Internal consistency and reliability were established and predictive analytics software was implemented in analysis of the data.

Survey findings

In the return rate of 70.8% (n = 85), a large number of parents (90.6%) indicated they had received information, with the majority receiving this on the day of surgery. Parents perceived that this information benefited them in preparing themselves and their child for the impending surgery.

Interestingly, only 32.9% of parents indicated they would like to receive more information on the procedures that occurred in the operating room. More than 96% of the parents who responded to the questionnaire received verbal information, with only 9.4% receiving written material. This information was provided by nurses on the ward and in the department, anaesthetists and surgeons.

Parents were asked to rate the information they received using a Likert scale relating to 12 specific items pertaining to operating room procedures (see *Table 1)*. The mean values indicated that this information was rated very good and a high level of importance was attached to each statement.

Parents indicated a statistically significant difference ($p < 0.05\%$) in the level of importance on receiving information on five of these items: fasting time, dress codes for staff, the child and for parents in the operating room, and the journey to the operating room department.

Other results identified pamphlets (65.9%) and a visit from healthcare staff (50.6%) as the most desired type of information format, with the most popular time to receive this information as one week before the child's surgery (44.7%).

As previously stated, the majority of parents who responded to the questionnaire were satisfied with the information they received on the procedures relating to the operating room department. They indicated that all 12 items posed in the questionnaire were either important or very important and rated the information they received as mostly very good and excellent.

Most of the respondents received this information on the day of surgery. Yet previous studies have shown that giving information at least one week in advance of surgery is the optimal time for parents to receive it, as they have time to assimilate it and use it more effectively in preparing themselves and their child for the admission to hospital.[2,5,6]

Previous research has identified that nurses, doctors and parents were the main communicators to children during an admission to hospital[7] and the results in this study indicated a similar trend.

Research studies have shown that parents and their children can benefit from receiving information on the process and procedures involved in an admission to hospital. It can assist them to prepare for

the new and unfamiliar experiences they may encounter.[1,2,3,4]

Nurses and other healthcare personnel must endeavour to provide the best possible information to parents.[8,9] It has been established that receiving both written and verbal information may improve parents' knowledge and ensure satisfaction.[5,10]

In this study, mostly verbal methods were used to convey information. Clear communication can be effective and nurses can be central in this process.[11]

Interventions favoured by the respondents included a written information booklet or pamphlet, or a visit from healthcare staff working in the operating room department. This supports previous research highlighting written information booklets/pamphlets as a popular choice[1,6,10,11]

Respondents also commented that they would like information to be more child-friendly. This would facilitate children to understand its content and become more actively involved in preparation for their own admission.

Nurses can be central in facilitating improved outcomes for children undergoing surgery and for their parents who support them.[8] They can become key figures in developing strategic systems of communication between healthcare staff in the children's day unit, the operating room department and healthcare users.

Nurses have the skills to facilitate and deliver on clinical practice initiatives such as the creation of information booklets or co-ordinating pre-operative visits to the children's day unit.[1]

Furthermore, nurses have the capacity to undertake research investigations in the clinical field, both individually and within an interdisciplinary team approach. It is with these skills and competencies that nurses can go forward and create information systems to meet patients' information needs.

A child orientated information booklet on a trip to the operating theatre is available on the Cork University Hospital website at **www.cuh.hse.ie** under the children's services section. This is in addition to a suite of information available to both parents and children about preparing for the child's stay in hospital.

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References

1. Felder-Puig, R, Maksys, A, Noestlinger, HG, Stark, H, Pfluegler, A & Topf, R. Using a children's book to prepare children and parents for elective ENT surgery: results of a randomized clinical trial. International Journal of Otorhinolaryngology. 2003; 67: 35-41

2. Rice, M, Glasper, A, Keeton, D & Spargo, P. The effect of a preoperative education programme on perioperative anxiety in children: an observational study. Pediatric Anesthesia. 2008; 18: 426-430

3. Brewer, S, Gleditsch, SL, Syblik, D, Tietjens, ME & Vacik, HW. Pediatric Anxiety: Child Life Intervention in Day Surgery. Journal of Pediatric Surgery. 2006; 21(1): 13-22

4. Li, HCW, Lopez, V & Lee, TL. Effects of Preoperative Therapeutic Play on Outcomes of School-Age Children Undergoing Surgery. Research in Nursing & Health. 2007; 30: 320-321

5. Spencer, C & Franck, LS. Giving parents written information about children's anaesthesia: Are setting and timing important?. Pediatric Anesthesia. 2005; 15: 547 – 553

6. Wisselo, TL, Stuart, C & Muris, P. Providing parents with information before anaesthesia: what do they really want to know? Pediatric Anesthesia. 2004; 14: 299– 307

7. Dreger, VA & Tremback, TF. Management of Preoperative Anxiety in Children, AORN. 2006; 84(5): 801-804

8. O'Neill, C. Preparing children for hospital: what does the evidence say?. Journal of Children and Young People's Nursing. 2007; 1(5): 242 – 247

9. Department of Health and Children (DoHC). Quality and Fairness – A health system for you. Dublin: Hawkins House, 2001

10. Bellew, M, Atkinson, KR & Dixon, G. The introduction of a pediatric anaesthesia leaflet: An audit of its impact on parental anxiety and satisfaction. Pediatric Anaesthesia. 2002; 12: 124-130

11. Stone, KJ & Glasper, EA. Can leaflets assist parents in preparing children for hospital? British Journal of Nursing. 1997; 6(8): 1054 – 1058

Reducing pre-hospital delay time in ACS events

An examination on whether an educational intervention is effective in reducing pre-hospital delay times for acute coronary syndrome patients

ACUTE coronary syndrome (ACS) includes unstable angina and the two categories of myocardial infarction (MI); ST elevated and non-ST elevated MI.[1] These conditions are associated with reduced coronary perfusion, thereby indicating the importance of early diagnosis and risk stratification to guide management and improve short and long-term outcomes.[2,3,4]

While time is of less importance for those with unstable angina and non-ST elevated MI (NSTEMI) than those with ST-segment elevation MI (STEMI), coronary ischaemic time should be kept to a minimum in all cases.[5,6] In the presence of ACS, patient delay contributes most significantly to delayed admission to the emergency department (ED).[7,8]

In light of this, using a randomised controlled trial, this study tested whether an individualised educational intervention would be effective in reducing patient pre-hospital delay time among patients who were re-admitted to an ED with ACS symptoms. Pre-hospital delay time refers to the time from ACS symptom onset until arrival at the ED.[9,10]

Patients were recruited to the study from the coronary care units and cardiology wards of five large tertiary hospitals in Dublin. The study was ethically approved by each hospital's ethics committee. The gatekeepers for the study were the clinical nurse managers and staff nurses in the clinical areas. They screened the patients for eligibility and gave their names to the research nurse who met the patients and informed them about the study before seeking informed consent. Enrolment to the study was generally within two to four days of hospital admission.

Patients were randomly assigned to the control or intervention groups. This was determined by their study numbers, which were generated using a computerised system. Using the ACS response index,[11] baseline data were collected. Those assigned to the intervention group received a 30-40 minute educational intervention that focused on reducing patient pre-hospital delay time.

Unlike previous research studies, all patients recruited to this study were admitted via an ED with an ACS diagnosis. Pre-hospital delay time was measured on admission (baseline), and again for all patients on their first subsequent readmission with ACS symptoms, within two years of recruitment to the study.

The control and intervention groups received usual in-hospital care from their healthcare provider. It is worth noting that usual care did not appear to be standardised within or between the research sites. Pre-discharge patient education broadly comprised information about medications, modifiable risk factors and advice about lifestyle adjustments. None of the sites delivered extensive information that focused on pre-hospital delay or the factors that influence it.

The intervention content

The aim of the intervention was to reduce patient pre-hospital delay time. Most of the emphasis was on patient-decision delay, which accounts for up to 75% of pre-hospital delay time.[12]

The session was prefaced with a reminder about the purpose and aim of the study. The educational intervention was underpinned by Leventhal's self-regulatory model of illness behaviour (see *Figure 1*).[13,14]

This model advocates that the onset of symptoms triggers an individual to make behaviour adaptations. These adaptations occur in three stages that are processed cognitively (problem-solving) and emotionally and are influenced by internal and environmental stimuli. Internal stimuli include sociodemographic factors, such as age, while environmental stimuli include messages from family or friends.

The intervention addressed informational, emotional and social factors as these are the variables that are known to influence pre-hospital delay time. These three factors mirror Leventhal's cognitive, emotional and environmental components of the self-regulatory model of illness behaviour.

Information or cognitive stage

Using the intervention manual that was devised for the study, the education began with a simplified explanation about atherosclerosis and the mechanism by which a heart attack occurs.

The concept of the golden hour was then explained to patients. The golden hour refers to one hour of golden opportunity to receive optimum care that could save a life or prevent worsening disability when a heart attack occurs.

The benefits of prompt hospitalisation in the presence of heart attack symptoms were outlined. This included reference to the importance of early reperfusion to restore blood flow to the myocardium and the other therapeutic options that are available for the treatment of a heart

attack. Patients were also informed that many people miss out on the best possible outcomes because they delay too long before seeking care.

The next informational message was centred on symptoms. The range and variability of symptoms were discussed. Typical ACS symptoms such as chest pain, tightness and discomfort were highlighted together with left arm discomfort, indigestion and breathlessness. Less typical symptoms were also emphasised and these include gum, neck and jaw discomfort, intrascapular discomfort and nausea. Patients were informed that symptom onset could be sudden or gradual and that they could be continuous or intermittent.

They were made aware that the 'Hollywood heart attack' was only one of a range of manifestations of a heart attack or ACS symptoms. It was made clear that ACS symptoms are not individualised and that symptoms that are experienced on one occasion may differ on a subsequent occasion.

They were informed about the potential for symptom variation among different groups, such as older people and those with diabetes. However, this aspect of the informational message was tailored to each patient and their circumstances.

Patients were then reminded that their current ACS diagnosis rendered them more susceptible to a future ACS event than those without a history of ACS. They were instructed that the appropriate behaviour to take in the event of symptom occurrence was to stop and rest in the presence of symptoms, and if nitrates were prescribed, to use them. They should also inform another person about the symptoms and if they persisted beyond 15 minutes, they were asked to call 999 or 112 for an ambulance without summoning the advice of a GP.

Emotional issues

In addressing emotional issues, advice was given about the role of emotions when ACS symptoms are present. It was acknowledged that emotional responses could interfere with symptom identification, acknowledgement and coping.

The potential for emotions such as fear, denial, anxiety and embarrassment to interfere with treatment-seeking behaviour was discussed.

Patients were advised that people often fear the consequences of acknowledging their symptoms. Consequently, they may deny the seriousness of symptoms or engage in symptom misattribution, which can delay the time in seeking treatment.

The reasons for delay were discussed objectively. The objective discussion avoided blame-focused messages or implications of wrong-doing by the patient. Much of this discussion took place in the first person plural. One example of this was with respect to the role of anxiety in patient pre-hospital delay. The words used to explain this were as follows: 'anxiety can cause us to think less clearly and make excuses about what is happening…' and 'fear causes many people to delay seeking care'. These words indicate that delay-related responses were not isolated to the patient, but could be applied generally to individuals with ACS symptoms.

Scenarios and role play were used to re-enact a recurrence of an ACS event. This was to increase the likelihood of appropriate future reactions, to challenge emotional responses to symptoms and to reinforce the intervention message. Patients were encouraged to treat unresolved ACS symptoms as an emergency. This was important, as behaviour in threatened-health is dependent on how the individual views that threat.[13]

Previous ED admission experiences were discussed, as negative experiences could impact on the person's willingness to return to the ED in future. Unpleasant past experiences were acknowledged, but these were reconciled with the intervention message that the beneficial rewards of seeking treatment promptly would outweigh everything else.

Positive messages were disseminated, such as early attendance at the ED would enhance preservation of heart muscle and increase the chance of survival. This was considered important, as positive messages

Figure 1: Leventhal's self-regulatory model of illness behaviour

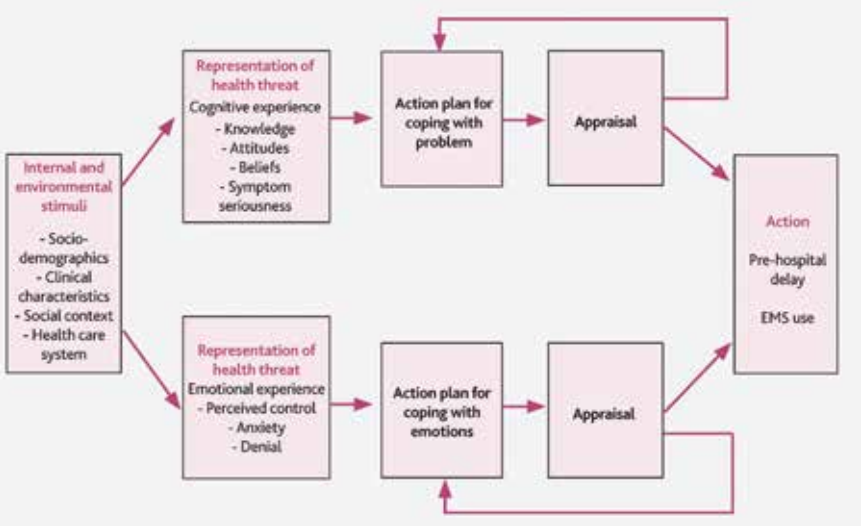
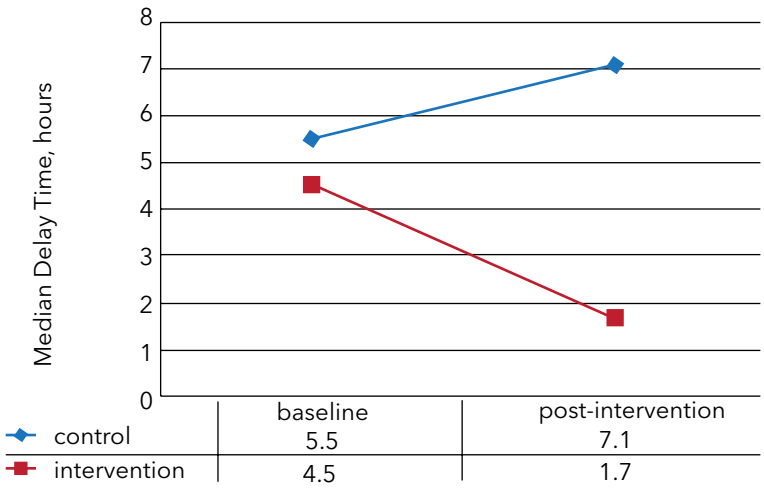


Figure 2: Effect of the intervention



are considered potentially more effective.[15]

While addressing emotional stimuli, the patient was asked to consider what they would do if they thought they were having a heart attack. A range of reactions were suggested, including adopting the stance that the symptoms were not heart related or not serious.

Further suggestions included emotional issues, such as concern about troubling others and embarrassment about seeking help for something that may transpire to be clinically insignificant. It was anticipated that normal reactions would be identified so that these could be acknowledged, addressed and set aside with a view to addressing self-care needs.

In the final ten minutes of the intervention, and to further address the role of emotional responses to a health threat, patients were given pre-prepared scenarios to consider. The scenarios that were most reflective of the patient's cardiac event experience were chosen from the range of scenarios available. Based on these, and using role play, patients were asked to anticipate some or preferably all of the emotions they might experience in the presence of ACS symptoms.

It was considered that the rehearsal of responses using role play would improve patients' levels of perceived control on a subsequent occasion. It has been suggested that anxiety levels reduce if a person is confident in their ability to act appropriately.[16] Furthermore, even when experiencing emotional reactions to symptoms, the use of guidance on the appropriate actions to take increases the likelihood of appropriate responses to a future health threat.[17]

Social and environmental stimuli

As part of the intervention, patients were informed that family and friends can delay them seeking care, as they may wish to deny the possibility of symptoms. The importance of avoiding consultation with a GP was discussed in the context of social stimuli. The misunderstanding by individuals that it is correct to summon the advice of a GP in the presence of ACS was clarified.

Patients then completed an action plan, which they were given to take home as a reminder of what to do if symptoms arose. This action plan included the name and phone number of the person they would call if symptoms occurred and the emergency numbers to call in the face of unresolved symptoms. A pre-printed wallet card with a summary of what to do in the presence of ACS symptoms was also given. The intervention was reinforced by telephone one month after the intervention was delivered and six months later, by post. Motivational interviewing techniques were used to promote the uptake of the intervention and to help patients reconcile elements of the intervention that they found challenging.

At the end of the education session, the information was summarised together with the correct course of action to be taken in the event of symptom recurrence. This included the following message: In the event of symptoms you should:

- Stop and rest
- If nitrates are prescribed, take these as directed
- Inform somebody about what is happening
- If symptoms persist for more than 15 minutes then call directly for an ambulance.

The research nurses used pre-printed flip charts and prescriptive scripts as educational aids. The educational intervention was individualised to the patient's specific needs and illness experiences and sought to address the range of potential cognitive, social and emotional effects that the person with ACS symptoms may have experienced.

The effect of intervention

The intervention was effective in reducing pre-hospital delay time among the intervention group. Among this group, the median pre-hospital delay time was reduced from 4.5 hours (at baseline) to 1.7 hours [25th percentile 1.1, 75th percentile 2.9] *(see Figure 2)*.

The post-intervention median pre-hospital delay time for the control group increased from 5.5 hours (at baseline) to 7.1 hours [25th percentile 2.7, 75th percentile 16.7]. These post-intervention readmission pre-hospital delay times represent an increase of 1.6 hours in the control group and a reduction of 2.8 hours in the intervention group, with a difference of 5.4 hours between the groups. The intervention was therefore very effective in reducing pre-hospital delay time.

From a European perspective, this was the first RCT to target a reduction in patient pre-hospital delay time. Furthermore, it was the first RCT in the world to be effective in this regard. Therefore, this study represents a major contribution to the body of existing knowledge about pre-hospital delay time. It could also pave the way for changes to nursing practice with respect to the content and delivery of usual pre-discharge education for patients with ACS.

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References

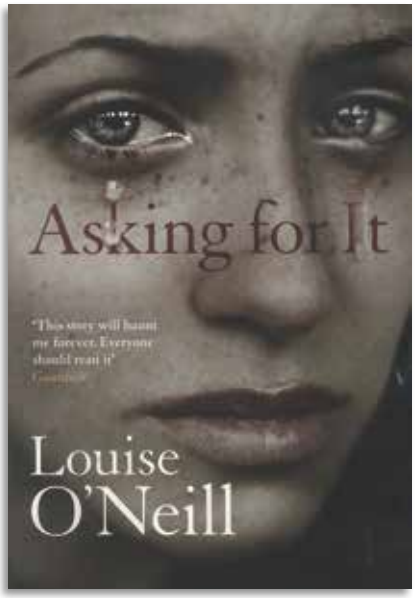
1. Anderson JL, Adams CD, Antman EM et al. ACC/AHA 2007 Guidelines for the Management of Patients With Unstable Angina/Non–ST-Elevation Myocardial Infarction. A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Writing Committee to revise the 2002 Guidelines for the Management of Patients With Unstable Angina/Non–ST-Elevation Myocardial Infarction). Developed in collaboration with the American College of Emergency Physicians, the Society for Cardiovascular Angiography and Interventions, and the Society of Thoracic Surgeons. Endorsed by the American Association of Cardiovascular and Pulmonary Rehabilitation and the Society for Academic Emergency Medicine. J Am Coll Cardiol. 2007; 50(7): 1-157
2. Fox K, Dabbous O, Goldberg RJ et al. Prediction of risk of death and myocardial infarction in the six months after presentation with acute coronary syndrome: prospective multinational observational study (GRACE). Br Med J. 2006; 333: 1091-1106
3. Granger C, Goldberg RJ, Dabbous O et al. Predictors of hospital mortality in the global registry of acute coronary events. Arch Intern Med. 2003; 163: 2345-2353
4. Karras C, Donlan S, Aitchison R, Aitchison P, Wang E, Kharasch M. Acute coronary syndromes. Disease a Month. 2013; 59: 202-209
5. Hamm CW, Bassand JP, Agewall S et al. ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation. Eur Heart J. 2011; 32(23): 2999-3054
6. Bassand JP, Hamm CW, Ardissino D et al. Guidelines for the diagnosis and treatment of non-ST-segment elevation acute coronary syndromes: The Task Force for the Diagnosis and Treatment of Non-ST-Segment Elevation Acute Coronary Syndromes of the European Society of Cardiology. Eur Heart J. 2007; 28(13): 1598-1660
7. Tubaro M, Danchin N, Goldstein P et al. Pre-hospital treatment of STEMI patients. A scientific statement of the Working Group Acute Cardiac Care of the European Society of Cardiology: Acute Coronary Syndromes. Acute Card Care. 2011; 13(2): 56-67
8. Garofalo D, Grey C, Lee M, Exeter D, Kerr AJ. Pre-hospital delay in acute coronary syndromes: PREDICT CVD-18. N Z Med J. 2012; 125: 12-22
9. Dracup K, McKinley S, Riegel B et al. A nursing intervention to reduce pre-hospital delay in acute coronary syndrome: a randomised clinical trial. The Journal of Cardiovascular Nursing. 2006; 21(3): 186-193
10. McKee G, Mooney M, O' Donnell S et al. Multivariate analysis of predictors of pre-hospital delay in acute coronary syndrome. Int J Cardiol. 2013
11. Riegel B, McKinley S, Moser DK et al. Psychometric evaluation of the Acute Coronary Syndrome (ACS) response index. Res Nurs Health. 2007; 30(6): 584-594
12. Rasmussen CH, Munck AM, Kragstrup JK, Haghfelt TH. Patient delay from onset of chest pain suggesting acute coronary syndrome to hospital admission. Scand Cardiovasc J. 2003; 37(4): 183-186
13. Leventhal H, Cameron L. Behavioral theories and the problem of compliance. Patient Educ Couns. 1987; 10: 117-138
14. Leventhal H, Safer M, Panagis D. The impact of communications on the self-regulation of health beliefs, decisions and behaviour. Health Educ Q. 1983; 10(1): 3-29
15. Dracup K, McKinley SM, Moser DK. Australian patients' delay in response to heart attack symptoms. Med J Aust. 1997; 166(5): 233-236
16. Moser DK, Riegel B, McKinley S et al. Impact of anxiety and perceived control on in-hospital complications after acute myocardial infarction. Psychosom Med. 2007; 69(1): 10-16
17. Leventhal H, Breland JY, Mora PA, Leventhal EA. Lay representations of illness and treatment: a framework for action. Handbook of Behavioral Medicine: Springer; 2010; 137-54.

We need to talk about consent

"WE NEED to talk about rape. We need to talk about consent. We need to talk about victim-blaming and slut-shaming and the double standards we place upon our young men and women."

So said Louise O'Neill in the afterword to her powerful novel *Asking for It* and, in writing this brave and brutal novel, she has succeeded in getting this conversation going. Alongside high profile rape cases, Louise O'Neill's book, her recent documentary of the same name in the RTE2 *Reality Bites* series, and her many media appearances and articles, have moved the issues of consent, sexual violence and rape culture way up the agenda.

Asking for It is about an 18-year-old girl from rural Ireland who goes to a party and is gang raped by members of the local football team. But it is about much more than this. It is about society's attitude to her after the event, when naked photos of her taken by her rapists are shared on social media. It is about how the town reacted to what was obviously non-consensual sex and sexual violence by shaming and questioning the victim, and supporting the perpetrators. Did she drink too much? Was she wearing provocative clothing? Was she asking for it?



It is not a straight-forward book. Emma, the girl at the centre of it, is far from a nice character. She is shallow, selfish and bitchy. The rape itself is not described in detail as Emma has no memory of it. It is touched on in flashes, hazily pieced together by photos and cruel comments on social media.

This book is about double standards applied to males and females, where if girls have too much sex they are considered sluts but boys who do the same thing are considered 'players', said Louise O'Neill. However, she stresses this is not a women's issue – that men must be part of the solution. We need to protect men as well as women so that there can be no grey areas. We need to talk about our attitudes to sex and sexuality. A couple should be able to talk openly about consent without hangups or shame.

"We need to teach our boys not to rape just as much as we teach our girls not to walk home alone at night. We need to teach our teenagers that sex without consent is a crime," said Louise O'Neill in the documentary.

Asking for It was named Specsavers Children's Book of the Year in 2014 and 'Book of the Year' at the BGE Irish Book Awards in December 2015. Calling it children's/young adult fiction is a misnomer. While it should be required reading for older teenagers, equally it is a book that everyone needs to read, especially those in contact with young adults.

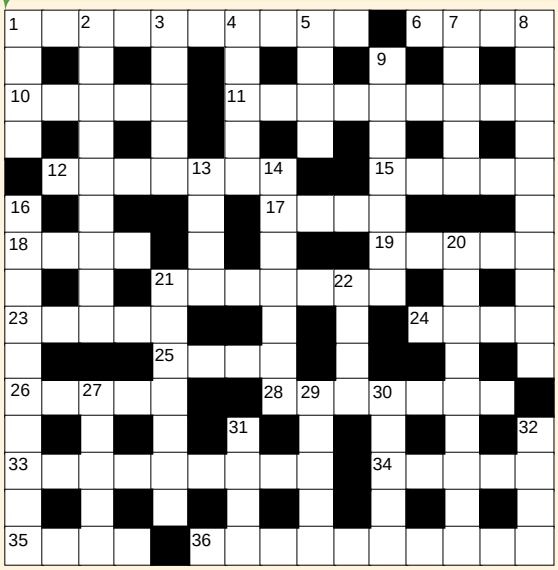
You will not feel comfortable after you have read this book – but that is the point.

– Tara Horan

Asking for It by Louise O'Neill is published by Quercus, 2015. ISBN: 9781784293208.
Asking for it?: Reality Bites. RTE2 (Nov 1)

Crossword Competition

WIN A €30 BOOK TOKEN



Across

1. There are even more stars here than in Hollywood! (5,5)
6. Support or assist someone in wrongdoing (4)
10. Great enthusiasm (5)
11. By the grace of God, aid triage by arrangement! (3,6)
12. Variety stage show (7)
15. Countryside walker (5)
17. African warrior group from some slim pickings! (4)
18. The first murderer in the Bible (4)
19. It describes a disease found by six (right before a novice) (5)
21. Inhale and exhale (7)
23. Uptight (5) 24. Doing nothing (4)
25. Greek drink comprising some braking fluid! (4) 26. Allege (5)
28. Musical piece about a cholera outbreak (7)
33 & 32d. There will be much excitement here when 34 across visits! (9,4)
34. Bearded Christmas visitor (5)
35. Dip a biscuit into a drink (4)
36. 'Slept' for the winter (10)

Down

1. Lady - perhaps Russian - breaks out of gaol (4)
2. A native of Australia's island state (9)
3. Type of Spanish wine (5)
4. Term of address to a chaplain (5)
5. A model of Our Lord's birthplace (4)
7. Craft involved in presenting chopped bait to the king (5)
8. You can really tote around cuppas on this! (3,7)
9. Repository of public records (7)
13. Bellow (4)
14. It sank tragically in 1912 (7)
16. What gives vinegar its sharpness (6,4)
20. Mars' nickname suggests it is ruled by communists! (3,6)
21. The dumb are confused in this island (7)
22. Light around a saint's head (4)
27. Extraterrestrial (5)
29. Unseemly or inconsiderate speed (5)
30. You can rinse out this sticky stuff (5)
31. Bigfoot (4) 32. See 33 across

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

The prize will go to the first all correct entry opened.
Closing date: Friday, January 20, 2016
Post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin

Solutions to November crossword:

Across:
1. Fin 3. General Post Office 8. Lumbar puncture 10. Own up 11. Swamp 13. Music 15. Everest 16. Ravioli 20. North 21. Saint 23. Bravo 24. Star sign 26. Pride and joy 27. Ewe

Down
1. Full of beans 2. Nominate 3. Grasp 4. Express 5. Laces 6. Ocular 7. Tee 12. Pleistocene 13. Mason 14. Crash 17. Organise 18. Drained 19. Diwali 22. Taste 23. Buffy 24. Sop

The winner of the November crossword is:

Fionuala McGuinn
Dunboyne
Co Meath

Expanding cardiac services in Galway

A NEW state-of-the-art interventional cardiology suite planned for Bon Secours Hospital, Galway will treat patients requiring procedures such as angiography, cardiac angioplasty and electrophysiology, including the insertion of cardiac pacemakers.

The €6 million development, of which Taoiseach Enda Kenny 'turned the sod' for at the end of November, will consist of a cardiac catheterisation laboratory using the most up-to-date Siemens technology plus a 10-bay patient recovery area to accommodate those patients being discharged home on the same day.

The development also signifies a number of new jobs for the Galway area including 20 clinical posts to staff the unit and ancillary jobs in the construction industry.

Speaking at the turning of the sod on the new development, Bon Secours Hospital Galway chief executive, Gerry Burke stated: "This new development will significantly expand the range of services for patients choosing to attend Bon Secours Hospital in Galway. The development marks our entry into interventional cardiology. It meets an urgent need for patients in our catchment area as there is currently a shortage of capacity for such facilities. Consultants in other specialties and their patients will also benefit greatly from the increased availability of consultant cardiologists in the hospital and we are excited by the prospects offered by the new development."

Pictured (l-r) at the turning of the sod on the new cardiology suite for Bon Secours Hospital in Galway were: *Gerry Burke, CEO, Bon Secours Hospital, Galway; Bill Maher, CEO, Bon Secours Health System; Denis O'Sullivan, group head of projects, Bon Secours Health System; An Taoiseach, Enda Kenny; and Peter Lacy, chairman, Bon Secours Health System*

Bill Maher, CEO of Bon Secours Health System, welcomed the new cath lab for Galway: "This new development, complemented by the most up-to-date medical technology, will significantly expand cardiac care offered at Bon Secours Hospital Galway."

Construction on the cardiology suite is already well advanced and it is expected that the first patients will be treated in March 2017.

Premature births: Blueprint for a family-centred approach to care

BETTER Together: A Family-Centred Care Guide for Your Premature Baby was recently launched in conjunction with World Prematurity Day and is aimed at guiding families on how they can parent their infant in a positive way, despite the clinical surroundings of their environment. It also highlights how their involvement must be seen as a necessary component of care delivery in the NICU.

The guide, which was launched in November by Minister for Health Simon Harris, was created by the Irish Neonatal Health Alliance (INHA) and it outlines 10 family-centred care giving activities that families can participate in when they have an infant in the NICU.

Family-centred and developmentally centred care is playing an increasingly larger role in Irish NICUs each year. The concept acknowledges the family as central to the care of the child, and, in conjunction with developmentally supportive caregiving strategies, has a greater potential for long-lasting effects when the family is an integral aspect of implementation in the neonatal setting.

It is hoped that the guide can act as a blueprint for NICUs who are implementing a family-centred approach to care.

For more information on family centred-care, and to download the 'Better Together Guide, visit **www.INHA.ie**.

Steering parents through childbirth: A practical handbook

BUMP to Birth to Baby, a new eBook which combines two previous eBooks (*From Bump to Birth* and *After Birth*), is a handbook of practical advice to steer parents through the months of pregnancy, the hours of labour and childbirth, and the first few weeks of life and is available to download now from Amazon at €2.99.

Bump to Birth to Baby is a guide for all expectant mothers (and fathers) packed with need-to-know information and straight-talking advice that has been tried and tested. Parents can find tips on alleviating pregnancy symptoms, keeping healthy, preparing for birth, and caring for mother and newborn. They can also read advice from midwives and mums on coping with labour, infant care and feeding, postnatal health, and common concerns.

To download a copy of the book go to: **www.amazon.co.uk/dp/B01M2YTEBB**

Risk of depression during pregnancy

A NEW survey launched in November by Trinity College Dublin's research team and the Irish Obstetric Services has shown that 16% of pregnant women attending maternity services across Ireland are at probable risk of depression during their pregnancy.

Ireland has the second highest birth rate in Europe, with an average of just under 68,000 births a year. This means that in one year more than 11,000 women could be experiencing, or are at risk of, depression in pregnancy. The 'Well Before Birth' study shows that prevalence rates of depression among women giving birth in Ireland are high, and may be higher than those recorded in other OECD countries.

Veronica O'Keane, professor in psychiatry at TCD and the lead research investigator, said that women in Ireland should be screened for depression early in their antenatal care plan and should be encouraged to seek help.

Emerging and increasing scientific evidence has shown that women who have depression during pregnancy have an increased risk of pre-eclampsia, Caesarean section and epidural during labour, pre-term delivery and low birth weight. For the baby, it may lead to neurodevelopmental and behavioural disadvantage during infancy and an increased risk of mental health problems in childhood and later life, Prof O'Keane explained.

The Irish study also shows that rates of depression increase with advancing pregnancy. Women in Irish maternity services show rates of 13.8% in the second trimester and 17.2% in the third trimester. This compares with rates of 12% and 14% respectively in a landmark UK study (Avon Longitudinal Study of Parents and Children). The study also shows that rates of depression are higher among women from lower socio-economic groups and with lower educational attainment. Rates of depression are also higher for younger pregnant women.

This survey is part of a longer-term research study being undertaken by the REDEEM research group at TCD, investigating the effects of depression on pregnant women, the foetus and the infant.

At the Mercer's Hospital 1950s-1980s reunion, which took place on June 21 in the Shelbourne Hotel, Dublin were (l-r): *Eleanor Power-Doyle, committee member; and Annette Halton-Doyle, chairperson. With thanks to Annette Halton-Doyle, Margaret Lowery-Hynes, Maire Mulcahy, Anna Patterson-Dody and Eleanor Power-Doyle who organised the successful event. Nurses travelled from all over Ireland to attend this reunion*

Pictured at a celebration mass for the 15 graduates of the BSc nursing programme in Bon Secours, Cork, which is run in conjunction with University College Cork, were (l-r): *Ber Mulcahy, director of nursing,Bon Secours Health System, and Michelle Kelleher, staff nurse from Dublin Pike, Cork. Ms Kelleher was awarded the Potel Award for Excellence in Clinical Learning nurses*

MONEY MATTERS

Keep your car and home winter safe

Ivan Ahern offers tips to keep your car and home safe this winter and save some money on the way

REALISTICALLY, your house is your biggest and most valuable asset. While home insurance is not legally required, we strongly recommend making sure you take out a home insurance policy. Be careful when you're estimating the value of your house. Your home insurance premium needs to cover three main aspects:

Home insurance

Whether it is time to take out a new policy or to renew your existing one, here are three quick ways that might save you money on your home insurance premium.

The building/structure

Your home insurance premium needs to cover the structure of your home itself including permanent fixtures and fittings, outbuildings, garages, fences, conservatories, etc.

Household contents

Contents insurance can be a tricky thing; you may be tempted to insure everything in your home, but you are better served to go from room to room and catalogue everything you would take with you if you were to move house. These are the contents that are most valuable to you and so should be covered in your home insurance policy. Generally, contents cover also insures any items in your shed/garage.

Extra cover

If you have a high-value item like your engagement ring that you want to insure, you'll need optional risk cover or item cover. When your house (the structure) is being valued for home insurance, the sum is based on the current rebuild cost. Your house may be worth more or less than when you first built or bought it.

Whether you're looking into getting your home insurance policy renewed or you want to change policy, make sure you have valued your contents correctly. Don't overvalue! Also, make sure you've got an accurate rebuild cost. Overestimating the value of your house or not getting a proper rebuild value could see you paying more into your home insurance premium than you need to.

Ensure your home is as safe as possible

The best way to keep your home insurance premium costs down is by making your home as safe as possible and safeguarding against having to make any claims: install a security system; always lock doors and windows when you leave the house; buy a fire extinguisher and install smoke alarms.

Getting your wiring checked every five years or so by an electrical contractor will ensure that your house is safer too, as faulty wiring can be the cause of many accidental house fires.

It's a good rule of thumb to contact your home insurance provider whenever you make any changes to your house. I'm not talking about letting them know if you're adding a new lick of paint, but if you call in contractors to improve security and safety measures in your home, you should give your home insurance provider a call.

Tips for car safety

Taking 20 minutes each week to look over your car can help to avoid major car trouble in the long-term, but can also help you save money and keep you safe. It doesn't have to cost you a great amount of time or money, but these regular checks will ensure that your car is geared up for the week ahead and any planned or unplanned longer drives you might have to take:

- Check all lights
- Check the oil in the engine, brake fluid, windscreen wash and the level of antifreeze
- Check the grip on your tyres and look out for uneven wear – a sign of suspension problems or wheels out of alignment
- Take the time to plan your journey before you set off and give yourself some extra time to allow for any unforeseen delays that you may encounter. This will reduce your risk of speeding and keep you and your passengers safe
- When planning a long journey, factor in time to stop off for some light refreshments and a stretch break
- Shop around for fuel. The price difference between petrol station fuel prices can be significant. Websites such as **www.pumps.ie** provide great price comparisons nationwide
- How you drive can impact your fuel consumption – the harder you brake and accelerate, the more fuel your car consumes
- Avoid rush hour traffic to reduce fuel use
- Travel light – remove heavy items such as golf clubs, roof racks and bike racks, which can weigh down your car and increase fuel consumption.

Top tip when shopping for Insurance

When shopping around it's important to compare like with like, especially when it comes to benefits. It's important to read thoroughly through the small print and to know exactly what you're getting and at what price.

Ivan Ahern is a director of Cornmarket Group Financial Services.

January

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

Wednesday 18
Telephone Triage Section AGM. 11am. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 21
ODN Section meeting and AGM. Cavan General Hospital. 11.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 21
School Nurses Section meeting and AGM. INMO HQ. 10.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Wednesday 25
RNID Section meeting and AGM. INMO HQ. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Thursday 26
Retired Nurses and Midwives Section meeting and AGM. INMO HQ. 10.30am. Talk on sports injuries. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 28
CNM/CMM Section meeting and AGM. INMO HQ. From 10am to 2pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 28
Third Level Student Health Nurses Section meeting. INMO HQ. From 10am to 3pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

February

Friday 3
Nurse/Midwife Education Section AGM and meeting. INMO HQ. 11.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 4
Midwives Section AGM and meeting. Cork University Maternity Hospital. 2pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

March

Wednesday 8
Care of the Older Person Section conference. Limerick Strand Hotel. 11.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Friday 24 and Saturday 25
ODN Section conference and meeting. Crowne Plaza Hotel, Santry, Dublin 9. Log onto www.inmoprofessional.ie or contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Study day

- The Irish Stoma Care and Colorectal Nurses Association study day will take place on Friday, March 24, 2017 at the Mater Misericordiae University Hospital, Dublin. The title of the study day will be 'colorectal innovations: a fusion of clinical excellence. The study day programme will be issued in the coming months. For further information email@stomacare@mater.ie

INMO Membership Fees 2016

A Registered nurse *(Including temporary nurses in prolonged employment)*	€299
B Short-time/Relief *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 *Working (employed in universities & IT institutes)*	€116
E Associate members *Not working*	€75
F Retired associate members	€25
G Student nurse members	No Fee

Condolence

- The INMO extends its sincere condolences to the family of Pauline Carberry, who passed away on October 5, 2016. Pauline was an active INMO member and was also active with the Third Level Student Health Section. RIP

Reunion

- St James's Hospital Dublin invites all nurses and midwives who trained and worked in St James's Hospital Dublin to attend a 50-year anniversary reunion on Friday, March 24, 2017. If you would like further information or wish to attend email: 50year@stjames.ie