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# WIN



Journal of the  
Irish Nurses and  
Midwives Organisation

Latest INMO  
CPD education  
programme  
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# Hope and courage in 2018



I WANT to share with you two words I associate with the new year, 'hope' and 'courage' – or 'dóchas' agus 'misneach' in Irish – and the reasons I have chosen them. I think these two words resonate well with nurses and midwives, as hope and courage feature in our interactions with patients: from imparting treatment plans, advising on care, encouragement to courageously continue with often difficult treatments, and the ability to see, with hope, the end of illness and recovery.

When it comes to the working conditions of nurses and midwives however, hope of improvement is in short supply. The dawn of 2018 was a mirror image of January's past, with overcrowded hospitals, long waiting lists, a shortage of nurses and midwives, and patients being cared for in inappropriate circumstances. Listening to various commentators over the past number of weeks, each with their own version of the cause of the problems and a variety of solutions, you would be tempted to shout STOP! We are tired of analysis, we know the causes: poor planning; re-configuration and moratoriums on employment; increases in administrative posts; and reduced frontline posts coupled with reduced bed capacity. Can we focus on the solutions now?

Undoubtedly, the capacity of our acute hospitals will have to be increased significantly and out-of-hospital care must be developed in a planned, interlinked manner. I am concerned that we will be in the same place next January, unless by some miracle the *Sláintecare* report recommendations for reform are prioritised for implementation in 2018. However, the HSE service plan announced in December 2017 does not provide for this. It appears that the HSE will wait for the Department of Health to provide the plan and the funding and will cry 'funding does not allow' any time reform is mentioned.

Increasing capacity will require a major increase in the employment of nurses and midwives. Current employment figures remain stubbornly below 2007 levels when hospital activity was lower. To get to the baseline this year, agreement had been reached with the HSE to grow the nursing

and midwifery workforce by 1,224. This has, despite many plans and recruitment initiatives, proven impossible, as the recruitment rate is outflanked by the numbers leaving. The total number of starters in 2016 was 2,872 across all nursing grades, with 2,861 leaving, a difference of 11. It is abundantly clear that we have a recruitment and a retention problem. Now in 2018 we know, there is only one untried solution to turn this tide – the pay of nurses and midwives, which falls well behind colleagues requiring the same entry qualification in the public service, must be improved.

So, *misneach*, where will it surface? The Public Service Pay Commission (PSPC) has the evidence: it is tasked with examining the submissions and presentations made to it and reporting to government by May/June. I hope all parties, the HSE, the Department of Health and the Commission members, will have had the courage to confirm that the issue of recruitment and retention in nursing and midwifery will not be corrected without pay improvements. When the government receives the report from the PSPC, I hope it has the courage to break the cycle of low pay and use the protections within the Public Service Stability Agreement, which confirms that the output from the PSPC will not give rise to any cross-sectoral relativity claims, to set fair and equal pay for the female-dominated professions of nursing and midwifery.

If not, I know INMO members have the courage to pursue the correction of this cycle of low pay and I know the Executive Council and INMO team has the courage to lead. I sincerely hope the process under the Public Service Stability Agreement, fully engaged in by the INMO and its members, delivers, so that all energies can then be focused on implementation, which would be a courageous and hopeful start to the next chapter for nursing and midwifery pay in 2018.

**Phil Ní Sheaghda**  
General Secretary, INMO

# Your priorities with the president

Martina Harkin-Kelly, INMO president



## New year, old problem

IN MY first column of 2018 – which sees the centenary of women getting the vote – I open by welcoming Phil Ní Sheaghda, our new general secretary, to the helm. Her first week was a baptism of fire, with a peak of 677 patients on trolleys on January 3. The figures did drop later that week and the media was awash with the measures that were being taken to ameliorate the situation. Yet, despite this, the HSE's main concern was figures, reporting that there were 426 on that same day – as if this made it any better. This was done with an air of dismissal, echoing the school yard bully. I would remind the HSE that in 2006 the then Minister for Health, Mary Harney, declared a national crisis when the figure crept above 400. Not once during 2017 was the Winter Initiative Target of 236 ever achieved. Therefore the figure of 426 was nothing to shout about, in fact, it was a pathetic attempt to deflect. I agree with Róisín Shortall TD when she described the 677 figure as "disgraceful, predictable and avoidable". These are not temporary blips, this is a daily occurrence in many of our EDs where at best we move trolleys around to get to other patients on trolleys, like pieces of a Jigsaw, to try to provide care for those who are ill in our so-called first world country.

There was a level of despair in many of the messages I received from members, with emotions ranging from upset to extreme anger to relief at having survived. As one member said to me "it was a luxury to get to the toilet today and I didn't want to leave the safety of that cubicle to go back out to the war zone". I met with Phil in early January and it is our intention to keep the heat on the HSE and not to allow them any room to manoeuvre. We will make a formidable team and will use all measures at our disposal to strive to put right a decade of wrong doing committed against our members.

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THE INMO's submission to the Public Service Pay Commission (PSPC) was comprehensive, citing international evidence that inferior pay scales are a major factor affecting recruitment and retention of nurses/midwives in the Irish health service. Our pay scales are 15-20% lower than allied health professionals who require identical entry qualifications and have a shorter working week. This contrasts with international findings where pay is on par. The submission also emphasised the negative affect of nursing/midwifery shortages on patients. The PSPC was left in no doubt that expansion or implementation of initiatives will require substantial additional recruitment and retention of the nursing and midwifery population as an enabler. In addition, the INMO has sought an opportunity to make oral submissions and presentations to the Commission so that we can provide expert testimony to support the evidence presented in the written submission.

## INMO Centenary Planning Committee

THE Centenary Planning Committee continues to meet to ensure a fitting tribute in 2019 to mark the 100th anniversary of the founding of this Organisation. As it is the members who make the INMO, it is only right that ordinary members are involved at planning level and we are delighted to announce that Mary Dunne, Gobnait Magner, Jennifer Foyne and Edel Peoples are on board. Numerous initial plans are already underway to ensure that prominent dignitaries are invited. National broadcasters have also received correspondence inviting their involvement. Last September I developed a centenary celebration proposal plan which ensures that the celebrations will span the year and have a wide national involvement from all branches and sections. All branches and sections should ensure that the centenary plan is on the agenda of all AGMs so that members can forward ideas. Prudent management of this celebration is important and that is why there will be a questionnaire and a debate on the matter at this year's ADC.

## Quote of the month

*"We must be unanimous, there must be no pulling different ways, we must all stick together"*  
- John Hancock

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THE Executive Council oversaw the recent launch of Paediatric Trolley Watch, an additional element to our existing trolley and ward count. This will see the INMO publish trolley figures for Ireland's children's hospitals. The hospitals are: Our Lady's Children's Hospital, Crumlin; The National Children's Hospital, Tallaght; and Children's University Hospital, Temple Street. If children are on trolleys in any of our regional hospitals with paediatric units these numbers will be recorded as an addition to the adult figure. We had hoped this would never happen, but it is a further symptom of the deteriorated state of our health service. The need for this service was brought to Executive Council's attention in mid 2017 by the National Children's Nurses Section of the INMO, which was concerned that children were enduring long waits in EDs between admission and securing a bed. At the launch Catherine Sheridan, a member of the Executive Council and National Children's Nurses Section, addressed the press. She outlined recent demographic changes and the resultant pressures that this poses to the system and the negative outcomes patients are exposed to. She said that possible remedies were linked to recruitment and retention, pay and system capacity.

Normal business resumed following the press conference with the subcommittees concluding their business. The full executive meeting saw discussion on the Richmond Events Centre, which is in the final phase of completion, the theme for this year's ADC, along with programme planning. Many of the issues/developments are expanded in this journal. The Executive is also looking forward to seeing many of you at the forthcoming branch and section AGMs. Please see [inmo.ie](http://inmo.ie) for notification of same.

## Get in touch

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Irish Nurses and Midwives Organisation

Cumann Altraí agus Ban Cabhrach na hÉireann

Working Together

# EXECUTIVE COUNCIL ELECTION 2018

All members are asked to note that 2018 is an election year for election, to the Executive Council, for a two year period (2018-2020). Elections will be conducted under the revised new Rule Book (Rule 8) adopted at the ADC in May 2016.

## ELIGIBILITY FOR NOMINATION TO EXECUTIVE COUNCIL (RULE 8)

Nominations for the Executive Council shall be submitted, on the appropriate form, to the General Secretary, on, or before, 5.00 pm on Wednesday, 7th February 2018. To be eligible for membership of the Executive Council a member must:

- i) have been a paid-up member of the Organisation, for not less than two years prior to the date of her/his nomination, and be on the Live Register of the Nursing and Midwifery Board of Ireland (NMBI); and
- ii) be proposed and seconded by Officers of their Branch or Section following endorsement of the candidate by that Branch or Section.

To be eligible for election as an undergraduate student nurse/midwife member of the Executive Council an undergraduate student must:

- i) have been a member of the Organisation for not less than six months prior to the date of her/his nomination; and
- ii) be proposed and seconded by undergraduate student nurses/midwives who have themselves been members of the Organisation for not less than six months or be proposed and seconded by Officers from their Branch.

## COMPOSITION OF THE EXECUTIVE COUNCIL

### Clinical: 16 seats

Includes all grades of Registered Nurse and Midwife (other than those eligible to go forward under the Education and Management Categories below), to be filled as follows:

- i) Registered General Nurse - at least two seats  
Registered Midwife - at least one seat  
Registered Nurse Intellectual Disability - at least one seat  
Registered Sick Children's Nurse - at least one seat  
Registered Public Health Nurse - at least one seat;

Please note persons elected, to these reserved seats, must be on that register and engaged in clinical practice in that discipline.

- ii) If these reserved seats are not filled, via the 16 candidates with the most votes, then they must be filled with reference to the next highest candidate, from that discipline, who is engaged in clinical practice in that discipline.
- iii) If there are no candidates meeting any of the six reserved seats (clinical) then the seats shall be filled by the candidate with the highest vote in the clinical category.

### Education: 2 seats

- i) One seat to be filled by members from all grades of Nurse/Midwifery Teachers, Clinical Teacher, and/or others with a Nurse/Midwifery Teaching qualification who are actively engaged in nurse/midwifery education.
- ii) One seat to be filled from members who are working in the wider field of nurse/ midwife education and its management including Clinical Placement Co-Ordinators/ Clinical Placement Facilitators/Specialist Co-Ordinators and Nurse/Midwife Practice Development Co-Ordinators.

### Management: 3 seats

Includes all members at, or above, Clinical Nurse Midwife Manager 3 who are actively engaged in management.

### Undergraduate Student Nurses/Midwives: 1 reserved seat

Open to all members undertaking the four year undergraduate degree programme.

- Provided always that only those grades for whom the Organisation has negotiation rights shall be a member of the Executive Council
- In the event of any of the seats allocated to the Education and Management categories not being contested, then those seats shall be filled by the candidates, in the **Clinical Category**, who receive the next highest vote, or votes, after the initial filling of the 16 seats taking into account the six reserved clinical seats.
- In the event of any dispute, as to the category for which a member may be eligible for election, then the Executive Council shall determine the category under which a member is eligible to contest the election.

## ELIGIBILITY FOR OFFICE OF PRESIDENT AND VICE PRESIDENTS (RULE 9)

**9.1.1** The President, first Vice-President (Honorary Treasurer) and second Vice-President shall be elected at the 2018 Annual Delegate Conference at which elections are scheduled.

**9.1.2** A separate election shall be held for President, first Vice-President and second Vice-President, and such elections shall be by secret ballot of all voting delegates at the Annual Delegate Conference.

**9.1.3** The elected candidate must secure an overall majority by exceeding 50% of the eligible votes cast. If no candidate has achieved an overall majority, as aforesaid, then the candidate, or candidates, receiving the lowest vote or votes, if their combined vote is less than the total vote of the highest candidate, shall be eliminated and a further ballot shall take place immediately.

**9.1.4** If there shall be a tie, another vote shall be taken, and if the result is still a tie, the outcome shall be decided by lot (drawing the name of the successful candidate) by the chairperson of the Standing Orders Committee.

**9.2** To be eligible for election to the office of President or Vice-Presidents she/he shall have been an elected member of the incoming Executive Council and shall have been a member of the outgoing Executive Council for the term immediately preceding her/his election.

**9.3** Nominations for the office of President, first and second Vice Presidents, together with their written consent must be submitted in writing to the General Secretary not later than 21 clear days before the Annual Delegate Conference for notification to delegates to that meeting at which the election will take place. (Closing date for nominations is 5.00 p.m. on Friday, 6th April 2018).

**9.4** The President shall preside at the Annual Delegate Conference and Special Delegate Conferences held during the year and at all Executive Council Meetings. In the absence of the President the first Vice-President shall take the Chair; in the absence of the first Vice-President the second Vice-President shall take the Chair.

**9.5** The office of President shall not be held by the same person for more than two consecutive terms.

# Your priorities with the president

Martina Harkin-Kelly, INMO president



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# Highest number on trolleys ever

Annual figures up 6% with a total of 98,981 inpatients on trolleys in 2017

THE INMO trolley/ward watch counted a record 2,408 patients on trolleys during the first week of 2018. This marks an increase of 221, or 10%, on the same period in 2017.

The record figure comes at a time when the Organisation's trolley/ward watch analysis for 2017 confirmed there were 98,981 admitted patients on trolleys during 2017 (see Table). This is also a record figure for any calendar year since the trolley watch began and shows a 6% increase on 2016.

In response to the record

numbers in the first week of the year, in acute hospitals where full capacity protocol had been implemented, the INMO called for the mandatory de-escalation policy to avoid overcrowding spreading throughout hospitals and to reduce the risk of cross infection, poor patient outcomes and burnout among staff.

The INMO met with the HSE which confirmed it had advised all hospital group CEOs to meet with the INMO at group level immediately on the severe overcrowding issue.

The ED Taskforce then met on January 9, 2018 to set out immediate, medium and long-term practical approaches to the current recurring problem of hospital overcrowding.

Commenting that the meeting with the HSE was productive, INMO general secretary Phil Ní Sheaghda said: "We now have a clear focus on implementing patient flow measures, agreed as part of the INMO/HSE January 2016 WRC agreement. This agreement was designed to improve hospital overcrowding and where

it has been implemented fully the results demonstrate significant improvement."

The INMO then sought immediate engagement with the HSE/Department of Health on the Nursing and Midwifery Funded Workforce Plan for 2018 (see page 10).

## Trolley/ward watch annual analysis 2017

Overall, throughout 2017, 98,981 admitted patients were recorded on trolleys:

- University Hospital Limerick recorded the highest annual number of 8,869

Table. INMO trolley and ward watch analysis (Full year analysis 2006 - 2017)

| Hospital                                | 2006          | 2007          | 2008          | 2009          | 2010          | 2011          | 2012          | 2013          | 2014          | 2015          | 2016          | 2017          |
|---|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| Beaumont Hospital                       | 4,304         | 6,164         | 8,065         | 8,748         | 8,195         | 7,410         | 6,327         | 7,062         | 6,565         | 8,243         | 6,130         | 3,609         |
| Connolly Hospital, Blanchardstown       | 2,418         | 2,709         | 2,706         | 2,667         | 3,562         | 4,207         | 3,937         | 5,852         | 5,062         | 5,165         | 2,698         | 2,499         |
| Mater Misericordiae University Hospital | 4,248         | 5,083         | 5,984         | 4,910         | 5,425         | 3,936         | 4,213         | 2,854         | 3,576         | 4,704         | 4,473         | 5,238         |
| Naas General Hospital                   | 3,025         | 1,323         | 2,268         | 3,797         | 3,282         | 4,409         | 2,116         | 1,836         | 2,951         | 3,210         | 3,054         | 3,361         |
| St Colmcille's Hospital                 | 1,267         | 751           | 1,104         | 2,589         | 2,231         | 2,208         | 2,201         | 1,130         | n/a           | n/a           | n/a           | n/a           |
| St James' Hospital                      | 2,008         | 1,022         | 2,471         | 2,441         | 1,366         | 1,590         | 1,288         | 1,706         | 2,220         | 2,654         | 1,851         | 2,178         |
| St Vincent's University Hospital        | 4,190         | 6,093         | 5,694         | 5,427         | 6,063         | 6,403         | 4,735         | 2,872         | 2,478         | 5,150         | 4,836         | 2,497         |
| Tallaght Hospital                       | 4,941         | 3,962         | 5,782         | 6,044         | 7,011         | 4,784         | 1,906         | 3,943         | 3,717         | 4,718         | 4,166         | 4,847         |
| <b>Eastern</b>                          | <b>26,401</b> | <b>27,107</b> | <b>34,074</b> | <b>36,623</b> | <b>37,135</b> | <b>34,947</b> | <b>26,723</b> | <b>27,255</b> | <b>26,569</b> | <b>33,844</b> | <b>27,208</b> | <b>24,229</b> |
| Bantry General Hospital                 | n/a           | n/a           | n/a           | n/a           | n/a           | n/a           | n/a           | n/a           | 147           | 233           | 627           | 779           |
| Cavan General Hospital                  | 2,816         | 2,779         | 2,189         | 1,975         | 3,291         | 4,572         | 2,569         | 1,954         | 460           | 1,000         | 771           | 482           |
| Cork University Hospital                | 3,867         | 3,615         | 4,516         | 4,539         | 7,021         | 6,649         | 4,230         | 4,102         | 3,574         | 4,670         | 6,032         | 6,815         |
| Letterkenny General Hospital            | 3,059         | 1,253         | 388           | 378           | 474           | 592           | 539           | 1,277         | 2,755         | 2,814         | 2,047         | 4,889         |
| Louth County Hospital                   | 200           | 88            | 152           | 146           | 25            | n/a           | n/a           | n/a           | n/a           | n/a           | n/a           | n/a           |
| Mayo University Hospital                | 2,285         | 1,391         | 1,207         | 1,454         | 1,760         | 599           | 1,525         | 1,145         | 1,908         | 1,868         | 2,241         | 1,663         |
| Mercy University Hospital, Cork         | 1,431         | 1,270         | 1,534         | 1,270         | 1,910         | 1,943         | 1,922         | 2,491         | 2,196         | 2,227         | 2,859         | 3,145         |
| Mid Western Regional Hospital, Ennis    | 867           | 961           | 252           | 368           | 431           | 411           | 324           | 333           | 7             | 125           | 330           | 175           |
| Midland Regional Hospital, Mullingar,   | 169           | 91            | 183           | 528           | 1,921         | 3,204         | 2,398         | 2,845         | 3,908         | 4,366         | 4,849         | 4,844         |
| Midland Regional Hospital, Portlaoise,  | 469           | 283           | 425           | 297           | 426           | 1,926         | 539           | 824           | 1,589         | 2,162         | 3,364         | 3,203         |
| Midland Regional Hospital, Tullamore,   | 64            | 34            | 95            | 77            | 766           | 1,857         | 1,303         | 1,156         | 3,746         | 2,758         | 4,748         | 4,774         |
| Monaghan General Hospital               | 106           | 287           | 293           | 119           | 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           | 59            | 103           | 93            |
| Our Lady of Lourdes Hospital, Drogheda  | 3,444         | 2,811         | 2,927         | 3,415         | 3,484         | 7,449         | 6,761         | 3,349         | 6,249         | 7,783         | 5,608         | 2,791         |
| Our Lady's Hospital, Navan              | 520           | 847           | 851           | 1,084         | 453           | 1,469         | 745           | 1,029         | 1,059         | 1,000         | 595           | 2,435         |
| Portiuncula Hospital                    | 403           | 281           | 306           | 605           | 840           | 941           | 821           | 813           | 912           | 1,100         | 892           | 1,569         |
| Roscommon County Hospital               | 589           | 764           | 725           | 755           | 1,036         | 719           | n/a           | n/a           | n/a           | n/a           | n/a           | n/a           |
| Sligo Regional Hospital                 | 784           | 732           | 667           | 955           | 1,754         | 1,505         | 2,086         | 963           | 2,017         | 2,478         | 2,308         | 2,406         |
| South Tipperary General Hospital        | 727           | 784           | 881           | 500           | 666           | 768           | 2,138         | 2,762         | 1,959         | 2,028         | 5,399         | 5,249         |
| St Luke's Hospital, Kilkenny            | n/a           | n/a           | n/a           | n/a           | 140           | 1,034         | 695           | 1,817         | 1,921         | 3,514         | 3,144         | 4,505         |
| University Hospital Galway              | 1,654         | 2,414         | 3,470         | 3,444         | 4,103         | 6,544         | 4,193         | 3,907         | 5,312         | 6,514         | 5,807         | 6,563         |
| University Hospital Kerry               | 1,144         | 507           | 763           | 337           | 623           | 672           | 606           | 694           | 1,005         | 1,389         | 1,664         | 2,215         |
| University Hospital Limerick            | 1,814         | 1,367         | 1,735         | 2,422         | 3,715         | 3,658         | 3,626         | 5,504         | 6,150         | 7,288         | 8,090         | 8,869         |
| University Hospital Waterford           | n/a           | n/a           | 496           | 589           | 1,349         | 1,165         | 1,590         | 2,269         | 2,249         | 2,445         | 3,835         | 5,525         |
| Wexford General Hospital                | 2,907         | 736           | 1,306         | 1,833         | 2,536         | 3,857         | 975           | 1,374         | 1,399         | 1,333         | 1,100         | 1,763         |
| Country total                           | 29,319        | 23,295        | 25,361        | 27,090        | 38,724        | 51,534        | 39,585        | 40,608        | 50,522        | 59,154        | 66,413        | 74,752        |
| NATIONAL TOTAL                          | 55,720        | 50,402        | 59,435        | 63,713        | 75,859        | 86,481        | 66,308        | 67,863        | 77,091        | 92,998        | 93,621        | 98,981        |

**Comparison with total figure only:** Increase between 2016 and 2017: 6%  
 Increase between 2015 and 2017: 6%  
 Increase between 2014 and 2017: 28%  
 Increase between 2013 and 2017: 46%  
 Increase between 2012 and 2017: 49%  
 Increase between 2011 and 2017: 15%  
 Increase between 2010 and 2017: 31%  
 Increase between 2009 and 2017: 55%  
 Increase between 2008 and 2017: 67%  
 Increase between 2007 and 2017: 96%  
 Increase between 2006 and 2017: 78%

- Cork University Hospital and University Hospital Galway recording 6,815 and 6,563 respectively
- The Mater University Hospital, Dublin was the capital's most overcrowded hospital with 5,238 patients on trolleys during 2017
- Smaller hospitals such as Our Lady's Hospital, Navan showed increases from 595 in 2016 to 2,435 in 2017, and Portiuncula Hospital, Ballinasloe recorded 1,569 patients on trolleys compared with 892 in 2016.

Reacting to the level of overcrowding, Ms Ní Sheaghda called on the HSE to explain how the predictable increases in ED admissions remain outside of the scope of hospitals to manage and control.

"Overcrowding in late December and early January is getting worse. Despite investment in winter plans, smaller hospitals are now severely overcrowded which is manifestly unsafe and leads to higher cross infection and poorer outcomes for patients. Nursing staff cannot be expected to put up with this obvious neglect of duty of care to them and the patients they try to care for any longer."

Ms Ní Sheaghda, who has taken over the role of co-chair of the HSE ED Taskforce, said the system of de-escalation which is mandatory for hospitals to follow, before spreading overcrowding to the entire hospital, was abandoned during the Christmas period:

"Our figures show that on December 28 and 29, 11 of the 29 hospitals used their full capacity protocol and placed additional patients on wards. Under HSE policy, the joint chairs of the Taskforce must be notified in advance of use of Full Capacity Protocol. I can confirm that no notification was provided, by any hospital, to me which demonstrates an abandonment of the system for dealing with overcrowding."



**INMO launches paediatric trolley watch:**  
 With members of the INMO Children's Nursing Section in the back row, pictured at the launch of the extended trolley and ward watch count were (front, l-r): Dave Hughes, deputy general secretary; president Martina Harkin-Kelly; Phil Ni Sheaghda, general secretary; Catherine Sheridan, Executive Council member and children's nurse

# INMO extends count to new reality of children on trolleys

THE INMO has launched an additional element to its longstanding trolley and ward watch count, due to the new phenomenon of children admitted to hospital being cared for on trolleys due to a lack of inpatient beds.

From Monday January 15, 2018 the Organisation is now counting and publishing trolley figures for Ireland's children's hospitals – Our Lady's Children's Hospital Crumlin; National Children's Hospital, Tallaght; and Children's University Hospital Temple Street. If children are on trolleys in any of the regional hospitals this will also be recorded.

Children are now regularly being admitted for hospital care without an inpatient bed. The presence of trolleys in paediatric hospitals is a new phenomenon and the INMO Children's Nurses Section highlighted that these trolley numbers have not previously been included in the count.

The INMO Executive Council, at its October meeting, agreed to launch a paediatric trolley watch count and the Organisation has been monitoring the number of children on trolleys since November 2017. In the first two weeks of January 2018, a total of 73

children were being cared for on trolleys in the three paediatric hospitals.

INMO general secretary Phil Ni Sheaghda said: "The negative outcome for patients arising from long trolley waits is proven and accepted. Exposing children to extended periods in an emergency department is unsatisfactory on many levels, not least of which is the possible exposure to traumatic events. All systems, processes and procedures must aim to avoid unnecessary waiting times in EDs as a matter of urgency."

Catherine Sheridan, INMO Executive Council member and children's nurse, said: "Attending hospital is a fearful and anxious experience for children and their families, this can and must be kept to an absolute minimum. It is simply not acceptable to us that environments that are totally unsuitable are added to this anxiety and fear."

INMO president Martina Harkin-Kelly said: "It is vital that this union puts the health and safety and timely care of all patients, particularly those most vulnerable in our society, under the spotlight so as to ensure that appropriate measures are taken to provide



**Catherine Sheridan, INMO Executive Council member and children's nurse:**  
 "It is simply not acceptable that environments that are totally unsuitable are added to the anxiety and fear of sick children"

safe, effective quality care. Therefore, it has been necessary to bring attention to this unfortunate development by expanding the trolley watch figures to include children. It is something we hoped would never arise and the sooner such practice ceases the better from the INMO's point of view."

The INMO trolley watch counts the number of patients for whom a decision to admit has been made, but who are still waiting for a bed at 8am. INMO ward watch records those patients moved to wards but still waiting for a bed.



## INMO gives welcome to bed capacity review

HEALTH Minister Simon Harris's acknowledgement, in the *Health Service Capacity Review 2018* published in January, that investment and reform must

go hand in hand if we are to break the cycle of hospital overcrowding was welcomed by the INMO.

Through its trolley watch, the INMO has been to the forefront in highlighting the constant overcrowding in acute hospitals.

INMO general secretary Phil Ni Sheaghda said: "The recruitment of nurses is the key to the realisation of the necessary increased capacity and the simple reality is that, under the current conditions, the Irish health service is failing to either attract or retain nurses. The Public Service Pay Commission should recognise this and allow the government the freedom to do what is necessary to meet the clear needs identified in this report."

The report identifies that the acute hospital sector, under its current configuration, requires 7,150 extra hospital beds in public hospitals and, with the necessary reforms, would reduce this requirement to 2,600. The report also forecasts, with or without reform, a projected increase of 190 adult critical care beds and 13,000 for residential older person services are required.

Ms Ni Sheaghda said: "All of these beds need a planned funded recruitment and retention strategy for nurses on a multi annual basis. We are currently losing this battle and unless conditions are significantly improved for nurses this year, 2031 will remain an aspiration".

## Beds and staffing central issues for ED Taskforce

THE Emergency Department Taskforce, which is jointly chaired by INMO general secretary Phil Ni Sheaghda and HSE chief operations officer John Connaghton met on January 9, 2018 to consider measures to tackle the current pressures on Irish hospitals.

The meeting was called at the request of the INMO on behalf of all health staff in the light of the pressures felt because of the chronic overcrowding in late December/early January.

At the meeting HSE officials confirmed that all acute hospitals had been advised to make every acute bed available, particularly isolation beds and intensive care beds if needed. The taskforce confirmed that strict adherence to the agreed escalation policy, all patient flow measures, including cancellation of elective surgery/

procedures and utilisation of beds in private hospitals, was required.

The HSE public health advisor advised that the impact of influenza is likely to increase this week and peak. The HSE also confirmed that the peer vaccination programme, introduced in conjunction with the INMO and its members, has contributed substantially to the uptake of the flu vaccine among staff. This programme will continue with, as agreed, the backfill of those involved in the vaccination of their colleagues to ensure that frontline services are not depleted.

Following the meeting Ms Ni Sheaghda said: "There is a realisation by all that acute beds are needed to correct the capacity problem and that without additional nurses such beds cannot be put into use.

"Current efforts to recruit

and retain nurses are failing and it is clear that real investment and incentives are needed to attract and retain sufficient numbers of nurses if utilisation of the additional beds is to be realised." Ms Ni Sheaghda spoke of the urgent need for a meeting to agree the funded workforce plan for nursing and midwifery for 2018. This is extremely important and must include matters such as ensuring the maximum of Irish graduates remaining in Ireland post-qualification this September," she said.

"A number of medium to longer term agenda items for the taskforce have been set, the main one being that winter planning must occur much earlier in the year. It is of greater benefit to start this planning in March/April rather waiting until later in the year."

## HSE service plan is cold comfort

THE INMO expressed disappointment that the HSE National Service Plan 2018 announced just before Christmas fell short of meeting the growing demands of the public health services.

The HSE has confirmed that it will need to make significant savings during 2018 to deliver services. The INMO expressed disappointment that the HSE placed little emphasis on protecting the front-line workforce of nursing and midwifery.

In the service plan the HSE did not confirm any increased funding to expand the nurse Staffing/Skill Mix Taskforce, which provides evidenced based safe staffing levels, that is currently being piloted on 16 medical and surgical wards in Irish acute hospitals.

The INMO pointed out that

building the nursing and midwifery workforce is essential. The crisis relating to recruitment and retention means that there are 3,000 less nurses and midwives at work in Ireland today than there were in 2007. The Organisation stressed that this cannot be ignored as this scenario poses high risks for the delivery of safe patient care and will further exacerbate the exodus of nursing and midwifery staff from the public health service.

Within hours of the HSE's announcement of the service plan for 2018, the Minister for Health had to intervene and issue correspondence to the INMO providing clarifications and assurances in relation to honouring in full the agreement reached in February 2017 allowing for a fully funded

increase of 1,224 nursing and midwifery posts by December 2017.

INMO general secretary Phil Ni Sheaghda then demanded an urgent meeting to agree the next step which is the development of the nursing and midwifery workforce plan for 2018.

"The Service Plan will be cold comfort for nurses and midwives at work as their workloads will continue to grow without specific resource building measures being identified, or funded, by the HSE," said Ms Ni Sheaghda.



# INMO and RCM Brexit proof midwives

THE INMO and the UK's Royal College of Midwives (RCM) signed an historic partnership on January 22, at the Irish Embassy in London, marking a unique international partnership between the two midwife representative bodies.

With the signing of the Memorandum of Understanding, the two organisations effectively agreed to adopt the members of their sister organisation when they are working, on a temporary basis, in the jurisdiction of the other representative trade union.

Both organisations are members of the Irish Congress of Trade Unions and the European Public Services Union. This partnership represents a unique initiative between trade unions across borders.

In the context of Brexit and regardless of the outcome those negotiations, the partnership will strengthen the ability of midwives to practise across the two jurisdictions.

Midwives who are members of the INMO, under a licence agreement which is part of the Memorandum of Understanding, will now have a gateway

into the massive repository of midwifery research and education, provided by the RCM for its members.

In the event of a hard Brexit, the INMO will work as a conduit for the RCM to the European Commission, ensuring a two way flow of information relevant to the care of mothers and babies in the UK and the Republic of Ireland.

The Memorandum of Understanding was signed by INMO president Martina Harkin-Kelly and general secretary Phil Ní Sheaghda and RCM president Kathryn Gutteridge and CE/general secretary Gill Walton.

The initiative has been welcomed by the Department of Health and the signing of the memorandum was overseen by the Irish ambassador to the UK Adrian O'Neill, who hosted the official launch at the Irish Embassy in London.

Speaking at the launch INMO president Martina Harkin-Kelly said: "This is an exciting development for our midwives. The RCM is a world leader in terms of progressive evidence based midwifery



**Historic partnership**

INMO general secretary Phil Ní Sheaghda signing the INMO/RCM Memorandum of Understanding at the Irish Embassy in London.

Also pictured are (L-r): Julie Richards, RCM board chair; Gill Walton, RCM general secretary and Martina Harkin-Kelly, INMO president

practice and education and development. We look forward to a rich collaborative partnership where the needs of mothers and babies, through the professions of midwifery, can be advanced and developed, maintaining the record of these islands as the safest places in the world for childbirth".

INMO general secretary Phil Ní Sheaghda said: "The mutual representation rights confirmed between our two organisations is a unique experiment for unions in Europe. It is timely given Brexit

and it may set an example for greater co-operation into the future in advancing the rights and entitlements of professional workers in our health services."

The Irish Congress of Trade Unions has endorsed and welcomed the INMO/RCM initiative.

2018 is the centenary year of the first all-Ireland Midwives Act and the launching of the partnership is the first of a series of celebrations of the midwifery profession on the island of Ireland throughout the year.

## National Patient Survey highlights short staffing

THE National Patient Experience Survey, which was conducted during May 2017, with the results released by the HSE, Department of Health and HIQA in December, confirms that once patients are admitted to hospital they are, for the most part, very positive when commenting on care they receive. However, their main criticisms relate to delays in accessing services and treatment.

The majority of those who commented clearly outlined staffing and understaffing as a visible problem within the acute hospital services. One

example captures the sentiment, "nurses and doctors are doing their utmost to provide care to the best of their ability in poor conditions regarding staffing levels. One poor nurse is expected to provide care to 13 patients on her own. Management need sorting out."

Over the past decade the INMO has raised the consequences of the reduction by over 3,000 full time equivalents (FTEs) in the employment figures for nurses and midwives since 2007. As recently as September 2017 the INMO was advised that the HSE had only managed to build the nursing/

midwifery workforce by 13 WTEs since December 2016.

The problem is no longer confined to recruitment. The problem is very clearly, and firmly, the inability to retain staff once recruited. The INMO's position is that without real improvement to pay of nurses and midwives this problem will not go away and next year's survey will be saying exactly the same thing.

INMO general secretary Phil Ní Sheaghda said: "This survey was conducted in May, at a time where the number of patients on trolleys was at 8,154. That figure has now

increased by 534 and at the end of November 2017, 8,688 were awaiting beds, on wards, in our acute hospitals. Clearly the waiting for services and treatment is now even more pronounced.

"The INMO welcomes the confirmation that nurses/midwives and doctors continue to work in very difficult situations but do their best and treat everyone with dignity and respect. This is reiterated throughout the survey and is important for those who work in these very difficult circumstances to hear this affirmation from the public."

# Agreement reached on PHN contract

## Contracts issued since 2015 will be reissued to reflect changes

AGREEMENT has been reached between the INMO and the HSE on the contents of the public health nurse contract; this is an issue that has been in dispute since 2015.

On foot of the agreement, contracts issued to PHNs since 2015 will now be reissued to reflect the agreement reached. The important terms of this agreement are:

- Firstly, PHNs will be assigned to a specific location within the Community Healthcare Organisation, for example, CHO 1, Cavan/Monaghan
- Secondly, the reporting

relationship to assistant directors and directors of public health nursing will be maintained, ensuring the protection of PHN management structures

- Thirdly, the required hours of attendance will reflect the current service provision of a Monday to Friday service, during core hours. However, if the HSE alters the provision of the service to an 8am-8pm service or expands it to a seven-day service, the HSE would have to commence negotiations with the INMO on introducing such a

change. This issue is covered under the Framework Agreement reached in 2008 with regards to the extension of the working day. Therefore, the current PHN working pattern of Monday to Friday is maintained and there is no requirement on PHNs or community RGNs to work weekends, which is provided via an essential on call service. Weekend work remains voluntary.

Separately the INMO is in negotiations with the HSE with regards to introducing a model for weekend working that is

reflective of the Dublin Agreement. These revised contracts will apply retrospectively to the intake to public health nursing in 2015/2016 and 2016/2017.

However, for those who graduated between 2012 and 2015 who may have a contract that varies from what is agreed, these shall be addressed on an individual case by case basis. The HSE has outlined that it is not its intention to treat these employees any differently.

– Tony Fitzpatrick, INMO director of industrial relations

## Changes negotiated to PHN transfer panel

ON foot of complaints from PHNs on the National Public Health Nursing Transfer Panel about the length of time it is taking to execute a transfer, the INMO initiated engagement with the HSE. Following several meetings, an agreement has been reached to streamline this process.

The HSE advised that as of December 15, 2017, there were 221 live panel members. By that date, 119 transfers had taken place and 39 were in process. A further eight transfers that had not yet been filled.

To make the transfer process more efficient and clearer for those seeking a transfer, the following was agreed.

PHNs should choose

one geographical area to transfer to from the list of community care areas provided. Current panellists will receive an 'expression of interest' notification, solely on the geographical area chosen. A post will be offered to the highest-ranking person on the panel who expressed an interest in that geographical area. If the preferred geographical option is offered and refused, the PHN is moved to the bottom of the geographical choice transfer panel. In all other circumstances, the individual remains on the panel. However, if a vacancy cannot be filled by consulting the geographical area choice panel it will be offered to the overall

transfer panel, by offering the post to the highest-ranking person who has expressed an interest in the post.

This means that PHNs have an overall placement on a national panel and a placement on a geographical area panel. *For example, Mary Bloggs is No 86 on the overall panel and No 7 for the Cork North panel.*

Health Business Services is writing to each person on the transfer panel in respect of their first choice of location and update the panel database accordingly. This should be completed by the middle of February 2018.

The INMO raised concerns about PHNs who were offered positions but were not being

released due to staffing difficulties in the service they were leaving. To ensure the smooth operation of the PHN National Transfer Panel, relating to the release of transferees, HSE HR circular 001/2015 shall apply. In such circumstances a transfer applicant should not be unduly frustrated if a suitable approved vacancy arises.

This agreement acknowledges that the release of the transferee is conditional on the maintenance of safe patient care and consideration of clinical risk in all cases. The INMO believes these changes will improve the effectiveness and the efficiency of the PHN transfer panel.

– Tony Fitzpatrick, INMO director of industrial relations

## Is your INMO membership up to date?

**In difficult times the INMO will be your only partner and representative.**

If you are not a fully paid up member, you cannot avail of the Organisation's services and support in such critical areas as: Safe practice, fitness to practise referrals, pay and conditions of employment, other workplace issues and continued professional development.

Please advise the INMO directly if you have changed employer or work location

Contact the membership office with any updates through the main INMO switchboard at Tel: 01 6640600 or email: [membership@inmo.ie](mailto:membership@inmo.ie)





Tony Fitzpatrick, INMO director of industrial relations,

## INMO pursues S39 pay restoration

THE INMO has been pursuing the restoration of pay to members who work within Section 39 organisations.

When pay cuts that were introduced as part of the FEMPI process, most Section 39 organisations reduced the pay of members unilaterally. However, the ongoing pay restoration in the public sector is not being paid to members in Section 39 organisations, despite the clear relationship between pay in the public service and Section 39 organisations.

S39 organisations have stated that they have no additional funding from the HSE to restore pay, and in turn the HSE indicated that it has received no additional

funding from the Department of Health and therefore, is unable to provide any funding for these organisations, and it would have to come out of their own budget.

Unfortunately, INMO members and the service users are caught in the middle. The INMO has pursued cases for members working in S39 agencies to the WRC and the Labour Court.

In one case regarding St Aidan's Day Care Centre, Gorey case (LCR 21630), the Labour Court has clearly stated that there "is alignment of salary levels of those working in S39 agencies and those working in equivalent grades directly employed by the HSE". The Court further states it

acknowledges the "entitlement of the staff concerned to payment of increments and to recommend concession of the unions' claims." The Court recommended that the parties jointly approach the HSE to secure the resources necessary to meet the cost of the recommendation.

Therefore, the INMO calls on all members working in S39 organisations who have not had pay restored or received increments to support the 'Don't Break My Heart' protest on the February 14, 2018 at 1pm outside the Department of Health, Hawkins House.

An Industrial Relations Officer Solution Group examined this issue and proposed that:

- The INMO collaborates with other unions including FÓRSA, UNITE and SIPTU on pursuing this matter
- The INMO writes to all health spokespersons to raise the matter in the Dáil
- The INMO participates in a campaign which may involve balloting members in various locations where disputes exist and will participate the 'Pay Up Now' campaign.

The INMO welcomed a motion passed in the Dáil seeking that the government addresses the issue of pay restoration in S39 organisations. The INMO was due to present the case to the Oireachtas Health Committee as we went to press.

## Retrospection payments due in older persons and disability services

SINCE July 1, 2017, members working within services of older persons and intellectual disabilities services should be in receipt of the time-and-one sixth payment between the hours of 6-8pm or to end of shift.

This arises from Appendix 7 of the Haddington Road Agreement and the related chairman's note of the Lansdowne Road Agreement, under which the HSE, the Department of Health, and the Department of Public Expenditure and

Reform reached agreement with the IMO, the INMO and SIPTU on the transfer of tasks.

The matter outstanding is the issue of retrospection due to these individuals and, as part of this process, the NVIG is due to conduct site visits with each of the community health organisations. These site visits are to be conducted throughout February 2018. Local implementation groups (LIGs) are already in existence and it is expected that

the LIGs will provide a short presentation to the NVIG outlining progress with regards to implementation.

The current verification process is to decide on the payment of 50% of retrospective payments, awarded by the independent chairperson.

Also, before July 2018, the second verification process must be completed to establish if the final 50% of retrospective payment is to be made. The site visits plans are:

- Feb 5: Dublin (CHO 6,7 and 9)
- Feb 7: Sligo (CHO 1 and 2)
- Feb 14: Cork (CHO 3 and 4)
- Feb 19: Kilkenny (CHO5)
- Feb 23: Mullingar (CHO 8).

The INMO director of industrial relations sits on the National Verification and Implementation Group and will be participating in each of the site visits. Members will also be represented in the LIGs by their local IROs and nurse representatives, who are participants in the LIGs.

## Restoration of nursing/midwifery allowances to new entrants

AS PART of the WRC Recruitment Agreement of March 2017, the INMO secured the restoration of certain allowances to new entrant nursing and midwifery staff, in the context of national pay negotiations.

As the national pay negotiation process was balloted on

in August/September 2017 and accepted by INMO members, sanction has issued to restore the following allowances from the Department of Health:

- Midwifery qualification allowance (public health nurse)
- RGN in the community
- Nurse co-ordinator allowance
- Specialist co-ordinator

allowance (nurse tutors)

- Nurses assigned to occupational therapy.

The circular 036/2017 regarding this matter is effective from July 1, 2017, therefore, staff should receive retrospective allowance payments to that date.

Another component of the

March 2017 agreement was the granting of an allowance to PHNs who have completed the child and maternal module. This was to be progressed through engagement with the HSE, however, to date, agreement has not been reached. The INMO continues to pursue this matter.

## Update on National Joint Council proceedings

THE INMO attended the most recent meeting of the National Joint Council (NJC) on January 23 with the expectation that following issues would be discussed and progressed.

### **Injury at work allowance**

HSE HR circular 13/2017 has been amended with an explanatory note to remove the reference to the vesting period for SPSPS employees and this circular has issued to the HSE and Section 38 agencies.

### **Fixed travel/subsidised canteen/subsistence**

This matter has been referred from the NJC to the Workplace Relations Commission and it is likely that a conciliation conference will take place in February 2018. The HSE is seeking to remove the payment of fixed travel and this mainly effects community nursing staff. A separate notice is due to issue to members affected by the proposal. The WRC will also deal with the issue of subsidised canteen and incorrect application of subsistence.

### **Compassionate leave**

The Civil Service issued Circular 01/2017 which dramatically increased the bereavement leave entitlement in the Civil Service. This was extended to local government and the INMO with other unions sought that the terms of this circular would apply in health.

Two WRC conciliation conferences have taken place, with the employer refusing to provide the revised terms. The HSE was due to provide a comprehensive costing to the INMO by January 19, 2018 and it is likely that the matter will be referred to the Labour Court.

### **Ballinacollig Community Nursing Unit**

Management committed at the meeting of November 30, 2017 to convene a meeting with the unions with regards to this unit and in sourcing of same. The matter was raised at the interim NJC meeting however, the meeting remains outstanding.

### **Theatre on call**

In September 2017, CERS committed to providing a draft term of reference to examine on call within theatres within a week. Despite numerous correspondence and the matter being raised at all subsequent NJCs, the INMO has not received the terms of reference. Again, it was raised at the interim NJC last week.

### **Pension calculation – senior staff nurse**

The staff panel has put forward dates for meetings with the HSE and these dates are under consideration.

### **Labour Court Recommendation 21434 re: on-call**

Again, the INMO raised this issue at the interim NJC and

management advised that they are currently in consultation with the National Federation of Voluntary Bodies with regards to determining the HSE's position on the matter. The Labour Court had recommended a national dialogue on the issue and a meeting is due to take place in February.

### **Holiday premium pay draft circular**

The staff panel has confirmed acceptance of the final version of this draft circular and management is currently engaging with voluntary hospitals, IBEC and with representatives of Section 38 organisations. This should be confirmed at the next NJC.

### **Cath labs/Saolta/St James's Hospital**

A meeting remains outstanding on staff working in Cath labs in the Saolta University Health Care Group and St James's Hospital, Dublin.

### **SATU nurses**

A follow up meeting to discuss issues relating to nurses working in sexual assault treatment units (SATU) is required and has been sought with CERS.

### **Allowances**

The HSE has issued a circular with regards to the restoration of allowances agreed under the Public Services Stability Agreement. Separately it should be noted that the application of allowance to PHNs who have

completed a child and maternal module remains outstanding. However, this will be dealt with in the Recruitment and Retention Oversight Group, chaired by Sean McHugh.

### **HOSPEEM-EPSU/joint declaration on CPD/LLL**

The staff panel met with the HSE on January 10, 2018. The HSE had committed at a meeting of November 1, 2017 to:

- Engage with the regulators
- Convene the appropriate personnel on the employer's side
- Conduct an exercise to ascertain the current spend and funding provision for CDP/LLL within the health service.

Regrettably, management was unable to complete these three commitments by the January 10 meeting. Management proposed the establishment of a working group on the issue of the joint declaration. The unions considered this at the interim NJC and it was confirmed to the HSE that the INMO was willing to participate in a joint working group with the aim of implementing the joint declaration in a timely fashion. The INMO said this working group's work would have to be time bound and independently chaired. The INMO has asked the HSE to forward its proposed terms of reference and membership. When this is received, the Organisation will work to establish the group.

## Intellectual disability expert group to be convened within INMO

IT IS planned to convene an expert group within the INMO to examine matters of concern that are outstanding with regards to Intellectual Disability Services including staffing, skill mix, reporting relationships,

medication management, RNIDs in the community and other matters.

Separately, the INMO has written to the HSE disability services and the Department of Health regarding nursing supports in schools and special

schools. The INMO understands that a group has been established in the Department of Health and the HSE to examine nursing support needs of children with special educational needs, especially in the cross over between

health and education. The INMO is seeking participation in the group, and the director of industrial relations has sought engagement with the chair of the group and a meeting with the national director of disability services.

# Labour Court grants key concessions for INMO members in TUSLA

THE INMO was recently successful in obtaining a significant concession for early years inspectors in TUSLA in relation to a change in eligibility criteria for those posts.

Early years inspectors were historically recruited exclusively from the public health nurse grade, however, a recent ministerial decision has decided to broaden eligibility criteria to include those with relevant qualifications related to early years services and education.

As part of the transition to this new arrangement the INMO argued for several important concessions for our existing members in TUSLA and potential future members. The Organisation claimed for:

- A 37-hour working week for those with a nursing qualification working in the inspectorate
- The exhaustion of all existing panels prior to commencing recruitment under the new eligibility criteria
- A confined competition going forward which would see a proportion of new posts confined to PHNs
- The introduction of the pre-retirement initiative for INMO members in TUSLA.

Very little progress was made in local discussions and the matter was referred to the Workplace Relations Commission and then to the Labour Court by the INMO.

In its recent determination the Labour Court granted the



**Edward Mathews, INMO director of regulation and social policy:**  
"the Labour Court has granted significant concessions for INMO members working as early years inspectors in TUSLA"

37-hour working week to our members working in TUSLA and determined that initially five PHNs currently on panels should be offered posts in a currently proposed recruitment process, and then a further

three currently on panels should be offered posts in future recruitment processes.

While all of the INMO's claims were not conceded, it is important to note that the PHN qualification remains within the eligibility criteria for future recruitment, a larger number of a members currently on panels will be offered posts arising from our efforts, and the granting of the 37-hour working week brings our members in TUSLA in line with those they are working alongside.

Negotiations with management on the Labour Court's recommendation will now commence.

– Edward Mathews,  
INMO director of regulation  
and social policy

# Plans to slash frontline staff condemned

HSE management has plans to cut nursing and frontline care hours at St Finbarr's Community Hospital, Cork despite the clear need to maintain safe staffing levels.

INMO members at St Finbarr's have balloted for industrial action, which is currently suspended to allow for discussions between the parties.

The INMO and the HSE met at the Workplace Relations Commission on December 1, 2017, and HSE management outlined its plans to cut 16 WTE nurses on financial grounds. The INMO rejected management's proposal as this would leave St Finbarr's

severely short staffed. The HSE agreed to reverse the cuts as an interim measure to prevent industrial action commencing on January 2, 2018, to allow for further talks.

The 160-bedded St Finbarr's hospital is pivotal to patient flow from Cork University Hospital and the Mercy Hospital within Cork.

According to INMO IRO Liam Conway, these savage cuts would have a detrimental effect on the care delivered within St Finbarr's. The HSE is also attempting to reduce the number of healthcare assistants at the facility. The plan to cut frontline staffing numbers by 21 WTEs (16 nurses and



Liam Conway, INMO IRO:  
"All best practice guidelines show that if you reduce nursing contact hours with patients, the quality of care will be compromised"

five HCAs) is absurd and will adversely affect the residents of the service.

Mr Conway said: "The INMO is continuing to engage with HSE management, seeking to ensure that these cuts are not implemented, for the sake of

patients, residents, staff and the people of Cork. St Finbarr's is an essential service and a very important facility in allowing patients to be discharged from the acute hospitals and any attempt to cut staffing will negatively affect the service provided.

"All best practice guidelines show that if you reduce nursing contact hours with patients, the quality of care will be compromised. There are already 16 WTE vacancies within St Finbarr's. Nursing staff have been working extra shifts to protect patients and maintain the service. However, this is unsustainable and will lead to staff burnout."

## INMO members highlight gross overcrowding at UHL

THE impact of the persistent and gross overcrowding in all areas at the University Hospital Limerick led to an emergency meeting of INMO members last month.

The significant turnout of nurses from all areas of the hospital gave a strong indication of the ongoing, unacceptable difficulties that members are tolerating. These include but are not limited to:

- A shortage of nurses, decreasing skill mix
- Nurses not being paid for all hours worked

- Higher levels of patient acuity
- Poor nurse to patient ratios,
- Over-scheduling of elective work throughout the hospital
- An increasing level of patient complaints
- Poor internal communications
- Unfilled CNM positions.

Nurses clearly stated that the HSE is interfering with their role as registered nurses to provide adequate care for patients, with many receiving care that is barely adequate.

The INMO informed the meeting that many of these issues have been raised

repeatedly with senior management and it has been accepted that the situation at the hospital is not improving despite ongoing meetings.

The meeting concluded with nurses nominating additional INMO representatives to co-ordinate, as a first step, the signing of a petition of all INMO members at the hospital, detailing the unsafe clinical nursing environment at the hospital for the attention of senior HSE management.

– Mary Fogarty, INMO IRO

## Critical shortage of nurses in Newcastlewest

THE INMO following representation from members in St Ita's Hospital Newcastlewest secured agreement from the HSE to suspend the opening of additional rehab beds until the present staff nurse deficits are resolved.

The HSE confirmed to the INMO following a number of meetings that 10 nursing

positions are approved for filling and that they were confident of securing commencement of newly recruited nurses by the end of January 2018. At the time of going to press these additional nurses had not commenced working at the hospital.

It was also confirmed by the HSE that a further three

additional staff nurse positions need to be filled to enable the opening in the future of the new rehab beds at the hospital.

The INMO continues to engage at local level with the HSE to ensure that the appropriate number of nurses are recruited before additional beds open.

– Mary Fogarty, INMO IRO

### Cork update

- A resolution has been reached in **Fermoy Community Hospital**, which sees the implementation of the WRC agreement reached locally on staffing levels. The INMO had sought that 31 WTE nurses were employed within the hospital and maternity leave covered. This is now the case, with four nurses recruited in the past month.
  - INMO members in **Bandon Community Hospital** continue to operate a work to rule prior to a Labour Court hearing on February 7, 2018. This relates to staffing levels for a new building.
  - The INMO is lobbying Cork TDs and councillors over the uncertainty of **Cobh Community Hospital** (Section 39). As of yet, staff have not received any of the LRA pay restorations. The INMO attended the WRC in late 2017 on this to no avail and the matter has now been referred to the Labour Court.
- Liam Conway, INMO IRO



INMO deputy general secretary **Dave Hughes** addressed the Global Forum on Human Resources for Health in Dublin recently

## No pressure, no progress

ADDRESSING the World Health Organization's Fourth Global Forum on Human Resources for Health in November 2017, which was held in the RDS, Dublin, INMO deputy general secretary Dave Hughes said that the story of progress for the Irish professions of nursing and midwifery was one of 'no pressure, no progress'.

In a potted history of the past 20-plus years, Mr Hughes told the audience that the Commission on Nursing report, which was published in September 1998, had been the blueprint and backdrop for the most positive development of the nursing and midwifery professions since. This was, he said, the blueprint for the professions at the start of the 21st century.

The Commission on Nursing itself, however, had not come easily, he said. A sustained campaign of pressure by nurses and midwives throughout the mid-1990s culminated, under the threat of strike action, in a Bluebook Agreement, which provided for some pay adjustments for the professions and the creation of the Commission on Nursing in 1996. The government accepted the Commission's report in 1998 but did not implement any part of it and rejected the Commission's three recommendations dealing with pay and allowances.

Mr Hughes said this led to the only ever national strike of nurses and midwives in Ireland and what was the largest withdrawal of labour in the history of the state. Through that action, the Commission recommendations were implemented and

they provided for the most radical change for nursing and midwifery ever.

Mr Hughes outlined the changes that followed, which included:

- The introduction of the four year bachelor degree requirement for registration and the moving of nurse and midwifery education into the university sector
- The recruitment of nursing/midwifery students through the Central Applications Office, as with all other third level graduate professions
- The introduction of clinical nurse/midwife specialists, and advanced nurse practitioner posts
- The creation of a layered management structure, including directors and assistant directors of nursing/midwifery, CNM3, CNM2 and CNM1 positions
- As well as providing for a senior staff nurse/midwife rate of pay, the settlement included a pathway for the further development of enhanced nursing and midwifery roles.

With the benefit of hindsight, the period 2002-2008 saw the professions flourish. The numbers grew and by the end of 2008 reached an all-time high of 39,000. Degree students emerged in the services from 2006 and international recruitment became a feature to fill the gap before the first students emerged that year.

In 2007 the working week of nurses and midwives in Ireland were revised downwards from 39 to 37.5 hours, again following a protracted period of industrial unrest. Services developed, demand

grew, and quality and patient outcomes improved. However, the same period saw the evidence that the cutbacks of the previous decade had left the country with a health service too small to cope with demand, which was evidenced in the emergence of significant emergency department overcrowding.

At the end of 2008 Ireland, as a nation, faced financial ruin and a consequent recession, which imposed merciless cuts to services and staffing of the health service. The number of nurses and midwives were cut from 39,000 in 2009 to less than 34,000 by the end of 2013. The hours of work, which nurses had fought so hard to achieve, were pushed back up to 39 a week, and recruitment and promotion ceased from 2009 to the end of 2013. In that period almost all graduating nurses and midwives left Ireland and emigrated. Poor work environments diminished patient care and, along with the exodus of Irish nurses and midwives, many of the overseas nurses and midwives who had joined the services also left the country during that period. Overcrowding throughout hospitals emerged and Ireland now has the longest waiting lists in the EU with hospitals operating at 100% capacity continuously.

### Collective advocacy essential

The lesson for the WHO, Mr Hughes said, is that collective advocacy, through nurse/midwife unions, is essential for patients across the globe. Improved nurse and midwifery management structures and dedicated staff for admitted patients



in EDs, which are clinical essentials, were only achieved following an IR settlement. Nurse staffing levels on medical and surgical wards, which had been stripped during the recession and which, for clinical reasons, needed to be determined based on dependency rather than funding was, again, only piloted through a taskforce as part of an IR settlement.

The National Maternity Strategy and Midwifery Strategy came about as a consequence of public scandals and an ultimate settlement to deal with the growing crisis in those services. The growing population and demand for health services, which required rebuilding of nurse and midwifery numbers, again, was only achieved through funded workforce plans agreed as part of an IR settlement for 2017, 2018 and 2019.

While the WHO's plenary forum had hailed the recent all party agreement on Ireland's 10-year health plan *Sláintecare* as a massive political achievement, Mr Hughes pointed out that this all party approach was, in fact, as a result of being promoted by the INMO through the Irish Congress of Trade Unions and became part of the programme for government as a consequence.

All of this demonstrates that real progress in our health services is entirely dependent on the advocacy of nurses and midwives through their organisations. However, Mr Hughes asked why is this not appreciated and why are nurses and midwives still the lowest paid professional grade in our public health service? It was, of course, a rhetorical question and he answered it by reference to a Bill Clinton cliché: *'It's the economy, stupid!'*

Patient care is labour intensive and requires the right knowledge and skill mix if patient need is to be addressed. However, governments across the world determine their numbers and skill mix by budget alone. This, Mr Hughes said, was clearly demonstrated in the approach taken by the British government when it effectively abandoned the findings of the Francis Report and the NICE Guidance, which advocated patient dependency as the determinant for numbers and skill mix.

Increasingly, nurse and midwife advocates across the globe campaign for the determining consideration to be based on patient dependency and mandated ratios. In Ireland's case this inevitably is fought out as an industrial relations exercise. The ultimate settlement tends to involve a mix of expert and academic advisers who are brought in to, on the one hand, validate the numbers demanded based on professional judgement and, on the other hand for the employers, to diffuse tension and prolong the exercise. This combination of expert and academic advisers with organisational advocacy are an essential combination to persuade governments to do the right thing for their populations in terms of their healthcare needs.

Challenging the audience, Mr Hughes posed a number of questions:

- Is the bar being set too high for patients, nurses and midwives?
- Safe nurse/midwifery staffing levels in care settings is probably the most studied workforce resource issue in human resources for health services – why?
- This usually seeks to establish a minimum and optimum staffing based on dependency so would it be a crime if wards and care settings were occasionally overstaffed?
- If so, against whom would the crime be committed and would it be terrible if nurses and midwives had more time to talk to their patients?
- What other group in the workforce is so precisely measured? What other function impacts so much on the welfare of those they care for?

#### Where to now for Ireland in 2018?

Agreement with government and the HSE provides for funded workforce plans in 2018 and 2019. The aim is to restore the numbers to a level equating to what they were back in 2009 and more to cope with additional demand. However, based on the 2017 funded workforce plan, it appears that the Irish health service is no longer capable of recruiting or retaining sufficient nurses and midwives to meet that demand. It is currently highly dependent on international recruitment in a market where there is a worldwide shortage of nurses and midwives and most developing countries are fishing in the same pool.

In 2016, the number of registrations from Irish-trained nurses was 1,728, while the number of nurses and midwives registered from other nations was 2,054. The pattern for 2017 is the same with 1,565 registrants from Ireland compared to 2,777 from overseas. Is this a strategy for a sustainable health service or is there a better way?

The INMO, in a comprehensive submission to the Public Service Pay Commission, has laid out the reality. The question now is will procedure work by accepting that reality and, if so, will it lead to increased pay and parity with other Irish health professionals and lead to Ireland being sufficiently attractive to retain our own graduates and attract nurses back in numbers necessary to meet our population needs.

The Irish health service needs nurses and midwives and it is failing to compete with the rest of the developed world for both its own trained and the international mobile workforce. What faces the Public Service Pay Commission is a simple question: does it allow the old prejudice and practice of allowing the numbers hold back the professions or will it set that aside and accept that patients and populations deserve better in the 21st century?

## World news



### Nurses and midwives in action around the world

#### Argentina

- UPCN denounces the government for not complying with nursing law

#### Canada

- Sit-ins held in Trois-Rivières to denounce situation in emergency rooms
- Workload, staffing top priorities for nurses in contract talks

#### Dominican Republic

- Unions demand appointment of a thousand nurses and fulfilment of agreement

#### India

- Contract nurses strike work in Bengaluru's Kidwai Hospital

#### Kenya

- Pay nurses' salary arrears to prevent strikes: Mohamed Kuti

#### Spain

- Most nurses claim to have suffered a biological accident
- SATSE protests against staff cuts that trigger delays
- Court awards compensation to temporary nurse for dismissal

#### UK

- Funding levels blamed as union claims Rotherham Hospital is 'under severe pressure'
- Europe – demand for nursing staff on the rise, UK sees biggest shortage of nurses
- Patients notice when there are not enough nurses, will policymakers too?
- Surge in flu cases prompts fresh call to make all nurses have jab

#### US

- Gloves off, fists up: nurses storm capitol to renew single-payer fight

# Liam Doran addresses biannual Retired Section conference at INMO HQ

RETIRING INMO general secretary Liam Doran addressed the biannual conference of the Retired Nurses and Midwives Section last December, sharing some stories of his time in the Organisation, through the great, the good and the not so good times.

Many of those gathered had worked through it all. It was a great occasion, and opportunity for the Section to wish Liam well on his retirement, and, of course, to encourage him to join their very active social group. Liam made a promise to join – once the golf society is up and running!

There was also a very practical paediatric CPR session, where everybody had the opportunity to get hands-on experience of practising infant and child CPR.



Retiring INMO general secretary Liam Doran addressing the biannual conference of the Retired Nurses and Midwives Section at INMO HQ in December

The group enjoyed a festive light lunch, with plenty of time for socialising and catching up with friends. The afternoon session was hosted by Sergeant David Cryan and Garda Liam Reynolds from the Neighbourhood Policing Unit of the

Bridewell Garda Station who gave a very informative and practical talk on crime prevention. They covered every aspect of personal security and security in the home along with practical tips of how to avoid credit card fraud. They also

highlighted the importance of never having anything of value visible when driving and to be cautious of where you park. Both speakers were extremely well received, and answered a great number of questions from the audience.

## Section round up

### ODN conference

Have you considered entering a poster into the annual ODN poster competition which takes place in Tullamore at the annual conference on April 20-21? Full criteria are available to download from [www.inmo.ie](http://www.inmo.ie) or contact Helen O'Connell at Tel: 01-6640616 or email: [helen.oconnell@inmo.ie](mailto:helen.oconnell@inmo.ie) See page 24 for full details and be in with a chance of winning part of the €1,000 prize fund.

### RNID Section set for conference in March

The RNID Section national conference is taking place in Portlaoise on March 22. Minister Finian McGrath has been invited to address the conference and we look forward to welcoming him, along with a number of other speakers including Dr Siobhan O'Halloran, chief nursing officer, Department of Health. The keynote address will be delivered by Prof Kay Mafuba from the University of West London. Prof Mafuba will speak on the lessons learned on decongregation in the UK setting. A number of other topics will also feature. See page 51 for full details. Bookings can be made at: [www.inmoprofessional.ie](http://www.inmoprofessional.ie)

### AGM reminders

Can all section members ensure that they check the website for details of the time date and venue of their AGM. At this important meeting, the section's motion for debate at the forthcoming annual delegate conference will be decided, and delegates will be nominated to attend and represent their section at this important event. The section's strategic plans for the year ahead are also decided on at this meeting and it is a great opportunity to have your voice heard.

## Exciting speaker line-up for COOP conference

THE upcoming conference of the Care of the Older Person (COOP) Section has a wonderful line up of speakers for the day, including Prof William Molloy who will deliver a talk entitled 'Let Me Decide'.

The role of the advanced nurse practitioner working in the community will be addressed by Tracy Keating, RANP, and Tony Fitzpatrick, INMO director of industrial relations will speak on the expansion of the role of the nurse working in the care of the older person setting.

A presentation on understanding wound dressings categories and indications will be given by an independent educational consultant on wound management.

An informative talk on pensions and what you need to

know will be given by an independent financial consultant Denis Brophy.

To finish up for the day, we will hear from Edward Matthews, INMO director of regulation and social policy, on governance and fitness to practise issues.

This conference is always both educational and enjoyable and we look forward to welcoming members again this year. Please book your places early.

The full programme for the national care of the older person section conference is on page 48, and bookings are available online at: [www.inmoprofessional.ie](http://www.inmoprofessional.ie)





# Facing forward

The INMO's new general secretary Phil Ní Sheaghda spoke to Alison Moore about her new role and the immediate tasks ahead

"THE most recent figures show the HSE is paying just over €1.1 million per week to supplement the workforce with agency staff which is a very expensive staffing model and conversion of agency to direct employees in better for nurses/midwives and services. It doesn't lend itself to continuity and or enable you to plan the development of services. At any time the supply of agency staff can slow. Our ability to recruit and retain has to be tackled now as the cost of not doing so is too great."

This was the warning issued by Phil Ní Sheaghda in an interview with *WIN* following her taking over the role of INMO general secretary. If the recruitment and retention crisis affecting nursing and midwifery – as well as the knock-on issues this has on the wider health services – is to be tackled then the HSE must address the issue of pay, and soon. It makes no sense to be losing skilled staff over poor pay and then have to pay more money to an agency to provide cover, said Ms Ní Sheaghda.

More shocking still, she explained that

the cost to the HSE to recruit staff from abroad is over €10,000 per head.

"The HSE has not been unable to identify the actual cost but it is estimated by nurse managers who participated in the recruitment process that the minimum per head – before the post is filled and anyone steps foot on a ward – is €11,000 per person, and that is conservative. It is nonsensical," she said.

Much like in 2008 when Ms Ní Sheaghda became the Organisation's director of industrial relations, there is a considerable job of work ahead of her in her new role. In 2008 the public service was facing into years of austerity that saw the INMO fighting to protect members' pay from cuts as much as possible. Now the Organisation is looking to secure not only the restoration of these cuts but to achieve pay parity with the other therapy grades in the health service.

#### **Work to be done**

The task ahead is clear and there will be no honeymoon period for Ms Ní Sheaghda in her new role – the ED trolley crisis has continued to escalate

since she took office and the recruitment and retention issue looms large. However, she pointed out that she would benefit from, and build on, the "excellent work" of her predecessor Liam Doran, who was "meticulous in his approach" during the handover period.

"Firstly, I would like to say that I had a very good lead-in time to taking over as general secretary. Liam handed over everything in excellent shape. He has been a natural teacher and an excellent mentor to me, both now and throughout my career, which has made the transition much easier and set me up as well as possible for the job ahead," she said.

As Ms Ní Sheaghda observed, the cost of the government not acting on the recruitment and retention crisis is simply too great. To illustrate this she showed me figures from 2016 that show while 2,573 staff nurses took up a new post, some 2,271 left the public service with 71% of those resigning their posts.

"That tells you that there is something wrong with the workplace," she said. Looking at nurse managers, the

resignation rate is still high at 51% but significantly lower than at staff nurse level, which tells you that when you get promoted and have a higher income the turnover of staff, while still significant, is not as high," she said.

The Public Service Stability Agreement which currently covers public service pay and has as a central point recruitment and retention measures have to be examined and settled independently, grade by grade, and the INMO is "absolutely determined" that it will get a fair hearing on this issues at the Public Service Pay Commission, which is charged to examine nursing and midwifery first, as negotiated by the INMO at the time of the Stability Agreement.

#### Mandate

"We have a clear mandate from members on recruitment and retention problem they face. Across all grades there is an absolute clear link between the inability to retain and poor pay. Recent public service agreements have determined pay restoration but in this case the Pay Commission can examine specific grades and if there are matters that it believes are linked to pay then the government has to meet with the unions concerned within four weeks of that recommendation issuing," explained Ms Ní Sheaghda.

The INMO has made two comprehensive submissions to the Pay Commission involving a body of research obtained through the International Council of Nurses' Workforce Forum.

"This has provided us with statistical information based on purchasing power parity, which is the currency that is used to compare the value of your salary depending on where you live. In the examination we have made, Ireland fares the worst out of all the main competing countries (US, UK, Australia, New Zealand and Canada) compared," she said.

"When we compared how those countries treat nurses and midwives' qualifications vis-à-vis other healthcare professionals, we fared very badly. Those countries pay the nurse on a par or above other healthcare professionals while we pay nurses and midwives between 10-17% less," Ms Ní Sheaghda added.

The Commission will advise the relevant parties on the outcome of its assessment, which in turn will be the subject of discussion between those parties. Crucially, it has been accepted that the output from this exercise will not give rise to any cross-sectional claims.

"That is really important as up to now

nurses and midwives have always been part of a general pay round and if awards were made other grades would claim the same increases. What this does is that it allows an award be made to nurses and midwives without knock-on claims being lodged by others. This should, we hope, secure some real examination for the first time on whether the nurses and midwives' pay in this country is appropriate for what they do and is it affecting our ability to retain nurses and midwives? We believe that it is a central plank of our inability to retain nurses and midwives," she said.

**"We have a clear mandate from members on recruitment and retention problems they face. Across all grades there is an absolute clear link between the inability to retain and poor pay"**

Ms Ní Sheaghda believes that while politicians can often be heard singing the praises of those who work on the front line of the health service, they do not genuinely value the work of nurses and midwives.

"When the general public interact with the hospital or community system they immediately get it and have positive feedback on the care. Unfortunately, that is taken for granted by the employer and also by government. There are a lot of plaudits, and 'Oh, aren't they great', but it is a patronising approach. It's like the mention of vocation, which drives our members mad. Nurses and midwives are skilled, committed professionals who have a career, dependants, responsibilities and costs. They go over and above in terms of ours worked and are very committed to their patients and their profession. They don't want plaudits; they want to be paid appropriately. Members are increasingly disillusioned that their skills and good will are being taken for granted," said Ms Ní Sheaghda.

#### Workplace structure

Outside of the issue of pay, Ms Ní Sheaghda would like to see more autonomy in nursing and midwifery, especially in the community setting. She observed that there is a reluctance to allow nurses and midwives to manage themselves as is in accordance with best international practice. HIQA has also made a number of recommendations in this area as well but resistance within the HSE persists.

"The autonomy seems to have been removed from areas of nursing and midwifery. In the reconfiguration of the hospital service we succeeded, after a long battle, to get group directors of nursing on a par with the group chief executive and clinical director. That is not the case in the community where you have a myriad of management grades but a great reluctance to appoint a chief nurse. This is a process we are pursuing at the moment," she said

The situation is similar in the maternity services: "It took the Portlaoise inquiry to recommend that each maternity service outside of the stand-alone maternity hospitals should have a director of midwifery.

"We are not of the opinion that nurses and midwives are here to provide front-line services and be managed by other grades. We believe we provide these services and manage them, working very closely with the broader healthcare team.

"Following a long battle the acute hospital division has put in place the model we believe is the right model and we believe this should apply across all of the services. We do not want to be handed a budget and told to get on with it. There has to be a clear input by nurses/midwives into the planning of nursing and midwifery services," she added.

#### Strategy

Looking at the broader agenda for the Organisation, Ms Ní Sheaghda referred to the "excellent management team" around her made up of the deputy general secretary (Dave Hughes) and the various directors – industrial relations (Tony Fitzpatrick), regulation and social policy (Edward Mathews), and professional development (Elizabeth Adams), who all work closely with the president, Martina Harbin-Kelly, and the Executive Council.

"The entire IRO team and staff of the regional offices, Organisation HQ and professional development team, are very committed to the single agenda of progressing the issues for nurses and midwives..

"We have a strategy meeting once a month and our governing body, the

Executive Council, meets on a monthly basis. I am also in regular contact with the president and we meet between those meetings to ensure we are pursuing the agenda that was set for us at annual conference," Ms Ní Sheaghda explained.

"We have a policy to always be honest with our membership and have very frank briefings with them. We do this regionally and we then go into the workplace and repeat it," she said.

Importantly, members of the Executive Council attend the national negotiations alongside INMO staff and because of this, according to Ms Ní Sheaghda, they are assured "that the position we hold and the gains we achieve are the best to be achieved at that time".

**Agreement**

For the moment, Ms Ní Sheaghda believes the Organisation is better off working within the Public Service Stability Agreement.

"What we have discovered is that the centrality and the method in which pay in particular is negotiated is very much embedded in the public service agreements. However, we have been negotiating over the past number of years for restoration of pay, not pay increases," she said.

"It is a different type of approach to collective bargaining at national level when you are talking about pay restoration. During the Haddington Road Agreement particularly, we successfully achieved maintenance of conditions of employment, particularly premium pay, for our members. If you remember we walked out of the first phase of those negotiations and mounted a campaign against it, causing it to fall. The renegotiations secured premium pay at the level that it had been, which was very important for the people that we represent," she added.

So, the INMO is not afraid to act and step out of a general agreement if and when it may be required.

"The strategy has been to stay within procedure to pursue our claims, in the event that this changes I have no doubt that our Executive Council will make the decision to change this in the full knowledge of the consequences of taking that decision.

"When procedure fails, this union has never backed away from industrial action to pursue claims for its members. But of course we are hoping procedure will work. It is designed to achieve outcomes and to avoid industrial strife and this will be a good test of it," Ms Ní Sheaghda said.

## Road to INMO HQ



*Phil Ní Sheaghda, pictured in INMO HQ*

PHIL Ní Sheaghda, originally from the Gaeltacht in Ventry, Co Kerry. She trained as a general nurse in Jervis Street Hospital, qualifying in 1988 and then worked in the intensive care unit in Beaumont and in St. Ita's Psychiatric Hospital in Dublin. After this, in 1989, many Irish qualified nurses were forced to immigrate to secure employment and Phil was one of those. She immigrated to the UK and spent three years in London. She initially spent three years in London where she specialised in intensive care nursing. From London she travelled to south east Asia and Australia. In Australia Phil worked in intensive care nursing for a year and also spent time travelling around the vast continent. From there she travelled through New Zealand and then on to the US, where she worked for a year in an intensive care unit in Memorial Sloane Kettering, in New York city, where she recently paid a return visit having travelled to the US for a wedding.

Returning to Ireland in 1993, Phil took a job in the intensive care unit in St Vincent's Hospital in Dublin. With her knowledge of overseas workplaces, Phil felt that the contrast between the nursing conditions she had experienced abroad and those at home needed to be highlighted and she became active in the INMO. From her experience of working in different countries she felt that nursing autonomy was greater abroad than in Ireland, especially in the US. This is an issue that is still very much on her agenda in 2018.

Not long after getting involved with the INMO, Phil was elected secretary of the Dublin Branch and subsequently took the decision to study industrial relations, completing a diploma in trade union studies in 1997 and later completing a masters degree in industrial relations and human resource management. Following a stint as a nurse representative during the pay campaign in 1996/7 she was bitten by the bug and applied for the post of industrial relations officer with the Organisation, taking up the position in January 1998.

Ten years later in 2008 she was appointed to the post of director of industrial relations, holding this position for a decade until her appointment as general secretary designate in 2017 and her eventual succession in January this year.



# Stronger together

Alison Moore spoke to Neal Donohue on his vision for his new role as the INMO's incoming student and new graduate officer

NEAL DONOHUE, who has recently taken up the reins as student and new graduate officer for the INMO, has nothing but respect and admiration for those who have chosen to enter the professions of nursing and midwifery knowing how challenging an environment that currently exists. Front and centre of his agenda is to put in place additional support structures for students and new graduates to ensure that they are able to take care of their mental health and manage the inevitable stress of the job.

"One of my goals is to look at the environment that students are stepping into. When you have shortages in staff, these students may not have the same levels of support that I had when I was training – and it is a very difficult training.

"Stress is the one thing that intertwines every aspect of the job at the moment. The stress of working in this environment, the stress of not having enough money to pay your bills, etc. So, while we are looking at the payment part we also need to look at helping people to cope," he told *WIN*.

Neal qualified as an RGN in 2006 and worked in the area of intellectual disabilities in Galway with the Brothers of Charity following graduation. Having started his career at the tail end of the Celtic Tiger, he has a very different experience compared to those who have graduated in recent years.

"I got into nursing because I love working with people. There were a lot of reasons but it boiled down to the fact that when I see someone in trouble I genuinely want to help them and to know how to help them. Nursing gave me a broad knowledge base on mental health, physical health, disabilities, everything. I felt very fulfilled for my first few years in training and working but then things changed.

"I have gone through the recession. I have gone through all those tough times. I have seen staff levels depleted and the difficult things that happen as a result," he said.

### Stronger together

When the challenges brought about by austerity arose, Neal tried going it alone in his attempts to improve matters for himself, his colleagues and his patients, but he found that he had a limited impact. By 2016 he decided that circumstances were so bad that it was time to step up and to start making changes to see if there was anything he could do to make a more positive environment.

"The way I did that was by contacting the INMO. I wasn't really an active member until then and when I stepped up as a rep I met a group of people who were able to give me the support that I needed.

"I was coming from a position where we were all tired and finding things difficult. I

found people within the INMO who were professional and informative and really inspirational," he said.

Neal attended his first ADC in 2017 and says that was where everything really hit home for him.

"I realised what this Organisation was about. Seeing so many people in a room who had this positivity and drive to improve things, and so much knowledge on how to go about doing it that I wanted to be part of it."

### Protecting yourself

Now, through his new role with the INMO, Neal would like to make sure the next generation of nurses and midwives know how to protect themselves and are more informed on how to support themselves and their colleagues.

He has a certificate in counselling and psychotherapy which he feels has given him an insight into mental health and self care, and has also opened his eyes to how other students are supported during their training.

"During the training I found that while I was not dealing with half the issues and pressure that I dealt with as a student nurse, I was given far more personal support in coping with it.

"Student nurses are faced with every aspect of a person's life directly and while you have support from a staff nurse, they

themselves might be under pressure with their own workload and are too busy and stressed to offer the time and level of support that might be required by the student," he said.

Neal believes that psychological support would be best offered outside of the workplace or colleges.

"For students it can be difficult to walk down a corridor where there is a class going on and be seen by everyone who knows where they are going. Where the room is situated is so important as if it is removed from the place of work or learning, people can walk out the door and walk away," he explained.

Neal hopes that in the future self-care will be built into the curriculum to prepare student nurses and midwives to look after their mental health at work.

He points out that while there are already supports available for those of college age, specific support is needed for student nurses and midwives on clinical placements.

"There is a culture in nursing and midwifery to be resilient and to just get through it because it is the norm. Something that would be a crisis in another person's life is the everyday for the nurse and midwife. What I am hoping to do is find specific supports for nurses and midwives. I'm trying to get in touch with other groups who are looking for the same thing for workers in other areas of the health service and I am going to try to rally some students to also get involved," Neal said.

Rather than wait for a crisis to occur, he is hoping that by making self-care a part of the curriculum, instead of taking place on an exceptional basis, graduates will be better prepared in the workplace.

"We need to get in first and talk to students about what they may experience and things that they can do for themselves and to know where to go for help if needed. We are dealing with so much, you could go into the ED as a student and have a patient who has attempted to take their own life and then have to deal with a patient from a road traffic accident and then you go home at night, so how do you sleep and how do you make sure that you're okay? This is what I'm hoping can be taught. So that in first year you start learning good lifestyle habits and to learn to recognise in yourself if you may be having a problem," he said.

Neal is looking into setting up a pilot programme to deliver this and, pending its success, to then roll it out to all nursing and midwifery students nationally.

### What can the INMO do for you?

From Neal's perspective, he doesn't just want to talk about what the INMO can offer students, rather he wants to see what the students want from him.

"It's not me telling them what they need to be doing. I need to connect with them and that's what I will be doing over the next year, travelling around and using social media to ensure that they know what is available to them and asking them what they need. I want to know about any issues they are having and if I can do anything I will step in and do it for them," he said.

**To really affect change, takes a group of people working together and going in one direction and that is why I am now here with the INMO**

There are courses run by the INMO's Professional Development Centre (PDC) that are beneficial for students and Neal would like to raise awareness of these.

"I was just in Beaumont Hospital where the INMO PDC was running the Tools for Safe Practice course for fourth-year student nurses. When you are going into a challenging work environment it is really good to look at health and safety and to know how you complete documents correctly. It is that level of professionalism that I have seen in the INMO that really supports nurses and midwives and students. That is where you get a really high standard that you can bring out on to the wards. It can help you to sleep better at night time to know that you have done things to that standard," explained Neal.

"When you are on your internship you take on a lot of responsibility and it is important to know where the boundaries lie. That's what this course is all about; how to do your job to the best of your ability while also ensuring you are documenting

everything correctly and protecting yourself. It is very practical and improves the standards of care across the board," he added.

According to Neal, all nursing and midwifery graduates need to know to learn how to stand alone as a professional; to be confident and competent, and he believes that the INMO has a great deal to offer in that capacity.

He believes that the PDC has much to offer new graduates such as help with CVs and preparing for interviews as well as courses such as 'Tools for Safe Practice'.

"I know that when I qualified this is what I wanted and it is really great that the INMO provides this as it would cost a lot of money to get these privately. At the moment those who pre-register with the INMO before they qualify will get a voucher for a course at the PDC to the value of €90," he said.

I asked Neal if he had a message for students, first-years in particular, about the role the INMO can play in their student careers and beyond.

"For students, the INMO is about connecting first and foremost. It is not about taking on the entire world and seeing what's needed. If first- and second-years are interested, I would like them to get involved in some very positive, fun charity events. It is a good way of connecting with people and can tie in nicely with looking after their mental health.

"Reps will have practical information if they need it but there should be more available than just information; I want to show them what is available to them and support them in whatever they want for themselves. Especially for the new students – they are coming in when they know how tough things are and that is impressive.

"I know what it takes and I know what it is like for them. I will do absolutely anything to ensure that their experience as student nurses and midwives is better. Whatever I can do to help them go in the right direction, that's what I am here for.

"People think of unions as being all about industrial relations but we are here to support people in their professional capacity and we will help in any way we can to get them through their training. Everything else in time," he said.

### Get in touch

If you would like to get in touch with Neal, you can reach him by email: [neal.donohue@INMO.ie](mailto:neal.donohue@INMO.ie) or by phone at Tel: 01 6640628.

# Global Nurses United: Solidarity in action



Edward Mathews reports from the annual conference of Global Nurses United, which was held recently in Quebec

THE INMO is a founder member of Global Nurses United (GNU), which brings together 17 national nursing and midwifery unions that share the common goal of defending and improving members working conditions and ensuring recognition of the pivotal role played by nurses and midwives in our health services. The recent GNU annual meeting, which took place in Quebec City, Canada, was attended by INMO president Martina Harkin-Kelly, first vice president Mary Leahy, Executive Council member Bernie Stenson and myself.

The event was preceded by the conference of FIQ, the Quebec nurses and midwives union, and while observing that conference and visiting a local hospital our delegation learned of the similar struggles faced in Quebec to combat violence against nurses and midwives, achieve mandated staffing levels, combat the deprofessionalisation of care, and to ensure competitive remuneration to attract nurses and midwives in an internationally competitive market.

Ms Harkin-Kelly gave a comprehensive address to the FIQ conference dealing with the challenges that have faced nurses and midwives in recent years, the INMO's work to militate against the worst excesses of the employers, our important achievements in advancing terms and conditions, and our plans for the future. The president then participated in a panel discussion and explained how our members have, despite the worst of circumstances, maintained solidarity and in doing so have made progress.

The GNU conference saw nursing and midwifery leaders from 17 countries discuss a range of issues of common concern. The conference first reflected on the status and role of the GNU as the only global network of nursing and midwifery unions. In founding the GNU, the INMO, among other nursing and midwifery leaders, recognised the importance of a global network of activists whose sole concern was the status of nurses and midwives. The GNU provides a vital link in the advocacy work undertaken

across the world to improve the terms and conditions of members.

Reflecting on violence in the workplace, the GNU has adopted an initiative, spearheaded by the INMO, to establish an international action network of nursing and midwifery trade unions to respond to attacks on healthcare workers and facilities in times of conflict. This initiative is the first of its kind and is supported by Amnesty International and the Safeguarding Healthcare in Conflict Coalition.

The INMO will co-ordinate this network on behalf of the GNU and where we become aware of such attacks, we will urgently raise these issues with our domestic governments and international governmental organisations. We also had an opportunity to consider the steps being taken to reduce attacks on healthcare workers in Quebec, and to attend a protest at a local hospital where reduced staffing levels were contributing to unsafe conditions and increased physical attacks on nurses.

One aspect of this network of action and information sharing is understanding how our colleagues internationally are facilitated or impeded in their ability to advocate on behalf of their members domestically. The conference heard of particular difficulties in Brazil, Paraguay and Guatemala in terms of our sister unions' abilities to effectively advocate on behalf of their members. In the face of accounts of persecution and criminalisation of union leaders, the GNU has agreed to initiate an international response to such, and each union has agreed to use the offices of their national government and relevant international organisations to seek assistance for these unions.

The conference also considered mandated staffing levels as an essential method of securing: safety for patients; better working conditions for members; and to resist budget to budget cuts that are dangerous for both patients and staff.

From an Irish perspective we reported on the ongoing and expanding work of the Taskforce on Staffing and Skills Mix in acute

medical and surgical areas; the progress made on midwife to birth-rate ratios; expansion of the taskforce methodology into the ED setting; plans for the future for the community; our wish to extend the taskforce methodology into care of the older person settings; and the emerging importance of staffing levels being reported on in the Oireachtas arising from the Section 10 Health Act Order issued by the Minister arising from our threatened industrial dispute.

We obtained important insights from recent research in Canada relating to overall healthcare savings associated with adequately resourced nursing budgets. Californian research also displayed systemic benefits of mandated staffing levels, and we learned of important work undertaken in Australia regarding mandated staffing levels in the aged care sectors. These insights add to our evidence base in advancing our efforts to obtain safe and effective staffing levels and skills mix.


At the request of the INMO, GNU also agreed to issue a statement in respect of World AIDS Day which coincided with the conference. GNU called for a recognition of the need for further action to end the epidemic, universal access to free testing, freedom from stigma arising from a diagnosis, an end to discrimination, and a reflection on the 'right to health' as an important motivator in increasing access to diagnosis, testing, treatment and counselling to bring this epidemic under control.

The conference also considered the effects of global warming and climate change and GNU has agreed to make this an action programme. Finally, it was agreed that GNU members would co-ordinate their actions around World Nurses' Day in 2018.

The conference was an important opportunity both to learn from the valuable work of others, to contribute to that work, and to build on the system of global solidarity which helps us to both defend our members and help others to defend theirs.

*Edward Mathews is INMO director of regulation and social policy*



**Xydalba™**   
500 mg  
(dalbavancin hydrochloride)  
powder for infusion

# IV antibiotic that could reduce pressure on nurses

An intravenous antibiotic that could help benefit patients and alleviate pressure on hospitals is now available in Ireland

CURRENTLY, IV antibiotic treatment for acute bacterial skin and skin structure infections (ABSSSI) can be administered in the hospital, through outpatient departments, or OPAT (Outpatient Parenteral Antimicrobial Therapy) centres. There are many health and social issues which can exclude patients from OPAT services, which can result in these patients being admitted and spending a period of time in hospital.<sup>1</sup>

Xydalba™ (dalbavancin hydrochloride) is an IV antibiotic for the treatment of ABSSSI in adults. It is the first and only option for ABSSSI that gives a complete course of IV therapy delivered as a single 30-minute infusion and offers the opportunity for these patients to be treated and discharged home earlier.<sup>3</sup> Xydalba can be delivered as either one 1500mg dose or as a two-dose regimen of 1000mg followed one week later by 500mg, each administered over 30 minutes.

Said senior staff nurse Sharon Falconer, who runs the Aberdeen Royal Infirmary OPAT centre: "Xydalba is a real step forward in how we treat patients. Instead of having to spend up to two weeks in hospital or make daily trips to OPAT, patients can have a 30-minute infusion and go home. Xydalba also reduces nurses' workloads as they are giving only one or two infusions compared to multiple infusions over several days in some cases. Also, if the patient remains in hospital, this not only uses resources, but increases the risk of patients contracting further infections."

Xydalba's clinical development programme also demonstrated that it was as effective and as well tolerated as other intravenous antibiotics.<sup>2,3,4</sup> Xydalba was also shown to be effective against MSSA and MRSA bacteria.<sup>2</sup>

ABSSSI can be potentially life-threatening. They include conditions such as cellulitis/erysipelas, wound infections and major skin (cutaneous) abscesses. There were nearly 6,000 admissions for cellulitis into public hospitals in Ireland in 2015, with each staying a mean average of seven days as in-patients at an average cost to the hospital of €818 per day.<sup>5,6</sup>

Compared to other IV antibiotics

## The Patient Experience

A patient who benefited from treatment with Xydalba is 35-year-old David who over the past two years has spent nearly 40 days in hospital as a result of three serious skin infections.

Once he was hospitalised for two weeks and on another two occasions more than 10 days each time, following recurring infections. However, when a serious skin infection occurred for a fourth time in June 2017, David was treated and discharged the same day, after being given Xydalba at an OPAT centre.

Explained David, who currently cares for his 79-year-old mother: "This new treatment makes a big difference. It means you can continue getting on with your day-to-day life.

"My mum had just come out of hospital when I had my last infection, so it was great that I didn't end up having to stay in hospital for two weeks, otherwise there would have been no-one to look after her."

that may need to be administered for several days and often require hospitalisation, in clinical trials, Xydalba successfully treated a majority of patients as outpatients.<sup>4</sup>

Over 26,000 patients have already been treated with dalbavancin hydrochloride globally.<sup>7</sup>

Xydalba is contraindicated in patients with hypersensitivity to the active substance or to any of the excipients. Caution should be exercised in patients with known hypersensitivity to other glycopeptides due to the potential for cross-hypersensitivity and in patients who present with symptoms indicative of clostridium difficile-associated diarrhoea during treatment with Xydalba.

Caution should be exercised when treating mixed infections in which Gram-negative bacteria are suspected; patients should also be treated with an appropriate antibacterial agent(s) against Gram-negative bacteria. The use of antibiotics may promote the overgrowth of non-susceptible micro-organisms. Rapid infusions of glycopeptide agents can cause reactions that resemble 'Red-Man Syndrome', including flushing of the upper body, urticaria, pruritus, and/or rash. Stopping or slowing the infusion may result in cessation of these reactions.

The most common adverse reactions occurring in ≥1 % of patients treated with dalbavancin were nausea (2.4%), diarrhoea (1.9%), and headache (1.3%)

and were generally of mild or moderate severity.

For further information go to [www.xydalba.co](http://www.xydalba.co)

Additional information is available on request.

Marketing authorisation number: EU/1/14/986/001. Date of revision of the text: March 16, 2017. For prescription only. Refer to Summary of Product Characteristics before prescribing: [www.medicines.org.uk/emc/medicine/32656](http://www.medicines.org.uk/emc/medicine/32656)

This article is sponsored by Cardione Pharma Corp, Correvio (UK) Ltd, Lakeside House, 1 Furzeground Way, Stockley Park, Uxbridge, UB11 1BD

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# Continuing professional development for nurses and midwives

Maintaining your competency  
Maintaining your registration

# education programmes

2018

PULL OUT



**Elizabeth Adams**  
Director of The Richmond  
Education and Event  
Centre

## 80 years on – INMO returns to delivering education in The Richmond

The Richmond Education and Event Centre will open in mid-February to welcome member nurses and midwives. It will be 80 years to the day since the Organisation first delivered post graduate programmes in The Richmond. The first few programmes will be used to commission the building and test the services before the formal opening in April 2018.

The INMO has been delivering education to nurses and midwives for more than 95 years. Over the decades the organisation has worked to empower nurses and midwives to achieve their full potential as key contributors to the health services in Ireland. The INMO was originally founded in 1919 as a branch of the Irish Women Workers' Union by a small group of nurses and midwives in Dublin who met to discuss improving pay conditions, and setting professional standards for the performance of their duties through a range of educational initiatives.

### A brief history of The Richmond

The site that both INMO buildings are on is post-medieval. The first Benedictine Convent was founded in 1688 on this site. In 1772 a new Act of Parliament sought to further improve the relief of the poor of Dublin. Among its provisions was one for the establishment of hospitals to be known

as 'Houses of Industry'. Subsequently the Hardwicke Fever Hospital (1803), The Richmond Surgical Hospital (1811), the Whitworth Medical Hospital (1817) and The Richmond Lunatic Asylum (1815) were built. The current Richmond Hospital was built in 1897 at an estimated cost of £25,000, paid for by the humane donations of a number of generous benefactors and officially opened in 1901.

The Richmond Hospital finally closed its doors as a hospital in 1987. In 1996 The Richmond building was leased by the government Office of Public Works for use as District Courts. The Irish Nurses and Midwives Organisation purchased the building for members as an education and event centre.

The rich history of the Organisation has been documented since 1925 in the INMO's regular member publications – which have had various names and differing content and scope throughout the years. These publications also detail the changing professional, educational and social structures of the nursing and midwifery professions in Ireland throughout the 20<sup>th</sup> century, as well as labour and women's histories.



*Irish Nurses Organisation Postgraduate Graduate Education Programme February 14, 1938*

**A POST-GRADUATE COURSE FOR NURSES**  
will be held in the Richmond Hospital (by kind permission of the Governors and Lady Superintendent)  
From Monday the 14th to Saturday the 19th inclusive.  
Tickets 10/6 each, to be had from the Lady Superintendent, Richmond Hospital, or the Secretary, Irish Nurses' Organisation, 24 Nassau Street, Dublin.

*Irish Press February 10, 1938, pg 14*

"No words of praise or thanks can adequately convey our appreciation of what Matron, Nursing and Medical Staff of the Richmond Hospital have done and also our 'Guest Lecturers' who were called in with very short notice and who responded so readily. Happy memories of these days in the Richmond will linger long in the minds of those who availed of the privilege of attending the course. During the week it was obvious that the spirit of service animated both teacher and pupil with the desire to help further the noble work they were all devoted to 'the care of the sick.' We hope that this will prove an inspiration to many a nurse who is valiantly doing her duty, sometimes in spite of heavy odds."

*Editorial, Irish Nurses Journal, April 1938, pg 95*

In 1938 the Irish Nurses Organisation (INO) delivered our inaugural postgraduate annual programmes which commenced on February 14, 1938 in the Richmond Hospital. It is with pride that we will deliver programmes 80 years on, to the day, with nurses and midwives who are members of the INMO owning this landmark building. In addition to the building enhancing and supporting all INMO services for members, the investment has been proven to be very wise for INMO members with the recent reinstatement value of € 10, 449300. Our educational opportunities for nurses and midwives take place in a range of geographical areas and will also be provided from the new centre. Once the building is fully tested, in April 2018 members will be able to book a tour to see the building through our INMO Professional website. There will be a sequence of tours throughout the year, but booking early to secure your preferred slot is recommended.

In preparation for the opening, a wider variety of programmes have been developed and are available on the INMO Professional website and published in the current edition of Education and Continuing Professional Development Directory for Nurses and Midwives - Maintaining Your Competency; Maintaining Your Registration. The Directory features the Richmond Education and Event Centre and includes more than 100 education programmes with Category 1 approval from the NMBI and dedicated continuing education units (CEUs). In addition, the Directory provides information about the many ways the INMO Professional service can assist nurses and midwives with their professional development needs. The Directory provides a full listing of all our education programmes with an overview, an outline of the day, learning outcomes and a sample reading list. To assist in recording continuing professional development (CPD), sample templates are included. It also provides information on how to use the INMO Professional website – an online resource dedicated to education, research and continuing professional development for nurses and midwives in Ireland – as well as outlines on how to book one of the INMO Professional Development programmes. The website includes a safe and secure online booking system, a facility to maintain your professional profile and CPD record. It also includes reading lists and the new calendar of events.

The INMO Professional website ([www.inmoprofessional.ie](http://www.inmoprofessional.ie)) is an online service which provides access to booking all events such as education programmes and conferences 24 hours a day, seven days a week. Additionally, our telephone booking service is available to you during office hours at Tel: 01 6640641 or by email: [pdcc@inmoprofessional.ie](mailto:pdcc@inmoprofessional.ie).

# Education Programmes

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

**Venue:** INMO Professional Development Centre,  
The Whitworth Building,  
North Brunswick Street,  
Dublin 7

**Tel:** 01 664 0641/01 664 0618.

**Email:** [pdc@inmoprofessional.ie](mailto:pdc@inmoprofessional.ie)



Check out our New Courses at the Professional Development Centre!  
For more information log onto [inmoprofessional.ie](http://inmoprofessional.ie)



| Date   | Programme   | Fee                            | CEUs |
|--------|---|--------------------------------|------|
| Feb 28 | <b>Wound Care Management</b>  | €90 members; €145 non-members  | 5    |
|        | This programme enhances professional competency in the area of wound care management as per the latest research and the Health Service Executive National Best Practice and Evidence-Based Guidelines for Wound Management. An overview will be provided on the physiology of acute and chronic wounds as well as differences in their treatment. Participants will be advised on how to conduct a holistic assessment of a patient with a wound and implement a care plan. Topics that will be covered include: wound healing, wound bed preparation and treatment options, as well as a practical workshop on dressing selection.   |                                |      |
| Feb 28 | <b>Training Delivery and Evaluation Module 6N3326 – Level 6 QQI</b>   | €625 members; €875 non-members | 34   |
|        | See page 36 for details of this programme. Please note in your diary that the 28th February 2018 is the closing date for members to avail of special early bird rate of €550.   |                                |      |
| Mar 1  | <b>Introduction to Palliative Care</b>  | €90 members; €145 non-members  | 5    |
|        | This programme will explore the principles and practice of palliative care and provide nurses with skills and tools to support people in their end of life journey. It will focus on the holistic care of the patient including the physical, psychosocial and philosophical aspects of palliative care. The individual needs of each patient will be explored and the role of the nurse, symptom management and pain management will be explored. Death, last offices and care after death will be discussed. Guidance will be provided on how to communicate effectively with persons with a life-limiting illness in the last days of a person's life and also with their families, carers and significant others.               |                                |      |
| Mar 6  | <b>Subcutaneous Administration of Fluids</b>  | €95 members; €145 non-members  | 5    |
|        | This programme will educate participants in the administration of fluids by the subcutaneous route. It will cover topics such as accountability, indications for subcutaneous infusion, suitable sites and identification of fluids most commonly used. Calculation of the rate of infusion, the principles of an aseptic technique and complications which could occur before, during or after the procedure will be explored. While this programme will provide the necessary knowledge and skills to undertake subcutaneous administration of fluids, it will be necessary for each nurse and midwife attending to ensure that they abide by their local policy on subcutaneous administration of fluids in their place of work. |                                |      |
| Mar 7  | <b>Competency-based Interview Skills</b>  | €90 members; €145 non-members  | 5.5  |
|        | This programme assists participants to prepare for a competency-based interview, which is based on the premise that past experience can predict future behaviour. This is an increasingly common style of interviewing that enables candidates to show how they would demonstrate certain behaviours and skills in the workplace by answering questions about how they have reacted to, and dealt with, previous workplace situations. The programme will provide an overview of curriculum vitae development and will outline the steps in the interview process. Role play will be used to ensure that participants are able to communicate their knowledge and experience effectively for any future interviews.                 |                                |      |
| Mar 8  | <b>Overcoming Weight Stigma in Healthcare</b>   | €95 members; €145 non-members  | 5.5  |
|        | This programme will explore research on weight stigma in health care and provide tips and tools to support patients of all sizes to live healthy lives. It is based on the 'Preventing weight bias' toolkit (developed by the Rudd Centre for Food Policy and Obesity), the 'Health at every size' principles (a social justice movement) and 'Body mind intelligence' (a workbook developed by Peggy Stella, exercise physiologist). Recent research suggests that weight stigma may influence the quality of care and outcomes for patients who are obese, and is a barrier to attending medical appointments. This programme will equip participants with tools to help mitigate weight stigma.                                  |                                |      |

| Date        | Programme  | Fee                                | CEUs |
|-------------|--|------------------------------------|------|
| Mar 13      | <b>Best Practice in Medication Management</b>  | €90 members; €145 non-members      | 5    |
|             | <p>This education programme supports nurses and midwives in providing safe, evidence-based practice in the area of medication management. The programme will cover key topics such as: the key principles of medication management, the medication management cycle, management of controlled drugs and medication safety. Furthermore, it will explore relevant policy and legislation and will present scenarios in order to illustrate the various principles. Participants will have the opportunity to update their knowledge in line with the most up-to-date Nursing and Midwifery Board of Ireland and Health Information and Quality Authority requirements for medication management.</p>                          |                                    |      |
| Mar 14      | <b>Introduction to Clinical Audit</b>  | €95 members; €145 non-members      | 5    |
|             | <p>This programme equips participants with the necessary skills to implement clinical audit in their practice and enable them to deliver evidence of improved performance for safer and better care for patients. Participants will be provided with an overview of clinical audit and be informed about each stage in the clinical audit cycle: topic selection, standards development, data collection, data analysis, reporting, implementing changes and re-audit. A detailed overview will be given on the characteristics and dimensions of quality as well as how best to measure and monitor quality in the workplace. There will be an emphasis on continuous quality and safety improvement in healthcare.</p>     |                                    |      |
| Mar 14      | <b>Assessment and Management of the Patient with Sepsis</b>  | €90 members; €145 non-members      | 5    |
|             | <p>This programme enables nurses and midwives to increase their knowledge, experience and clinical skills to meet the complex and varied needs of patients with sepsis. Sepsis can occur at any age and in any clinical situation. It is considered a medical emergency and continues to have a high mortality rate despite advances in treatment. This course assists nurses and midwives with the skills and knowledge to take the lead in the assessment and management of sepsis. Early identification of sepsis and the implementation of appropriate interventions in a timely manner can improve patient outcomes.</p>  |                                    |      |
| Mar 20      | <b>Healthcare provider CPR and AED: Adult, child and infant</b>  | €125 members; €195 non-members     | 6    |
|             | <p>This Healthcare Provider Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillation (AED) programme provides the theory, rationale and practical skills reflecting the latest American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care. Adult, child and infant CPR and AED will be covered. The course will use video, practice and discussion as well as a practical and written assessment. Nurses and midwives are required to adhere to a two-year certification period for basic and advanced life support. Successful completion of this programme will assist participants in meeting this requirement.</p>                           |                                    |      |
| Mar 21      | <b>Retirement Planning Seminar</b>   | €10 members; €45 non-members       |      |
|             | <p>See page 70 for the full details of our retirement planning seminar which has been designed to ensure that you are fully prepared for a secure retirement.</p>  |                                    |      |
| Mar 27      | <b>Practical Skills in the Management of People with Diabetes</b>  | €90 INMO members; €145 non-members | 5    |
|             | <p>This programme provides nurses and midwives with understanding, knowledge and confidence when delivering care to individuals with diabetes. It offers a practical approach to diabetes. Many theoretical aspects of diabetes are covered such as: the different types of diabetes, national and international guidelines, how to offer lifestyle advice to patients, treatment options, and understanding blood results, as well as dealing with complications in diabetes. Continuing professional development through this education programme promotes excellence amongst nurses and midwives who provide care to the patient with diabetes, informed by current best practice and evidence-based learning.</p>        |                                    |      |
| Mar 27 & 28 | <b>Management in Practice</b>  | €220 members; €350 non-members     | 5    |
|             | <p>This two-day programme is an intense, comprehensive and participative workshop developed to improve effectiveness in managing people and processes. It is focused on the changing role of management, as well as coaching, motivating and developing participants. It will stimulate participants' thinking and guide them through a review and assessment of how to put managerial skills into practice. Respected well-trained managers boost morale, and improved morale boosts staff retention. The programme will guide nurses and midwives in how best to encourage colleagues to realise their potential so that standards, competency, skills and exceptional care is provided at all times.</p>                  |                                    |      |
| Apr 11      | <b>Promoting Safe and Effective Medication Management for Older People in Residential Care</b>   | €90 members; €145 non-members      | 5.5  |
|             | <p>This programme focuses on the professional, legal and best practice requirements for safe and effective medication management for older people at all stages of the medication management cycle. Medication management is a fundamental activity of nursing, which carries important responsibilities in terms of promoting both the efficacy and safety of meeting residents' medication needs. Recent regulatory documents emphasise additional responsibilities of nurses in safeguarding residents' rights in the medication management cycle. These include the right to make autonomous decisions, which place additional responsibilities on nurses to ensure that residents are supported in decision making.</p> |                                    |      |



| Date        | Programme   | Venue | Fee                                   | CEUs                 |
|-------------|---|-------|---------------------------------------|----------------------|
| Apr 11      | <b>Phlebotomy</b>   |       | <b>€90 members; €145 non-members</b>  | <b>4</b>             |
|             | <p>This programme provides participants with the skill and theory to perform phlebotomy in a competent and safe manner. It will cover topics such as sites used for phlebotomy, criteria for evaluating a vein, principles of an aseptic technique as well as complications that may arise during and after the procedure. Guidance will be given on how to reassure the individual in relation to the procedure and on gaining their consent. While this course will provide the necessary knowledge and skills to undertake phlebotomy, it will be necessary for each nurse and midwife attending to ensure that they abide by their local policy on phlebotomy in their place of work.</p>   |       |                                       |                      |
| Apr 17 & 18 | <b>Coaching your people to improved performance</b>   |       | <b>€220 members; €350 non-members</b> | <b>13</b>            |
|             | <p>This new two day programme is aimed at nurses and midwives who work in management. It outlines how to use coaching to support staff development and attainment of organisational goals. Coaching helps the individual (coachee) manage their responsibilities, develop new skills and improve their well-being. It is a form of personalised support which can assist in dealing with any issues which are impacting on performance. The coach's role is to understand and believe in the potential of the coachee and guide them towards greater self-awareness, with a view to enabling the individual to achieve their professional and personal goals.</p>   |       |                                       |                      |
| Apr 17      | <b>Mindfulness and meditation in holistic nursing and midwifery care</b>  |       | <b>90 members; €145 non-members</b>   | <b>5</b>             |
|             | <p>Mindfulness and meditation practice can bring positive change both personally and professionally. This programme aims to harness the nurse or midwife's ability to provide holistic care with compassion and to bring positive change in the lives of their patients. Participants will learn techniques for incorporating mindfulness and meditation into their work and daily routine, which will facilitate them to promote stress management and relaxation in their patients. Topics explored during this programme include: the role of mindfulness in holistic care, self-awareness, compassion, holistic communication and the power of stillness of mind.</p>   |       |                                       |                      |
| Apr 18      | <b>Introduction to leadership for nurses and midwives</b>   |       | <b>€90 members; €145 non-members</b>  | <b>Awaiting CEUs</b> |
|             | <p>This new one-day programme provides an introduction to key leadership perspectives and approaches relevant to nurses and midwives. The programme explores how leadership has evolved to reflect the changes in society and the healthcare environment. Participants will gain an understanding of key leadership theories and their applicability to healthcare. Topics that will be covered include: the evolution of leadership, leadership competencies, leadership and management, transformational leadership, collaborative and shared leadership.</p>   |       |                                       |                      |
| Apr 18      | <b>Getting the Most of Your Library: Advanced Searching</b>   |       | <b>€90 members; €145 non-members</b>  | <b>5</b>             |
|             | <p>This programme is aimed at nurses and midwives who would like to develop their information seeking skills in order to avail of the most up-to-date information for clinical practice, reflection and policy development. This programme will assist participants who are undertaking academic programmes and will provide them with valuable lifelong skills in information literacy. Guidance will be provided on the use of keywords, Boolean logic, and limiting and broadening of results. The programme involves a practical element whereby participants will have the opportunity to develop a search strategy and use it to search a database. Strategies for the evaluation and critique of online resources will be discussed.</p> |       |                                       |                      |
| Apr 19      | <b>Management Skills for Clinical Nurse Managers and Staff Nurses</b>   |       | <b>€90 members; €145 non-members</b>  | <b>5.5</b>           |
|             | <p>This programme outlines the key competencies required for ward managers to be effective in their roles as leaders and managers in healthcare delivery. Clinical managers perform both managerial and leadership functions in order to provide effective healthcare delivery to patients. The programme will explore both management and leadership functions and how these are applied in practice so as to promote quality and safety of care. Key topics covered include: management principles and competencies, team building, delegation and clinical supervision. Participants will gain effective management competencies that can be applied in the workplace to promote quality and safety in healthcare delivery.</p>              |       |                                       |                      |
| Apr 19      | <b>Leg ulcer Management</b>   |       | <b>€90 members; €145 non-members</b>  | <b>5</b>             |
|             | <p>This programme enables participants to distinguish between the different causes of ulceration and associated pathophysiology and also epidemiology, risk factors and assessment. It provides participants with an opportunity for continuing professional development to ensure that their practice is founded on the latest research and guidance. The programme will involve a practical aspect whereby various compression bandages and techniques will be presented as well as a demonstration on the use of a Doppler for assessment of the lower limbs. Psychosocial issues and the impact of living with a leg ulcer on the person's day-to-day life will also be explored.</p>   |       |                                       |                      |

| Date  | Programme  | Fee                                 | CEUs          |
|---|--|-------------------------------------|---------------|
| Apr 24  | <b>Healthcare provider CPR and AED: Adult, child and infant</b>  | €125 members; €195 non-members      | 6             |
| <p>This Healthcare Provider Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillation (AED) programme provides the theory, rationale and practical skills reflecting the latest American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiovascular Care. Adult, child and infant CPR and AED will be covered. The course will use video, practice and discussion as well as a practical and written assessment. Nurses and midwives are required to adhere to a two-year certification period for basic and advanced life support. Successful completion of this programme will assist participants in meeting this requirement.</p>  |  |                                     |               |
| Apr 24  | <b>Training Delivery and Evaluation – QQI Level 6</b>            | €625 INMO members; €875 non-members | 34            |
| <p>This is the first day of this new five day course which will equip the nurse/midwife with the knowledge, skill and confidence to plan, deliver, access learning and evaluate training provision. For details of the early bird and more details see page 36.</p>   |  |                                     |               |
| Apr 25  | <b>Falls prevention, management and review</b>                   | €90 members; €145 non-members       | 5.5           |
| <p>This programme promotes a consistent approach to falls reduction and management for older people through risk assessment, individualised care planning and post-falls review. It will outline causes and risks for falls and will assist participants to identify those patients or residents who are at risk of falls. Risk assessment tools such as FRAISE, FRAT and STRATIFY will be explored. There will be a focus on individualised care planning to mitigate falls and promote patient safety, and falls reduction techniques, with the aim of improving patient safety and minimising injuries in the older population. Participants will practise completing a post-falls review.</p>   |  |                                     |               |
| May 2   | <b>Pain Management</b>   | €90 members; €145 non-members       | 5             |
| <p>This programme promotes excellence in pain management as per current research and best practice. It will demonstrate how to recognise and differentiate patient's pain more confidently, through understanding the concepts, meaning and classification of pain. Participants will learn about the link between pain and increased anxiety, lack of sleep, poor appetite, and the increased risk of complications such as chest infections, deep vein thrombosis and pressure sores. The programme will examine the relationship of pain to delayed recovery and increased hospital stay. Participants will learn skills in the early recognition and treatment of pain to help enhance patient comfort, well-being and recovery from illness, injury and surgery.</p> |  |                                     |               |
| May 3   | <b>Principles of Palliative Care</b>                             | €90 members; €145 non-members       | 5.5           |
| <p>This programme offers participants an opportunity to deepen their understanding of the palliative care approach. It provides an overview from a holistic point of view and explores a range of relevant topics such as symptom recognition and assessment, as well as strategies for their management. The topics of loss, grief and bereavement, and end of life care will be explored in detail. The meaning of quality of life in the context of palliative care will be discussed and strategies for supporting individuals to live as actively as possible will be demonstrated. The programme will also provide suggestions for applying the palliative approach in practice when caring for those with life limiting illness.</p>                               |  |                                     |               |
| May 23  | <b>Introduction to change management for nurses and midwives</b> | €90 members; €145 non-members       | Awaiting CEUs |
| <p>Change is a constant in life. This programme is an introduction to key concepts related to change management. The programme aims to enhance the understanding of participants of change management and strategies to improve the potential for successful change initiatives. The programme will include the following topics: the nature of change, leading change, initiating change, understanding and managing resistance, change models, the importance of communication and the role of stakeholders.</p>  |  |                                     |               |

## Clinical Placement Co-ordinators Seminar – date for your diary

This year the Clinical Placement Co-ordinators Section's seminar will take place on Thursday, 17 May 2018, in the INMO Professional Development Centre, from 10.00am – 3.00pm. Book this date in your diary as last year's event was very well attended and early booking is advisable.

For more details of this programme log on to [www.inmoprofessional.ie](http://www.inmoprofessional.ie) or call **01 6640641/18**

**Date:** Thursday, May 17

**Time:** 10am - 3pm

**Venue:** Professional Development Centre INMO HQ

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

Awaiting CEUs





# Education programmes coming to other venues



| Date   | Programme  | Venue                | Fee                            | CEUs |
|--|--|----------------------|--------------------------------|------|
| Feb 21   | <b>Promoting Safe and Effective Medication Management for Older People in Residential Care</b> | INMO Cork Office     | €90 members; €145 non-members  | 5.5  |
| <p>This programme focuses on the professional, legal and best practice requirements for safe and effective medication management for older people at all stages of the medication management cycle. Medication management is a fundamental activity of nursing, which carries important responsibilities in terms of promoting both the efficacy and safety of meeting residents' medication needs. Recent regulatory documents emphasise additional responsibilities of nurses in safeguarding residents' rights in the medication management cycle. These include the right to make autonomous decisions, which place additional responsibilities on nurses to ensure that residents are supported in decision making.</p> |  |                      |                                |      |
| Feb 27 & 28  | <b>Management in Practice</b>  | INMO Cork Office     | €220 members; €350 non-members | 5    |
| <p>This two-day programme is an intense, comprehensive and participative workshop developed to improve effectiveness in managing people and processes. It is focused on the changing role of management, as well as coaching, motivating and developing participants. It will stimulate participants' thinking and guide them through a review and assessment of how to put managerial skills into practice. Respected well-trained managers boost morale, and improved morale boosts staff retention. The programme will guide nurses and midwives in how best to encourage colleagues to realise their potential so that standards, competency, skills and exceptional care is provided at all times.</p>                  |  |                      |                                |      |
| Feb 27   | <b>Phlebotomy</b>  | INMO Limerick office | €90 members; €145 non-members  | 4    |
| <p>This programme provides participants with the skill and theory to perform phlebotomy in a competent and safe manner. It will cover topics such as sites used for phlebotomy, criteria for evaluating a vein, principles of an aseptic technique as well as complications that may arise during and after the procedure. Guidance will be given on how to reassure the individual in relation to the procedure and on gaining their consent. While this course will provide the necessary knowledge and skills to undertake phlebotomy, it will be necessary for each nurse and midwife attending to ensure that they abide by their local policy on phlebotomy in their place of work.</p>                                |  |                      |                                |      |
| Mar 7  | <b>Wound Care Management</b>   | INMO Cork office     | €90 members; €145 non-members  | 5    |
| <p>This programme enhances professional competency in the area of wound care management as per the latest research and the Health Service Executive National Best Practice and Evidence-Based Guidelines for Wound Management. An overview will be provided on the physiology of acute and chronic wounds as well as differences in their treatment. Participants will be advised on how to conduct a holistic assessment of a patient with a wound and implement a care plan. Topics that will be covered include: wound healing, wound bed preparation and treatment options, as well as a practical workshop on dressing selection.</p>   |  |                      |                                |      |
| Mar 22   | <b>Phlebotomy</b>  | INMO Cork office     | €90 members; €145 non-members  | 4    |
| <p>This programme provides participants with the skill and theory to perform phlebotomy in a competent and safe manner. It will cover topics such as sites used for phlebotomy, criteria for evaluating a vein, principles of an aseptic technique as well as complications that may arise during and after the procedure. Guidance will be given on how to reassure the individual in relation to the procedure and on gaining their consent. While this course will provide the necessary knowledge and skills to undertake phlebotomy, it will be necessary for each nurse and midwife attending to ensure that they abide by their local policy on phlebotomy in their place of work.</p>                                |  |                      |                                |      |
| May 15   | <b>Wound Care Management</b>   | INMO Limerick office | €90 members; €145 non-members  | 5    |
| <p>This programme enhances professional competency in the area of wound care management as per the latest research and the Health Service Executive National Best Practice and Evidence-Based Guidelines for Wound Management. An overview will be provided on the physiology of acute and chronic wounds as well as differences in their treatment. Participants will be advised on how to conduct a holistic assessment of a patient with a wound and implement a care plan. Topics that will be covered include: wound healing, wound bed preparation and treatment options, as well as a practical workshop on dressing selection.</p>   |  |                      |                                |      |

[inmoprofessional.ie](http://inmoprofessional.ie)

If you forgot your username/password – Tel: 01 6640641/01 6640618

or email: [pdc@inmoprofessional.ie](mailto:pdc@inmoprofessional.ie)



# JOANNA BRIGGS INSTITUTE EVIDENCE BASED PRACTICE DATABASE

This month the Library is going to focus on the Joanna Briggs Institute Evidence Based Practice database which is available to all members through [www.nurse2nurse.ie](http://www.nurse2nurse.ie). There is a wealth of useful information included in this database

The Joanna Briggs Institute is an internationally renowned research and development centre and a leading body in evidence based practice. The database includes a comprehensive range of resources including over 3,000 full text records in seven publication types. The database covers a wide range of subject areas and would appeal to both students and clinician groups. Like Cochrane Library, JBI produces systematic review protocols and systematic reviews, however, it goes further to show this research in practice with evidence summaries, evidence-based recommended practices, best practice information sheets and consumer information sheets. To use the Joanna Briggs Institute Evidence Based Practice database, just type what you are looking for into the search box and click on search. You can then limit the results to information type such as evidence summaries or best practice information sheet. Below we highlight some of the recently published and updated topics.

## Care of the older person

- *Falls: risk factors in the elderly* - evidence summary. What is the best available evidence regarding risk factors for falls in the elderly?
- *Oral health: implementation strategies for residential care* - evidence summary. What is the best available evidence regarding implementation strategies for improving the oral health of older people in residential care facilities?
- *Risk assessment of malnutrition: older people* - evidence summary. What is the best available evidence regarding the risk assessment of older people for malnutrition?

## Midwifery

- *Labour: transcutaneous electrical nerve stimulation (TENS) for pain relief* - evidence summary. What is the best available evidence regarding the effectiveness of transcutaneous electrical nerve stimulation use for pain relief in labour?
- *Newborn washing: delayed bathing* - evidence summary. What is the best available evidence regarding newborn washing in the immediate postpartum period?
- *Breastfeeding: expression of breast milk* - evidence summary. What is the best available evidence regarding the methods of milk expression for lactating women?
- *Infants: pacifier use* - evidence summary. What is the best available

evidence regarding the impact of pacifier use on breast feeding, sudden infant death syndrome (SIDS), infection and dental malocclusion?

## Wound care and management

- *Pressure injuries: preventing medical device related pressure injuries* - evidence summary. What is the best available evidence on prophylactic dressings to prevent medical device related pressure injuries (MDRPI)?

## Paediatrics

- *Sedation (paediatric): diagnostic and therapeutic procedures* - evidence summary. What is the best available evidence regarding sedation of paediatric patients undergoing diagnostic and therapeutic procedures?
- *Obesity (childhood): treatment* - evidence summary. What is the best available evidence regarding the effectiveness of interventions for the management of obesity in children?

## General

- *Basic life support: clinician information* - evidence summary and recommended practices. What is the evidence on the use of basic life support?
- *Injection: subcutaneous* - evidence summary. What is the best available evidence on subcutaneous injection?

## Surgical services

- *Surgical Site Infection: Surgical Hand Scrubs and Gloving* - recommended practices. What is the best available evidence regarding infection control strategies in pre-anaesthesia and intraoperative during surgery?
- *Medication safety in the perioperative setting* - evidence summary. What is the best available evidence regarding medication safety in the perioperative setting?

## Community health

- *Blood pressure: aerobic exercise* - evidence summary. What is the best available evidence on the effects of aerobic exercise on blood pressure in adults over 18 years?

## Library assistance

If you would like to learn more about Joanna Briggs Institute Evidence Based Practice Database or would like any further information about the library, please contact the INMO Professional Library on 01 6640614/25 or email: [library@inmo.ie](mailto:library@inmo.ie). Opening hours: Monday to Thursday: 8.30am - 5.00pm and Friday: 8.30am - 4.30pm.

## Getting the most from your library: Advanced Library Searching Techniques

**Next course date: Tuesday, February 27, 2018**

**Venue:** INMO HQ, The Whitworth Building, North Brunswick Street, Dublin 7

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

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



# Pregnancy associated dyspepsia

In the latest clinical update from Clarity Informatics, Rebecca Elliot, Nina Thirlway and Gerry Morrow focus on dyspepsia in pregnancy

DYSPEPSIA is a term used to describe a number of symptoms associated with the upper gastrointestinal tract that may include upper abdominal pain or discomfort, a feeling of upper abdominal 'fullness' or 'heaviness', reflux, heartburn, belching, nausea and vomiting. Dyspepsia in pregnancy is commonly due to gastro-oesophageal reflux.<sup>1</sup>

The cause of gastro-oesophageal reflux disease (GORD) in pregnancy is thought to involve both mechanical and hormonal factors. A decrease in lower oesophageal sphincter pressure is considered to be the predominant factor. Rising levels of progesterone and oestrogen are thought to be responsible for the decreased pressure. Altered oesophageal and gastric motility and increased abdominal pressure may also contribute, but the evidence to support their role is uncertain.<sup>2,3</sup>

## Symptoms of GORD

Gastro-oesophageal symptoms can start at any stage of pregnancy. The prevalence appears to increase with gestational age, with 30–80% of women suffering from dyspepsia at some time during their pregnancy.<sup>4</sup>

A study of the evolution of GORD symptoms during pregnancy found that of pregnant women, 12.5% had heartburn at least once a week in the first trimester, 21.5% in the second trimester and 35.3% in the third trimester. Daily heartburn occurred in around 10% of women in the third trimester. In the third trimester, 40.7% of women experienced regurgitation at least once a week (compared with 3.6% of non-pregnant women).<sup>4</sup>

Symptoms of gastro-oesophageal reflux prior to pregnancy, increasing gestational age and parity have been associated with gastro-oesophageal reflux symptoms in pregnancy.

The evidence for pre-pregnancy body mass index (BMI), weight gain during

pregnancy and maternal age as risk factors for GORD symptoms during pregnancy is less certain.<sup>3,5</sup>

Symptoms usually resolve without complications, however dyspepsia during pregnancy may increase the risk of developing subsequent gastro-oesophageal reflux symptoms in the future.

Heartburn and gastro-oesophageal reflux is associated with an increased severity of nausea and vomiting in pregnancy; managing heartburn and reflux may improve the severity of nausea and vomiting in pregnancy. Quality of life can be affected by dyspepsia symptoms.

Rarely, erosive oesophagitis, strictures, and bleeding may occur.<sup>3,6</sup>

Once gastro-oesophageal reflux symptoms have developed, there is a high likelihood (approximately 50% each trimester) of the symptoms persisting during the pregnancy. However, in most women, symptoms can be improved with lifestyle modifications and will disappear shortly after delivery. The severity and frequency of gastro-oesophageal reflux symptoms are thought to increase as pregnancy advances, but these findings are not consistent in all studies.<sup>3,4,5</sup>

## Diagnosis of GORD in pregnancy

Dyspepsia in pregnancy is predominantly caused by GORD. The diagnosis can be made on symptoms alone. A detailed history should be taken including:

- Questions about any previous history of dyspepsia or reflux symptoms
- The woman should also be asked about any other symptoms (such as abdominal pain and poor appetite) and how they are affecting her quality of life
- Aggravating factors include lying flat, eating food, and some medications such as nonsteroidal anti-inflammatory drugs (NSAIDs) should be discussed
- Alarm features include vomiting blood (haematemesis), weight loss and

difficulty swallowing (dysphagia) which suggests more serious underlying disease.

Ask the woman about treatments already tried, especially over-the-counter medication (for example antacids) and any features which may suggest an illness unrelated to pregnancy (for example symptoms of fever, rigors, vomiting and malaise).<sup>2,3,7</sup>

Examination is usually normal and investigations are generally not necessary. Where they are required, they are usually carried out in secondary care and may include manometry and pH probes, an upper GI endoscopy and non-invasive testing for *Helicobacter pylori*, which may be delayed until after delivery.<sup>1,2,3</sup>

Differential diagnoses include nausea and vomiting of pregnancy, pre-eclampsia, HELLP syndrome (haemolysis, elevated liver enzymes and low platelets), acute fatty liver of pregnancy (this is rare).<sup>7</sup>

Disorders unrelated to pregnancy which may present as GORD include gastric cancer, peptic ulcer disease, pancreatitis, cholecystitis, appendicitis, irritable bowel syndrome, acute viral hepatitis and cardiac disease.<sup>7</sup>

## Management

Give lifestyle advice as first-line management, advise the woman to eat smaller meals more frequently (every three hours), not to eat late at night (or less than three hours before bedtime), and to avoid known gut irritants (such as alcohol, caffeine, fruit juices and carbonated drinks, chocolate, and fatty and spicy foods).

Advise the woman to keep a food diary to identify triggers. She should avoid medications that may cause or worsen symptoms, if appropriate such as calcium-channel antagonists, antidepressants, and NSAIDs. If she smokes, advise the woman to stop. She may also try raising the head of her bed by 10–15cm.<sup>3,7</sup>

Offer patient information such as the

'Dyspepsia in Pregnancy' guide from the Health Service Executive at [www.hse.ie/eng/health/az/D/Dyspepsia-in-pregnancy](http://www.hse.ie/eng/health/az/D/Dyspepsia-in-pregnancy). Advise the woman to return if symptoms are not controlled by lifestyle changes, or if worsening or new symptoms develop.

#### Treatment

Antacids and alginates are recommended as first-line treatments, if symptoms are relatively mild and are not controlled adequately by lifestyle changes. Antacid products containing combinations of aluminium and magnesium (co-magaldrox) are recommended on an 'as required' basis, for example Maalox (off-label in pregnancy, not recommended for under 14 years of age) and Mucogel (off-label in pregnancy). Alginate products (for example Gaviscon Advance) are particularly useful if symptoms of gastro-oesophageal reflux are dominant.

Antacids are considered to be a non-systemic drug therapy, they are fast-acting and effective at providing quick symptomatic relief. Alginates are particularly useful where reflux symptoms predominate as they create a mechanical barrier by forming a 'raft' floating on top of the gastric contents.

Products containing magnesium and aluminium are generally preferred (except for magnesium trisilicate). They have limited absorption and no evidence of teratogenic effects. Be aware that magnesium-containing antacids may have a laxative effect,

aluminium-containing antacids may have a constipating effect, and calcium-containing antacids can cause rebound acid secretion, hypercalcaemia and alkalosis, and milk-alkali syndrome at prolonged high doses. Calcium-containing products are recommended for short-term or occasional use. Products containing sodium bicarbonate or magnesium trisilicate are not recommended in pregnancy.

If symptoms are severe, or persist despite treatment with an antacid or alginate, an acid-suppressing drug may be considered, such as ranitidine or omeprazole.

#### Referral

A woman should be referred immediately (same-day) if there is dyspepsia and significant acute gastrointestinal bleeding. Referral should be made urgently to a gastroenterologist if there are features suggestive of malignancy. Note that the classical alarm features of weight loss, an epigastric mass, persistent abdominal pain or iron deficiency anaemia may be difficult to interpret in pregnancy.<sup>1</sup>

A woman should be referred non-urgently to a gastroenterologist if symptoms do not adequately respond to antacids, alginates, ranitidine or omeprazole, the woman is unable to eat sufficiently because of symptoms, or there is doubt about the diagnosis.<sup>1</sup>

Referral to an obstetrician should be made if symptoms suggest a

pregnancy-related disorder other than dyspepsia, for example pre-eclampsia or HELLP syndrome (haemolysis, elevated liver enzymes, and low platelets) – clinical judgement should be used regarding the urgency of referral depending on the presenting problem.<sup>1</sup>

*Dr Rebecca Elliot is clinical author at Clarity Informatics, Nina Thirlway is style editor at Clarity Informatics and Dr Gerry Morrow is editor and medical director at Clarity Informatics. Clarity Informatics is contracted by the National Institute for Health and Care Excellence (NICE) to provide clinical content for the Clinical Knowledge Summaries service available through the Clarity Informatics Prodigy website at: [prodigy-knowledge.clarity.co.uk](http://prodigy-knowledge.clarity.co.uk)*

*References (full reference list available from Prodigy Dyspepsia – pregnancy-associated and management topic. <https://prodigy-knowledge.clarity.co.uk/>)*

1. NICE. Gastro-oesophageal reflux disease and dyspepsia in adults: investigation and management. (2014). Available from <https://www.nice.org.uk/guidance/cg184> [Accessed 2nd January 2018]
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Please be advised that there may be more than one correct answer to the Multiple-Choice Questions listed below. The correct answers (given below in the inverted text) are those deemed most appropriate by the author in the context of this CPD article.

#### 1. Symptoms of dyspepsia include:

- A) Upper abdominal discomfort
- B) Reflux
- C) Heartburn
- D) Belching

#### 2. In the third trimester what percentage (approximate) of women experience regurgitation?

- A) 10%
- B) 41%
- C) 13%
- D) 4%

#### 3. What do the differential diagnoses for dyspepsia in pregnancy include?

- A) Nausea and vomiting of pregnancy
- B) Peptic ulcer disease
- C) Gestational diabetes
- D) Symphysis pubis dysfunction (SPD)

#### 4. Lifestyle advice for women with dyspepsia in pregnancy should include:

- A) Raise the head of the bed by 10-15cm
- B) Raise the foot of the bed by 10-15cm
- C) Eating smaller meals, more frequently
- D) Eating larger meals, less often

#### 1. First-line treatment for dyspepsia in pregnancy include:

- A) Ranitidine
- B) Antacids and alginates
- C) Omeprazole
- D) Non-steroidal anti-inflammatory drugs

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.

## CPD Quiz



For further information and resources: [www.clarity.co.uk](http://www.clarity.co.uk)

Clarity  
informatics

Answers: Question 1: A, B, C, D Question 2: B Question 3: A, B Question 4: A, C Question 5: B



## Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick



### Query from member

I have a question about acting up and superannuation. I am acting up and a CNM1. Will this higher grade be taken into account for pension purposes?

### Reply

In 2016, the HSE issued a circular (018/2016) regarding temporary contracts to posts of a higher grade. This circular outlines the terms and conditions of the temporary assignment. With regard to superannuation, the circular outlines that:

- The permanent substantive grade and salary of an employee awarded a temporary contract to a post at a higher grade will not be impacted by the temporary appointment
- The employee will continue to accrue service at their

permanent substantive grade and this is the relevant grade for superannuation purposes

- The additional monies reflecting the difference between the permanent substantive salary and the salary of the higher post will, for pension purposes, continue to be treated as follows:

Employees that are appointed to a higher grade in a temporary capacity with remuneration at a level that applies to the temporary higher post are deemed to retain their permanent substantive grade and in this regard pensionable remuneration at retirement will be based on the salary relevant to the lower permanent substantive grade. The excess payment under the temporary contract up to the level of the higher post will be dealt with in accordance with the revised method of reckoning variable pensionable allowance for pension purposes ('best three in 10'). Should you have any queries in relation to this, please contact the INMO information office at Tel: 01 6640610/19.

### Query from member

I am a community RGN and have been made aware that I am entitled to a community RGN allowance reinstated following the recruitment and retention agreement. Is this the case?

### Reply

As part of the recruitment and retention agreement, the INMO secured the reinstatement of allowances removed in 2012. In December, the HSE issued circular 036/2017 which gave sanction to restore the following allowances:

- Midwifery qualification (public health nurse)
- Registered general nurse in the community
- Nurse co-ordinator allowance
- Specialist co-ordinator allowance (nurse tutors)
- Nurses assigned to occupational therapy.

Therefore, you are entitled to the registered general nurse in the community allowance, provided that you have a caseload. Any RGN in the community who does not have a caseload does not qualify. In the 2018 salary scales just issued from the HSE, the registered general nurse in the community allowance is €3,709 (if employed since January 1, 2010) or €3,904 (joined since September 1, 2008). Should you have any issue in relation to this please contact your local industrial relations officer or the INMO Information Office. Contact details can be found on <http://www.inmo.ie>

## 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](mailto:catherine.hopkins@inmo.ie), [karen.mccann@inmo.ie](mailto: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



# Quality & Safety

A column by  
Maureen Flynn



## Quality Care Metrics in nursing and midwifery

IN MANY health systems the contribution of nurses and midwives to high quality safe care has been difficult to measure. A national approach to the measurement of nursing and midwifery clinical care processes, entitled Quality Care Metrics (QCM) has been widely adopted across acute hospitals and community health-care organisations in Ireland. This month's column shares with you how research and the voice of nurses and midwives at the front-line of care have combined to determine the important areas of practice that can be measured; and outlines how you can find out more information to support you to incorporate QCM to achieve better service user experiences and care outcomes.

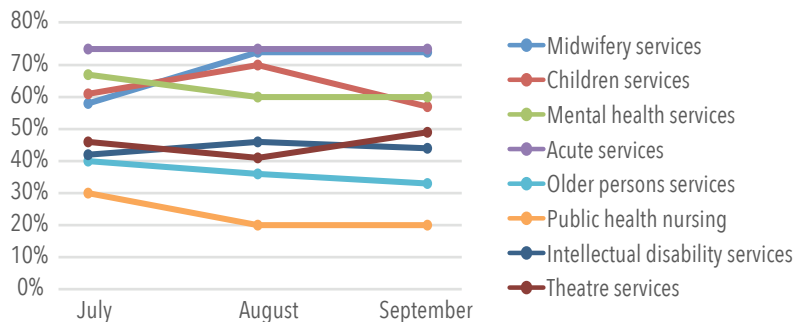
### Quality care-metrics

QCMs is a systematic method of measuring the care you provide. A web-based electronic audit system entitled 'Test Your Care' provides real-time quantifiable data on how your care processes are provided aligned to evidence-based and best practice standards. Measuring the degree to which these clinical care processes are delivered plays an important role in assuring, sustaining and improving the quality and safety of service user care.<sup>1</sup> The continual improvement in the quality and safety of care is part of our core nursing and midwifery values of care, compassion and commitment.<sup>2</sup> However, determining the important and fundamental aspects of our clinical care processes from the interpersonal and compassionate relationships of care to the technical aspects of what we do can be challenging to articulate.

### What we should measure

A range of QCMs are currently available for use, however feedback from front-line nurses and midwives recommended that a new suite of measures could reflect the contribution of nursing and midwifery in the following settings: (i) acute care; (ii) midwifery (iii) older persons; (iv) children's; (v) public health; (vi) mental health; and (vii) intellectual disability nursing.

Figure: Quarter 3 QCM National Status Report



A national research study conducted by UCD, UL and NUIG is now nearing completion that has incorporated the voice of nurses and midwives of all grades, across all settings, to determine and achieve consensus on the important aspects of nursing and midwifery care in Ireland that should be measured to ensure safe care. This study involved (i) a systematic review of the literature, (ii) a two-round online Delphi survey to determine the appropriate metrics, (iii) a two-round online Delphi survey to determine the indicators for the identified metrics, and (iv) consensus meetings with front-line staff and key experts. These new suites of metrics and indicators will be available for use on the 'Test Your Care' system in 2018.

### Who is using Quality Care Metrics?

The demand for QCMs and the participation of healthcare services from both the acute hospital and community healthcare organisations is continuing to increase. The *Figure* outlines the percentage of organisations currently collecting metrics data on the 'Test Your Care System' in Q3 of 2017.

### New Developments

To support the analysis of QCMs data an electronic clinical dashboard has been developed in conjunction with HSE ICT. The dashboard will enable the metrics data to be viewed in a range of formats to support effective decision making to improve care quality, patient safety and clinical outcomes. The dashboard will be available to demonstrator sites in 2018.

### Get involved

Whether you are an undergraduate nurse or midwife, or currently in clinical practice and want to become more involved in continuous quality improvement you can find out more about QCMs on the nursing and midwifery hub of HSE-land (<http://qcmhub.hseland.ie/>) or by contacting your local NMPDU.

### Learn more

Contact NMPDUs: West, Gillian Conway, Gillian.conway@hse.ie; South East, Leonie Finnegan, leonie.finnegan@hse.ie; South, Johanna Downey, johanna.downey@hse.ie; DML-Midland, Mary Nolan, mary.nolan13@hse.ie; DML-Dublin South, Ciara White, Ciara.white1@hse.ie; North West, Paula.kavanagh@hse.ie/Angela Killeen, anagela.killeen3@hse.ie/Deirdre Keown deirdre.keown@hse.ie; North Dublin, Caroline Kavanagh, caroline.kavanagh1@hse.ie; Dublin North East, Margaret Nadin, Margaret.nadin@hse.ie

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

### Acknowledgement

Special thanks to Anne Gallen, national lead for QCMs for assistance in preparing this column and the HSE Office of Nursing and Midwifery Services (ONMSD) and regional Nursing and Midwifery Planning and Development Units (NMPDU) teams for supporting this important development for quality care.

### References

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# Stepping up



## INMO organiser Albert Murphy focuses on the upcoming rep training courses and invites members to attend

THE IMPORTANCE of organisation in the workforce was never as crucial as it is now. The INMO is currently engaged in building a stronger union at local level. It is committed to supporting and developing workplace representatives and leaders. It is with this in mind that we have drawn up the following schedule of rep training courses for the upcoming months.

### Rep training courses

The INMO representatives programme got off to a great start in Limerick in January 2018. A total of nine members attended.

The rep training courses are designed at basic level to give existing reps the confidence and skills to become active at a local level in the workplace. The advanced rep course is for those who have some experience at being a rep and wish to expand on the basic course. If you are interested in becoming a rep or receiving training as a rep, we have some courses coming up and



**INMO reps:** At the rep training course in January 2018 were (back row, l-r): Mary Fogarty, INMO IRO; Patsy Collins; Norma Ryan; Marian Spellman; Jean Armitage; Karen Reilly; and Karen Liston, INMO Limerick Office. (front row, l-r): Albert Murphy, INMO organiser; Relinda Miranda; Mary Fitzgerald; and Niamh Mulcahy

would be delighted to see you there (see below for details).

### Ryanair pilots achieve union recognition

The announcement before Christmas that Ryanair had finally conceded trade union recognition to pilots working in Ryanair is an historic occasion.

It was also announced that Ryanair is to engage with other staff groups on

trade union recognition. The fact that this campaign has finally succeeded for the unions is highly significant and shows that when workers combine collectively they can assert and achieve the right to collective bargaining. We wish FÓRSA well in representing its members in Ryanair.

Albert Murphy is INMO industrial relations officer/organiser.  
Email: [albert.murphy@inmo.ie](mailto:albert.murphy@inmo.ie)



## REP TRAINING

Would you like to become an INMO workplace leader?

| Date           | Course   | Venue                            |
|----------------|----------|----------------------------------|
| February 7 & 8 | Basic    | Knightsbrook Hotel, Trim         |
| March 7 & 8    | Basic    | Mount Errigal Hotel, Letterkenny |
| March 27 & 28  | Advanced | Letterkenny                      |

For all enquiries email: [martina.dunne@inmo.ie](mailto:martina.dunne@inmo.ie)



# New GOLD standard in COPD guidelines

Ruth Morrow looks at the recent updates to the Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines and their implication for clinical practice

IN LATE 2016, the Global Initiative for Chronic Obstructive Lung Disease guidelines were updated.<sup>1</sup> This article addresses the changes in these guidelines and the implication for clinical practice.

## Definition of COPD

The definition of COPD has been revised to recognise the importance of precipitating factors. 'COPD is a common, preventable and treatable disease that is characterised by persistent respiratory symptoms and airflow limitation that is due to airway and/or alveolar abnormalities usually caused by significant exposure to noxious particles or gases. The chronic airflow limitation that is characteristic of COPD is caused by a mixture of small airways disease (eg. obstructive bronchiolitis) and parenchymal destruction (emphysema), the relative contributions of which vary from person to person'.<sup>1,2</sup>

The risk of developing COPD is related to tobacco smoke, indoor air pollution, occupational exposures, outdoor air pollution, genetic factors, age and gender, lung growth and development, socioeconomic status, asthma and airway hyper-reactivity, chronic bronchitis and infections.

## ABCD assessment tool

The assessment of COPD has been refined to include assessment of symptoms and risk of future exacerbations. With the original assessment tool, it was sometimes difficult to classify patients as some patients fell into more than one group. The spirometric assessment has been removed from the assessment tool which has simplified the classification. However, spirometry is still required for confirmation of diagnosis and to assess severity of airflow limitation (*Figure 1*). Spirometric assessment is based on post-bronchodilator FEV1/FVC ratio less than 70%.

To assess symptoms, two assessment

## Key points for therapeutic options for COPD (GOLD, 2017)

- Smoking cessation has the greatest capacity to influence the natural history of COPD. Healthcare providers should encourage all patients who smoke to quit
- The effectiveness and safety of e-cigarettes as an aid to smoking cessation is uncertain
- Pulmonary rehabilitation improves symptoms, quality of life, physical and emotional participation in everyday activities
- Appropriate pharmacologic therapy can reduce COPD symptoms, reduce the frequency and severity of exacerbations, and improve health status and exercise tolerance
- Pharmacological regimens should be individualised
- Inhaler technique needs to be assessed regularly
- In patients with severe resting hypoxemia, long-term oxygen therapy improves survival
- Influenza and pneumococcal vaccination should be offered depending on local guidelines
- In patients with stable COPD and resting or exercise-induced moderate desaturation should both be prescribed long-term oxygen therapy routinely
- In patients with severe hypercapnia and a history of hospitalisation for acute respiratory failure, long-term, non-invasive ventilation may decrease mortality and prevent re-hospitalisation
- In select patients with advanced emphysema refractory, surgical or bronchoscopic interventional treatments may be beneficial
- Palliative approaches are effective in controlling symptoms in advanced COPD

## Figure 1: Spirometric classification post bronchodilator FEV1/FVC <70%

| FEV1 (% predicted) |       |
|--------------------|-------|
| GOLD 1             | ≥80   |
| GOLD 2             | 50-79 |
| GOLD 3             | 30-49 |
| GOLD 4             | <30   |

tools are used – the Medical Research Council Scale and the COPD Assessment Test. Exacerbation history is based on the number of exacerbations in the previous 12 months. *Figure 2* illustrates the revised ABCD classification. The revised tool provides a more individualised approach to patient assessment and management.

## Pharmacological treatment

Bronchodilator therapy remains the mainstay in the management of stable COPD. Pharmacological therapies are used to reduce symptoms, reduce the severity and frequency of exacerbations, and to improve exercise tolerance and health status. The main groups of medications include:





- Beta-agonists – these relax smooth muscle by stimulating the beta-2 adrenergic receptors. Beta-agonists can be classified into short-acting (SABA) and long-acting (LABA), eg. salbutamol (SABA), salmeterol (LABA), indacaterol (LABA), vilanterol (LABA), formoterol (LABA), olodaterol (LABA)
- Antimuscarinic drugs block the bronchoconstrictor effects of acetylcholine on M3 muscarinic receptors. These can also be classified into short-acting (SAMA) and long-acting (LAMA), eg. ipratropium (SAMA), tiotropium (LAMA), umeclidinium (LAMA), aclidinium bromide (LAMA), glycopyrronium (LAMA)
- Combining bronchodilators may increase the degree of bronchodilation while lowering the risk of side effects compared to increasing the dose of a single bronchodilator agent
- Methylxanthines – this group of drugs remain controversial as to their mechanism of action. There is evidence of bronchodilation in stable COPD. Theophylline is the most commonly used. However, there are significant drug interactions with its use and clearance of the drug declines with age
- Inhaled corticosteroids (ICS) should not be used as a single agent in the management of COPD. In patients with moderate to severe COPD, the use of ICS combined with a LABA is more effective than using either agent alone in improving lung function, health status and reducing exacerbations.<sup>1</sup>

To date, there is no conclusive clinical trial evidence that any existing medications for COPD modify the long-term decline in lung function.<sup>1</sup>

Pharmacological algorithms are given for the initiation, escalation or de-escalation of treatment according to the individual assessment of symptoms and exacerbation risk. In previous publications of GOLD reports, recommendations were only given for treatment initiation. *Table 1* illustrates the pharmacological treatment options according to the patient's COPD classification.

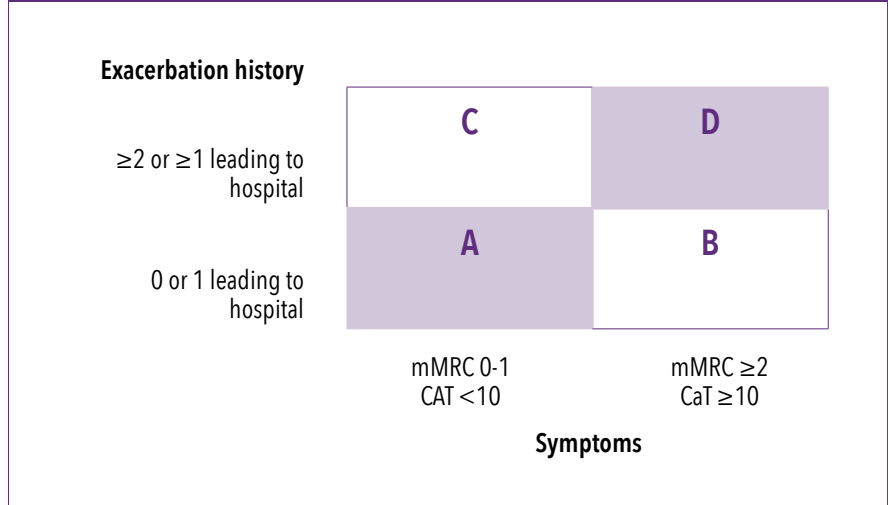
**Inhaler technique**

The use of multiple devices, lack of education on technique and older age may lead to poor inhaler technique. Assessment and regular review of inhaler technique has been added to the guidelines in an attempt to improve therapeutic outcomes. To improve technique, it is recommended that patients are educated and trained with the appropriate devices. The choice of

**Table 1: Pharmacological treatment options based on COPD classification (GOLD, 2017)<sup>1</sup>**

| COPD classification       | Treatment options  |
|---------------------------|--|
| A - Episodic symptoms     | Bronchodilator - LABA or LAMA  |
| B - Persistent symptoms   | Combination - LABA and LAMA  |
| C - Exacerbations         | Combination - LABA & LAMA or LABA & ICS  |
| D - Further exacerbations | Combination - LABA, LAMA and ICS.<br>Consider Roflumilast if FEV1 is <50% and patient has bronchitis.<br>Consider Macrolide in former smokers. |

**Figure 2: Revised ABCD assessment tool**



device should be tailored to the individual depending on the patient's ability to use it and taking their preference into account.

**Nonpharmacologic therapies**

There is increased evidence for pulmonary rehabilitation, self-management, integrated care and palliative care. Pulmonary rehabilitation has been shown to be the most effective intervention to improve dyspnoea, exercise tolerance and health status.<sup>3</sup>

**Management of co-morbidities**

Many patients with COPD have a co-existing illness such as diabetes, cardiovascular disease, osteoporosis or depression, to mention but a few. In general, the presence of co-morbidities should not affect COPD treatment and co-morbidities should be treated according to standards and guidelines. Lung cancer is common in patients with COPD. Gastro-oesophageal reflux is common and is associated with an increased risk of exacerbations and therefore should be managed optimally.

Osteoporosis is common due to recurrent use of oral steroids, lack of weight bearing exercise and being over or underweight. GOLD recommends that

treatments for co-morbidities should be kept as simple as possible to avoid polypharmacy.<sup>1</sup>

**Conclusion**

This article has focused on the GOLD (2017) guidelines for the diagnosis, management and prevention of COPD. The definition, classification, pharmacological, non-pharmacological, the importance of inhaler technique and co-morbidities have been addressed.

There have been significant changes to the assessment tool which has simplified the classification of COPD which will enable practitioners to individualise the patient's management and treatment and ultimately improve patient outcomes and quality of life.

*Ruth Morrow is an ANP in primary care and a registered nurse prescriber in practice in Leitrim*

**References**

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# Identifying the at-risk diabetic foot

As many as 85% of amputations can be avoided when management of the diabetic foot is optimised, writes Joe Kelly

PATIENTS with diabetes are estimated to be at a 15-40-fold increased risk of lower limb amputation than the non-diabetic population. It has been proposed that 85% of amputations could be avoided.<sup>1</sup> A challenge for those charged with caring for patients with diabetes is identifying the at-risk foot early to reduce or prevent ulceration and complications that often result in amputation. Identifying the at-risk patients from those of lower risk optimises management and interventions. Currently there is much variation in practice and access to footcare services in Ireland.

In 2011 a national model of care for the diabetic foot was introduced in Ireland.<sup>2</sup> Adapted from the NICE guidelines, it is directed at all health professionals involved in the care of diabetic feet. An objective is that patients will benefit from the assurance that they will be treated by a health professional with competencies specific to the management of diabetic foot disease and relevant to their needs, together with an emphasis on patient empowerment and education.

The model assigns three risk categories:

- **Low risk:** defined as a patient with palpable pedal pulses, no loss of sensation, no history of ulceration, no significant foot deformity or visual impairment. This foot may be managed by the primary care nurse annually with screening and education
- **At-risk:** stratified as moderate and high risk.
  - *Moderate risk:* defined as at least one of the following; impaired peripheral sensation, impaired peripheral circulation, significant structural deformity or visual impairment. These patients would be under the clinical governance of the GP and podiatrist in the community or hospital
  - *High risk:* equals a patient who has had both neuropathy and peripheral vascular disease or has had a previous foot ulcer, amputation or Charcot foot. These patients will be managed by the diabetes multidisciplinary team (hospital and community podiatrist)

**Table 1: Typical features of diabetic foot ulcers according to aetiology**

| Feature                              | Neuropathic                 | Ischaemic                     | Neuroischaemic                   |
|--------------------------------------|-----------------------------|-------------------------------|----------------------------------|
| <b>Sensation</b>                     | Sensory loss                | Painful                       | Degree of sensory loss           |
| <b>Callus</b>                        | Thick callus                | Minimal callus                | Minimal callus prone to necrosis |
| <b>Wound bed</b>                     | Pink and callus surrounding | Pale sloughy                  | Poor granulation                 |
| <b>Foot temperature/pedal pulses</b> | Warm bounding pulse         | Cool with absent pulses       | Cool with absent pulses          |
| <b>Other</b>                         | Dry skin with fissures      | Delayed healing               | High risk of infection           |
| <b>Location</b>                      | Weightbearing               | Tips of toes, borders of feet | Foot margins and toes            |
| <b>Prevalence</b>                    | 35%                         | 15%                           | 50%                              |

*Table adapted from Wounds International Guidelines Best Practice (p3)*

• **Active foot disease:** defined as an active foot ulcer. These patients will be managed by the foot protection team.

#### Who is at risk?

Patients with diabetes may present with neuropathy and peripheral arterial disease. In practice, neuropathy and ischaemia may co-exist as a neuroischaemic foot (see Table 1). Importantly, identification of the aetiology of the foot ulcer will determine the clinical treatment plan. Therefore the outcome may be dependent on the experience and competency of the health professional.

Those who are males, smoke cigarettes, have peripheral vascular disease, neuropathy, nephropathy (microvascular disease), hyperglycaemia, previous foot ulceration, deformity or amputation are at greatest risk.<sup>3,4</sup>

#### Loss of protective pain sensation

The diabetic triopathy of retinopathy, nephropathy and neuropathy are microvascular complications that may arise from a common pathway of hyperglycaemia and the generation of reactive oxygen species and leading to oxidative stress that can itself be neurotoxic and that secondarily can cause neural ischaemia from damage to the microvasculature.<sup>5</sup> The clinical features of diabetic peripheral neuropathy (DPN) are that of distal symmetrical polyneuropathy beginning at the apices of the toes and progressing in a stocking and glove distribution.

Patients may complain of 'positive' symptoms of burning, lancinating pain, pins and needles, allodynia and formication or 'negative' symptoms of numbness, dead, loss of balance or painless injury to the skin.

Diabetic foot ulcers usually result from two or more risk factors occurring together. Neuropathic ulceration may result from physical, chemical or thermal trauma. Motor neuropathy causes clawing or retraction of toes, pes cavus, ankle equinus and increased plantar forefoot pressures.

Compounding this, autonomic neuropathy may be associated with dry skin, heel fissures, callus and bounding pedal pulses. Because of loss of protective pain sensation, trauma and repetitive stress caused by elevated plantar pressures and/or ill-fitting shoes, are less perceived and ulceration develops.<sup>6</sup>

#### Testing for loss of protective pain sensation

A simple clinical test uses a Semmes Weinstein monofilament screening tool to determine the presence of neuropathy in patients with diabetes. The monofilament is a nylon filament that exerts 10g of linear force at the point where it buckles. It should be applied to the foot at various sites on the plantar surface of the foot and toes.

Common belief is that 10 points should be tested and that four or more missed points indicates a high risk for ulceration.

A positive result is the inability to feel the monofilament when it is pressed against the foot with enough force to buckle. Neuropathy may also be demonstrated by the inability to sense vibration from a standard 128Hz tuning fork at the distal interphalangeal joint of the big toe or >25 volts using vibrometry. A Vibratip is a new electronic device introduced recently and has shown similar reliability (see Figure 1).<sup>7</sup> The examiner must avoid testing areas of hyperkeratosis as false positives are likely.

Dr Paul Brand, orthopaedic surgeon and neuropathy researcher, states: "You don't need expensive equipment to diagnose the at-risk foot".

With this in mind, the diabetes team at Ipswich Hospital in England in 2014 proposed the Ipswich touch test (ITT).<sup>8</sup> The test requires no clinical tools. Three toes on each foot are tested. The big toe on each foot, both little toes and then the middle or third toes are touched by the examiner very lightly using only their finger. If the patient cannot feel at two of those sites then they are considered to have loss of sensation. The sensitivity and specificity of the ITT was similar to that of the monofilament.

### Ulceration

Neuropathy is usually symptomless and therefore a hazard to the unwary patient. Neuropathic ulceration occurs on the plantar metatarsal heads and apices of the toes. It is usually preceded by hyperkeratotic callus and if it is not removed, subkeratotic haemorrhage ensues and eventually tissue breakdown.

Tracking may be observed from areas of high pressure to areas of low pressure beneath the metatarsal heads distally towards the toes or arch of the foot. Secondary infection with *Staphylococci*, being the most common pathogen, and *Streptococci*, Coliforms and Anaerobic bacteria may lead to cellulitis, ulceration and osteomyelitis. In toes, whether apical or dorsal, interphalangeal joint ulceration infection complicates quickly and may lead to thrombosis of digital arteries and gangrene.

### Management

The model of care recommends referral of active ulceration and the high-risk cases to the specialist team for review. With reduction in plantar pressure, control of infection and wound care, most neuropathic ulcers will heal. A key principle for active ulceration and of off-loading is to redistribute the pressure under a foot over as large an area as possible or to transfer the pressure to an area less likely to



Figure 1: The Vibratip and monofilament have shown similar reliability

ulcerate. Hospital teams often supply the patient with various pneumatic or pressure walking boots to address these factors.

A consideration for the community health professional is that research has shown that a reduction in walking speed can reduce plantar foot pressures. However, it is seldom employed as a technique as it may require too great a discipline from the patient.

Activity levels of the patient is a factor to be considered. Often patients are involved socially in walking activities. Advising patients to stop walking may impact socially and psychologically. While the objective is to protect at-risk feet, often a good compromise is 'little and often'.

Footwear adaption inside the shoe and to the outsole, eg. rocker soles, have been shown to reduce forefoot pressure by assisting a rolling gait reducing active dorsiflexion of the toes and forefoot pressure significantly.<sup>10</sup> Some high street brands have these characteristics.

Soft materials, open cell foam and rubber constructed insoles have also been shown to help cushion and redistribute shearing forces beneath the foot, although more research is needed to establish superior materials or combinations that help achieve this goal. Socks specifically designed to reduce shear and constriction are available at several outlets, including at the Diabetes Ireland Care Centres in Dublin and Cork.

### Patient education

Patients should be advised to cut toenails straight across and if nail pathology or underlying risk factors are present, to see a podiatrist for advice and treatment. Often nails become onychauxic and subungual ulceration may occur as a result of pressure on the nail plate (see Figure 5).

It is advisable that patients use emollients to keep the skin soft and supple, avoiding interdigital areas, as these are prone to fissuring due to maceration and occlusion (see Figure 6).

Patients should be instructed to check their feet daily. The use of a mirror or a designated family member is helpful. Light



Figure 2: Subungual ulceration may occur as a result of dorsal pressure on the nailplate from footwear

Figure 3: Interdigital maceration, fissuring and corn formation between the toes

coloured socks help the unwary recognise injury due to staining. Footwear should be checked inside and out, examining the sole for undue wear and tear, puncture and penetrating objects such as tacks, glass and stone.

Checking inside footwear by hand helps identify excessive shoe wear, holes and worn inlays. Sometimes patients may have insoles placed accidentally in the wrong shoes or have an old sock rolled up at the toes, impacting the foot within the shoe.

In the event of concern the patient should be clear on what to do, who to contact, and how. Early identification of risk factors, poor vision, poor glycaemic control, foot ulcer history and deformity determines the clinical management. Ultimately, competency in these skills means early intervention and better outcomes for patients.

Joe Kelly is a podiatrist at Tallaght Foot Clinic and is chairperson of The Society of Chiropodists & Podiatrists of Ireland

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# Chronic pain: breaking through barriers

**Niall Hunter reports on recent Irish research identifying factors that may prevent a holistic management approach to chronic pain**

CHRONIC PAIN is recognised as a significant healthcare issue with wide-ranging effects on quality of life. Its management is often a challenge in both primary and secondary care, not least because in many cases of chronic pain, there may be no pathophysiological cause.<sup>1</sup>

In addition, the prevalence of chronic pain has a major societal impact. Pain causes a problem for individuals as well as a challenge for healthcare systems, economies and society: every year, approximately one in five Europeans is affected by chronic pain.<sup>2</sup>

According to the Irish Pain Society,<sup>3</sup> everyone suffering from a chronic pain condition has the right to access appropriate information for better understanding of this condition. The Irish Pain Society believes greater recognition and understanding is required at government level so that greater resources are made available to meet the needs of patients suffering from chronic pain.

The question of whether clinicians are always adopting the optimal approach to managing chronic pain has been explored in a recent study by the Centre for Pain Research and the School of Psychology at NUI Galway.<sup>4</sup>

According to the researchers, traditional treatment methods prescribed according to the biomedical model (conceptualisation of illness or disorder that includes biological factors but excludes psychological/social factors) can often fail to adequately manage chronic pain and may even contribute to further disability.<sup>5-7</sup>

## Biopsychosocial (BPS) approach

An alternative to this approach is based on the BPS model, which can provide a better foundation for understanding

chronic pain and can enhance management of the condition.<sup>8</sup> It can address the importance of psychological and social interactions as well as biological components in forming the individual's experience of their pain.<sup>9</sup>

There is much evidence that non-medical factors, both psychological and social, eg. pain catastrophising, fear avoidance beliefs and concerns regarding work and family are critical in the perpetuation of chronic pain.<sup>10,11,12,13,14,15,16</sup>

It is recommended that BPS risk factors should not exist in a vacuum and should be considered within a broader context. Situational and socioeconomic factors such as older age, healthcare provision, emotional impact on family and level of social integration are all interconnected with these psychosocial risk factors.<sup>17,18</sup> Physicians' adherence to guidelines for physical and psychosocial assessment, however, is low and there is a lack of knowledge among physicians in identifying and treating psychosocial risk factors.<sup>19</sup>

The NUI Galway researchers pointed out that medical students are more likely to adopt a BPS approach as part of their clinical decision-making, as they are more likely to have received some BPS education and therefore are potentially more open to psychosocial influences in the treatment of chronic pain.<sup>20</sup>

## BPS challenges

However, BPS is not without its challenges. Medical students claim they are not likely to apply the BPS model in clinical settings due to factors, including time pressures.<sup>21</sup> Although many studies indicate that the BPS model in treating chronic pain can have beneficial effects, there are a number of barriers to adopting

this approach in clinical settings.

In order to gain an insight into these challenges, the Galway researchers investigated medical students' conceptualisations of the factors that influence application of the biosychosocial approach to clinical judgement-making in chronic pain. They looked at modelling the relationships among these factors and sought to make recommendations on treatment policy based on the findings.

Some 14 third-year to fifth-year medical students from NUI Galway participated in the research. All of these had completed the relevant BPS aspect of their education and some clinical work placement.

The research showed the students identified a number of factors influencing application (or not) of a BPS perspective in chronic pain management.

Participants identified seven factors:

- Cost
- Time
- Primary care knowledge
- Primary care attitudes
- Patient-doctor relationship
- Biomedical factors
- Patient perception.

Overall, it was found that the critical drivers of whether this perspective would be applied were cost, primary care knowledge and attitudes, whereas the factor most influenced by other factors was patient perception. Primary care/GP attitude was the most critical driver identified, which referred to the willingness of a doctor to apply the BPS model and ensure that all the patient's needs under this heading were fulfilled. It was considered that attitude in primary care above all factors would dictate whether a BPS perspective would be applied.

Cost was a secondary factor identified, which referred to the cost of BPS treatment in comparison with biomedical treatment (eg. medication) and amount of health service interactions necessary for treatment with respect to system budgetary allocation and patient cost.

Primary care knowledge, another factor identified, included whether a GP had knowledge of treating chronic pain through a BPS approach. Time as an identified factor included whether a clinician had adequate time available for consultations to include the BPS approach, and also limits on patients' time (time traveling to surgery, waiting time etc).

The research, published in the journal *Pain Physician*, indicates that the results can be used for further research on factors influencing the application of biopsychosocial perspectives in chronic pain treatment. It suggests that such research could support overcoming barriers to existing healthcare policy in this regard, particularly in respect of cost, attitudes and knowledge in primary care.

The researchers felt the study contributes to an ongoing effort to better

understand factors that influence doctors in the treatment of chronic pain.

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## Nursing/midwifery salary scales as at January 1, 2018

|  |  |         |         |         |         |         |        |        |        |        |        |        |        |
|--|--|---------|---------|---------|---------|---------|--------|--------|--------|--------|--------|--------|--------|
| Student nurse/midwife/intellectual Disability              | 14,150 (Degree Students 36 weeks Rostered Placement)   |         |         |         |         |         |        |        |        |        |        |        |        |
| Staff nurse/midwife (post qualification, pre-registration) | 24,604   |         |         |         |         |         |        |        |        |        |        |        |        |
| Staff nurse/midwife  | 28,768   | 30,802  | 31,852  | 33,037  | 34,531  | 36,023  | 37,508 | 38,792 | 40,080 | 41,361 | 42,644 | 43,904 |        |
|  | LSI after three years max  |         |         |         |         |         |        |        |        |        |        |        | 45,248 |
| Senior staff nurse/midwife                                 | 47,424   |         |         |         |         |         |        |        |        |        |        |        |        |
| Dual qualified nurse *(Reg. in any 2 of the 5 disciplines) | 35,451   | 37,685  | 38,876  | 39,793  | 40,804  | 42,148  | 43,458 | 45,387 |        |        |        |        |        |
|  | LSI after three years max  |         |         |         |         |         |        |        |        |        |        |        | 46,733 |
| Senior dual qualified nurse                                | 48,982   |         |         |         |         |         |        |        |        |        |        |        |        |
| Clinical nurse/midwife manager 1                           | 44,731   | 45,550  | 46,707  | 47,882  | 49,040  | 50,205  | 51,503 | 52,713 |        |        |        |        |        |
| Clinical nurse/midwife manager 2/ specialist               | 48,570   | 49,375  | 50,054  | 51,166  | 52,393  | 53,598  | 54,803 | 56,160 | 57,421 |        |        |        |        |
|  | (plus allowance of €801 pa payable on a red-circle basis to Theatre/Night Sisters who were in posts on November 5, 1999) |         |         |         |         |         |        |        |        |        |        |        |        |
| Clinical instructor  | 50,678   | 51,498  | 52,105  | 53,232  | 54,367  | 55,593  | 56,825 | 58,055 | 59,284 |        |        |        |        |
| Clinical nurse/midwife manager 3                           | 55,889   | 56,995  | 59,791  | 60,890  | 61,996  | 63,116  |        |        |        |        |        |        |        |
| Nurse tutor  | 57,165   | 57,941  | 58,714  | 59,492  | 60,268  | 61,046  | 61,818 | 62,597 | 63,373 | 64,149 |        |        |        |
| Principal nurse tutor                                      | 59,952   | 61,083  | 62,116  | 65,343  | 66,472  | 66,514  | 67,805 | 69,538 |        |        |        |        |        |
| Student public health nurse                                | 32,829   |         |         |         |         |         |        |        |        |        |        |        |        |
| Public health nurse  | 47,326   | 48,110  | 48,780  | 49,836  | 51,049  | 52,225  | 53,410 | 54,741 | 55,980 |        |        |        |        |
|  | (plus allowance of €1,601 pa payable on a red-circle basis to staff who were in posts on November 5, 1999)               |         |         |         |         |         |        |        |        |        |        |        |        |
| Asst. dir. of public health nursing                        | 55,893   | 58,964  | 60,225  | 61,388  | 62,563  | 64,170  |        |        |        |        |        |        |        |
| Director of public health nursing                          | 73,378   | 75,602  | 77,833  | 80,158  | 82,292  | 84,523  |        |        |        |        |        |        |        |
| Advanced nurse practitioner                                | 56,429   | 57,521  | 58,576  | 61,813  | 62,832  | 64,015  | 65,122 | 66,222 | 69,541 |        |        |        |        |
| Asst. director of nursing band 1                           | 56,429   | 57,521  | 58,576  | 61,813  | 62,832  | 64,015  | 65,122 | 66,222 | 69,541 |        |        |        |        |
| Asst. director of nursing non band 1 hospitals             | 53,589   | 54,731  | 55,893  | 58,963  | 60,225  | 61,388  | 62,563 | 64,170 |        |        |        |        |        |
| Director of nursing band 1                                 | 74,848   | 76,929  | 79,013  | 81,090  | 83,169  | 85,256  | 87,335 |        |        |        |        |        |        |
| Director of nursing band 2                                 | 69,630   | 71,519  | 73,413  | 75,300  | 77,198  | 79,089  | 80,982 |        |        |        |        |        |        |
| Director of nursing band 2a                                | 69,093   | 70,281  | 71,472  | 72,658  | 73,849  | 75,035  | 76,225 |        |        |        |        |        |        |
| Director of nursing band 3                                 | 65,299   | 65,712  | 67,112  | 68,500  | 69,882  | 71,275  | 72,658 |        |        |        |        |        |        |
| Director of nursing band 4                                 | 61,014   | 62,861  | 64,700  | 66,548  | 67,355  | 69,147  | 70,934 |        |        |        |        |        |        |
| Director of nursing band 5                                 | 57,078   | 58,314  | 59,548  | 60,780  | 62,013  | 63,252  | 64,487 |        |        |        |        |        |        |
| Area director - nursing & midwifery planning dev unit      | 78,733   | 81,086  | 83,416  | 85,413  | 87,640  | 89,912  | 92,152 |        |        |        |        |        |        |
| Director - nursing & midwifery planning dev unit           | 71,731   | 73,668  | 75,802  | 78,148  | 80,718  | 83,358  |        |        |        |        |        |        |        |
| Director centre of nurse education                         | 65,630   | 66,651  | 68,640  | 70,631  | 72,619  | 74,610  | 76,598 | 78,672 |        |        |        |        |        |
| Hospital group director of nursing & midwifery             | 97,173   | 101,492 | 105,811 | 110,128 | 114,448 | 114,491 |        |        |        |        |        |        |        |



## Location and qualification allowances Applicable from January 1, 2010

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

| Grade   | Nature of Allowance  | Amount |
|---|--|--------|
| Registered nurses   | Employed on duties in the following locations:<br>• Accident & Emergency Depts, Theatre/O.R., Renal Units • Intensive/Coronary Care Units, Cancer/Oncology Units, Geriatric • Units/Long-Stay Hospital or Units in County Homes. High Dependency • Units, Neo Natal Units (ICU), Endoscopy Units, Specialist Ambulatory • Dialysis Units. Units for Severe and Profoundly Handicapped in Mental Handicap • Services, Acute Admission Units in Mental Health Services, Secure Units in Mental Health Services, dedicated Care of the elderly (excluding Day Care Centres) and Alzheimer Units in Mental Health Services • Intellectual Disability Sector* (including Psycho-geriatric Wards, Elderly Mentally • Infirm Units, Psychiatry of Later Life Services). (*Allowance effective from January 1, 2004).  | €1,858 |
| Registered nurses   | a) Employed on duties in specialist areas appropriate to the following qualifications where they hold the relevant qualifications.<br>• Accident & Emergency Nursing Course • Anaesthetic Nursing Course • Behaviour Modification Course • Behavioural Therapy Course • Burns Nursing Course • Child & Adolescent Psychiatric Nursing Course • Coronary Care Course • Diabetic Nursing Course • Ear Nose & Throat Nursing Course • Forensic Psychiatric Nursing Course • Gerontological Nursing Course • Higher Diploma in Midwifery • Higher Diploma in Paediatrics • Infection Control Nursing Course • Intensive Care Nursing Course (incl. Paediatric Intensive Care and Special and Intensive Care of New Born) • Neurological/Neurosurgical Nursing Course • Operating Theatre Nursing Course (incl. Paediatric Op. Theatre) • Ophthalmic Nursing Course • Orthopaedic Nursing Course • Higher Diploma in Cardiovascular Nursing/Diabetes Nursing/Oncological • Nursing/Palliative Care Nursing/Accident and Emergency Nursing • Rehabilitation Nursing Course • Renal Nursing Course • Stoma Care Nursing Course. | €2,791 |
| With effect from March 1, 2002, payment of the Specialist Qualification Allowance is extended to all specialist courses confirmed as Category II or equivalent by the NMBI. |  |        |
| Registered general nurses   | b) Holding recognised post-registration qualifications in midwifery or sick children's nursing and employed on duties appropriate to their qualifications.   | €2,791 |
| Public health nurses & asst. directors of public health nursing   | Qualification allowance  | €2,791 |

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

- Nurses who were paid on the dual qualified scale on October 1, 1996 and in receipt of a location allowance at August 1, 1998 or eligible for a new location/qualification allowance from March 31, 1999. In such cases the value of the location/qualification allowance is €1,395 which they receive in addition to their dual qualified scale
- With effect from November 26, 2003, nurses who are paid on the dual qualified scale and who then move to an area that attracts a location/qualification allowance will continue to be paid on the dual qualified scale and will also receive the abated value of the location/qualification allowance of €1,395. Payment of the allowance will cease if the nurse moves out of the qualifying area.

## Other allowances Applicable from January 1, 2010

| Grade  | Nature of Allowance   | Amount  |
|--|---|---------|
| Relevant nursing staff*  | Nurse management sub-structures - special allowance for weekends/public holidays                | €2,976  |
| Psychiatric nurses   | Community allowance   | €4,962  |
|  | Nurses assigned to occupational therapy (qualified)   | €3,732  |
|  | Nurses assigned to occupational therapy (unqualified)   | €1,702  |
| Public health nurses   | Island inducement allowance*  | €1,766  |
| Public health nurses   | Fixed payment   | €28.14  |
| Weekend work   | First call on Saturday and first call on Sunday   | €37.36  |
|  | Each subsequent call on Saturday and Sunday   | €18.71  |
|  | Payment in lieu of time off for emergency work  | €28.11  |
| Theatre nurses/midwives who participate in the on-call with standby - each day   | <b>On-call with standby - each day</b><br>Monday to Friday                                      | €42.34  |
|  | Emergency services Saturday   | €54.38  |
|  | Sunday and public holidays  | €73.51  |
|  | <b>Call-out rate - Monday to Sunday</b><br>a) Fee per operation per 2 hours (17.00-22.00 hours) | €42.34  |
|  | b) (i) Operation lasting > 2 hours and up to 3 hours (17.00-22.00 hours)                        | €63.49  |
|  | (ii) Operation lasting > 4 hours and up to 5 hours  | €105.83 |
|  | c) Fee per operation per hour (after 22.00 hours)   | €42.34  |
| <b>On-call without standby</b><br>(i) Fee per operation, call-in without standby   | €84.68  |         |
| (ii) Overruns from roster at normal overtime rates (no time back in lieu)  |   |         |
| <b>On-call over weekend:</b> In situations where no roster duty is available over the weekend, the following will apply on a pro-rata basis (ie. appropriate rate divided by 12, then multiplied by number of hours available). No time back in lieu will apply.   |   |         |
| <b>Nurse co-ordinator allowance:</b> A shift allowance of €18.09 will be paid to a staff nurse who undertakes the role of formalising the reporting and accountability relationship with the Theatre Superintendent. The allowance only applies to a nurse who fulfils specified duties when called in (D.O.H.C. circular refers). |   |         |
| Midwives providing domiciliary care under the maternity and infant care scheme   | <b>Fee per service</b>  | €131.00 |
|  | • Reduction with a/n visit is after 36th week of pregnancy                                      | €8.16   |
|  | • Patient removed to hospital before onset of labour and not accompanied by midwife             | €48.61  |
|  | • Patient removed to hospital before onset of labour and accompanied by midwife                 | €64.90  |
|  | • Patient removed to hospital after onset of labour and not accompanied by midwife              | €81.33  |
|  | • Patient removed to hospital after onset of labour and accompanied by midwife                  | €97.30  |
| • Abortions and miscarriages   | €64.89  |         |
| Specialist co-ordinator allowance  |   | €4,319  |
| *Review of allowances following review of allowances conducted by the Department of Public Expenditure and Reform, the government has decided to abolish certain allowances for new beneficiaries with effect from February 1, 2012.   |   |         |

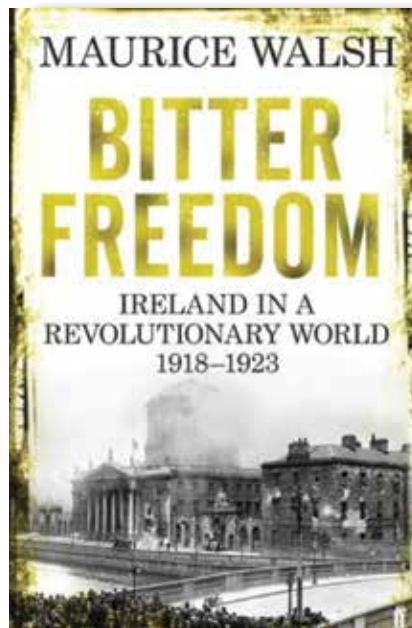


# Elegant account of the Troubles

*BITTER Freedom* opens with an account of two funerals. The first, of 1916 commander Arthur Ashe, followed his death on hunger strike in Mountjoy Prison. The second, in March 1918, was of John Redmond, leader of the Irish Parliamentary Party and keeper of the dying Parnellite flame of constitutional nationalism.

Times had changed. Redmond, four years previously, had nearly achieved home rule for Ireland but was stymied by the outbreak the First World War. However, the derailing of home rule probably also avoided an Irish civil war between unionists and nationalists, different and perhaps even potentially bloodier than the civil war that broke out in 1922.

By 1917-1918 physical force nationalism, in the form of Sinn Fein and the Irish Republican Army, was in the ascendant. Old-style boring constitutional nationalism was on the wane, but not nearly as dramatically as is often believed. It is sometimes forgotten that Sinn Fein lost a number of by-elections in the run up to its stunning victory in the general election of 1918. By early 1919 the IRA had started shooting policemen and a guerrilla war began, which, following many atrocities on both sides, eventually led to a greater



degree of constitutional independence (but not full independence) than had been planned in 1914. Cue a civil war, essentially over what some believed were constitutional technicalities, and further atrocities.

The opening to Maurice Walsh's book effectively sets the scene for a what is an extremely well-written and concise account of a traumatic period in Irish history – a period that defined and

influenced our history for the next century.

The book, subtitled 'Ireland in a Revolutionary World 1918-1923', seeks to put Ireland's struggle for self-determination at the time in the context of worldwide events that saw a major push for political freedom among nations following the break-up of old empires. This growth in nationalism gave many countries independence, but the flame that was lit led to terrible carnage on a wide and varied scale for many decades, encompassing the horrors of WWII, including the Holocaust, right up to the wars in the former Yugoslavia in the 1990s and beyond. Ireland, despite its traumatic bloodshed, got off relatively lightly.

*Bitter Freedom* was criticised by one historian for not quite succeeding, despite its subtitle, in placing Ireland's troubles in the proper international contemporary context. While true to a certain extent it's a little harsh. Maurice Walsh's book provides an authoritative and elegant narrative of the complex dynamics of the Irish 'Troubles' from 1916 to 1923, very effectively using first-hand accounts from those who lived through it.

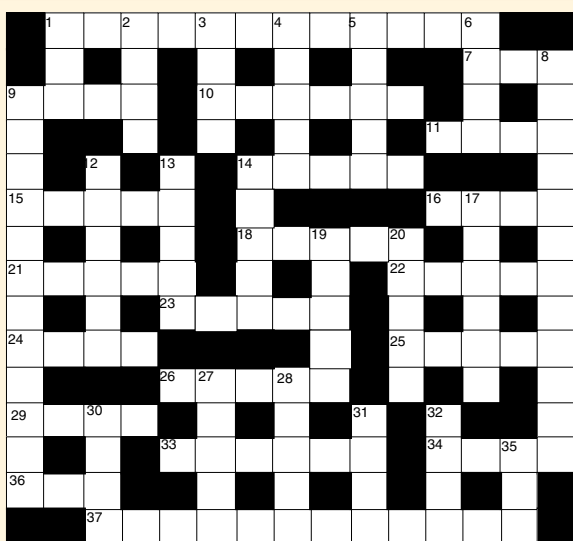
– Niall Hunter

*Bitter Freedom* is published by Faber and Faber  
ISBN: 978-0571243006, RRP £9.99 STG

## Crossword Competition



WIN A €30 BOOK TOKEN



### Across

- 1 So, uncurl us up somehow, being lacking in conscience (12)
- 7 Chunk of wood (3)
- 9 The smallest coin (4)
- 10 & 23a The woman on the ward is in the police? That would be your spouse's sibling (6-2-3)
- 11 You might rave about Mrs Lynn (4)
- 14 Stop; desist (5)
- 15 Mississippi swampland (5)
- 16 It's a bother being found among Corfu's sun-seekers (4)
- 18 A Swedish city can be seen some dismal mornings (5)
- 21 Animal of the Andes (5)
- 22 Criminal (5)
- 23 See 10 across
- 24 Ship's complement (4)
- 25 Precise (5)
- 26 Put your name forward - eg, for a job, (5)
- 29 Male bird (4)
- 33 Walk lamely (6)
- 34 Agitated part of a damaged gyroscope (4)
- 36 Type of flatfish (3)
- 37 Should a race of this distance be called Thon or Mara? (4-8)

### Down

- 1 Avail of (3)
- 2 Location for a building project (4)
- 3 Hurry to a town in Fingal (4)
- 4 No longer fashionable; dated (5)
- 5 City in Yorkshire (5)
- 6 & 35d Legions can literally make this drink (4,3)
- 8 Sounds like this classic text on the body concerns that of a white-coloured horse! (5,7)
- 9 Disinfectant will sort out the 'calico crib' ad (8,4)
- 12 Whirl, making Ray get upset (6)
- 13 City in the UAE, site of the world's tallest man-made structure (5)
- 14 The Ship of the Desert (5)
- 17 Get the cargo onto the quayside (6)
- 19 Humble (5)
- 20 Bid, tender (5)
- 27 Verification (5)
- 28 Sign of the Zodiac - The Scales (5)
- 30 Cork town that makes a male swan hot (4)
- 31 Hear about a Greek goddess (4)
- 32 Net (4)
- 35 See 6 down

### Dec/Jan crossword solution

- Across: 1 Disregards 6 Acts  
10 Nails 11 Pantomime  
12 Pulling 15 Sepia 17 Lost  
18 Rapt 19 Armed 21 Voucher  
23 Verdi 24 Tree 25 Nets  
26 On cue 28 Ego trip 33 San Marino 34 Rayon 35 Yale  
36 Cheekbones
- Down: 1 Ding Dong Merrily on High 2 Ski-jumper  
3 Easel 4 Aspen 7 Chirp  
8 Skedaddled 9 Dog Star  
13 Info 14 Glucose  
16 Previously 21 Vinegar  
22 Euro 27 Canal 29 Goose  
30 Throb 32 Onus

Name: .....

Address .....

The prize will go to the first correct entry opened

Closing date: Tuesday, February 20, 2018

Post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin

The winner of the December/January crossword is:  
**Imelda Browne Naas, Co Kildare**



# MONEY & MATTERS

## Shop around for health cover

Comparing health insurance plans annually can help you to cut costs, writes Dermot Wells

WITH more than 325 health insurance plans available across the market, and with new plans introduced each year, it pays to shop around for your health cover each year.

For 2018, insurers are reducing the costs of some of their health insurance plans and including some additional benefits to make plans more appealing to customers. On the other hand, they are also increasing prices across specific plans with effect from January 1, 2018. Therefore, if you have been on the same plan for a number of years, you need to review your cover to ensure you are getting a 'value for money' quote. This type of quote provides you with benefits that match your needs at the right price.

If you are considering switching your provider or plan, the process is very easy. You do not have to re-serve waiting periods and there will be no break in your health insurance cover. Your health insurance advisor or insurer will explain any changes in cover, answer any questions you may have and provide supporting documentation.

We've put together some top tips to help you manage the cost of your health insurance:

### Split your cover

It often doesn't make financial sense for all family members to be insured on the same health insurance plan. Did you know that each member can be insured on a different plan yet remain on the same policy? This allows you to choose separate plans depending on each family member's individual needs and their life stage, which could help to reduce your costs.

### Avail of kids' offers

It is important to remember that young children will not be treated in hi-tech hospitals such as the Blackrock Clinic or the Mater Private. Therefore a plan that offers cover for these hospitals may not be suitable for a child. However, by putting children on a different plan which is relevant to their needs, you may be able to reduce your costs. Also, it is worthwhile shopping around as some of the insurers provide half price offers for children on different plans throughout the year.



### Take on an excess

Health insurance plans that offer a higher excess allow you the option of saving money on your premium. An excess is the first part of the bill you will have to pay when making a claim on your health insurance. If your current plan does not have any excess and you are looking at ways to reduce your costs, then you could consider introducing a small excess. This could range anywhere from €50 to €150 per private hospital admission. The insurers currently provide plans which include excesses of up to €500 for inpatient private hospital admissions, so it's worth checking out what's on offer.

### Calculate day-to-day medical expenses

It can be beneficial to claim money back on your health insurance for day-to-day expenses such as GP, physio, dentist and specialist consultant fees. If you have four or more of these types of visits in any one year, then it may make financial sense to include this type of cover on your plan. You should sit down and do the maths at renewal to weigh up how much you are able to claim back on such expenses versus the added cost to the premium of your policy.

### Cut out unnecessary cover

Health insurance plans can vary considerably in the level of cover which they provide. Not all benefits may be of relevance to you, therefore it is important to establish what exactly you require before choosing a plan. For example, if you live in Cork or Galway, then you may not wish to travel to the Beacon Hospital in Dublin. In this instance, you may feel that a plan which includes this type of cover

is unnecessary for your needs. Similarly, the level of maternity cover provided on health plans varies considerably. So it is also useful to understand what benefits you don't require and choose a plan without these benefits to help you reduce your costs.

### Avail of young adult rates

Young adult rates have replaced student discounts and the good news is that the individual no longer has to be in full time or part time education to avail of this offer. You can avail of a young adult rate if you are aged between 18 and 25 years of age or if you have a dependant who fits within this age category. However, it is important to note, that not all health insurance plans offer these discounted rates for young adults, therefore you should ask your insurer/broker for the best value plan for young adults that matches their needs.

### Ask about corporate plans

Corporate plans are developed specifically for large company schemes, however any person can avail of these plans – all you have to do is ask. These provide a strong level of cover for private and hi-tech hospitals. In some instances, they can also include maternity benefits which allow members to claim back on certain fertility treatments such as IVF, IUI and ICSI. At your next renewal, ask about corporate plans to see if this type of plan offers you the cover you need at a price that suits your budget.

### Group discounts for INMO members

There are discounts available to members on a number of plans by contacting Cornmarket directly. The Health Insurance Comparison Service will explain the different plans and discounts available to INMO members. Further details can be found by contacting Cornmarket at Tel: 01 408 6212 or by visiting [www.cornmarket.ie/inmo/](http://www.cornmarket.ie/inmo/)

*Dermot Wells is general manager of Cornmarket's Health Insurance Division*

*Cornmarket Group Financial Services Ltd. is regulated by the Central Bank of Ireland. A member of the Irish Life Group Ltd. which is part of the Great-West Lifeco Group of companies. Telephone calls may be recorded for quality control and training purposes.*

# Temple Street tops flu vaccination uptake

TEMPLE Street Children's University Hospital topped the flu-vaccine-uptake league in HSE-funded hospitals and long-term care facilities in Ireland with a vaccination uptake of 63.7%.

The hospital set an uptake target of 60% based on headcount of 1,498 staff and the key campaign focus was on ease of access where the vaccine was offered on an 'any-time, any place, anywhere' basis by peer vaccinators.

The comprehensive campaign to reach the target included the following:

- Approximately 25% of staff were vaccinated on launch day. 'SelFLU' photos were encouraged and shared on TempleNet (intranet) with weekly prize winners. 'Pop-Up' clinics staffed by peer vaccinators were scheduled at locations and times which were convenient to suit frontline staff
- Photo collages of SelFLU shots were displayed in public areas with messages about the link between immunisation and protection of patients. Times and



*Pictured (l-r) at the HSE Excellence Awards, where Temple Street Hospital won the 'Improving Children's Health Award'; were (l-r): Mary Boyd, awards adjudication panel; Karen Murray, CNM, Occupational Health Department (OHD); Shellie Kane, CNM, OHD; Grainne Bauer, Temple Street Hospital director of nursing; Sharon Ryan, divisional nurse manager; Sarah Maidment, divisional nurse manager; and Dave Hughes, INMO deputy general secretary and adjudication panel member*

locations of pop-up clinics were promoted on TempleNet complemented by a barometer which showed the weekly increasing uptake of the vaccination. Clinic schedules were also promoted verbally at the daily nursing huddles

- The board of directors was the first group to be vaccinated, followed by consultants
- Monthly vaccination uptake reports were presented to the Board of directors, the

quality and risk committee, the hospital executive and the medical committee.

Temple Street is also proud to announce that the hospital won the 'Improving Children's Health' award for its 2016/ 17 Flu Vaccination campaign at the recent HSE Health Service Excellence Awards. The campaign was one of 11 shortlisted nominees from 300 applications to the awards scheme.

Irish Nurses and Midwives Organisation

**1919 - 2019  
CENTENARY  
BADGE  
COMPETITION**

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



**INMO**



The INMO will be celebrating 100 years in 2019 and as part of these celebrations we are giving all INMO members the unique chance of designing a commemorative INMO badge.

Entries must be submitted to [michaela.ruane@inmo.ie](mailto:michaela.ruane@inmo.ie) by **1st March 2018**. The winner will be announced at the 2018 INMO Annual Delegate Conference.

# Special Olympics calls out for nurses

Training and support is provided for all medical volunteers

IF YOU are looking for an exciting experience in 2018, why not join in the medical team of Special Olympics Ireland and take part in the 2018 Ireland Games.

The 2018 Special Olympics Ireland Games will take place at the Sport Ireland National Sports Campus in Blanchardstown over four days from Thursday, June 14 to Sunday, June 17.

Some 1,600 Special Olympics athletes from across the island of Ireland will travel to Dublin and will compete in 13 sports in venues around the city, as well as at one venue in each of Meath and Kildare.

The competitors will be accompanied by 600 coaches and official delegates and 3,000 family members and supporters

Special Olympics Ireland is looking for 120 nurses to join its medical team to support the games.

According to Louise Tinne, an RNID, who has volunteered with Special Olympics Ireland for over a decade it is a very rewarding experience.

"Thirteen years later, being part of the

medical team with Special Olympics has been rewarding, exhausting and addictive. To watch the face of families as their child or sibling participates at national or world level is so rewarding. Watching the faces of the entire place as tears flow freely as medals are won and lost... you will experience emotion like never before.

To know you have played a small role in supporting and making this happen, there really is no better way to give your free time."

Training and support for medical volunteers is provided to ensure volunteers are comfortable in their role and aware of their responsibilities.

#### Next steps

- Spread the word of this opportunity among your colleagues
- Join Special Olympics Ireland in the Campus Conference Centre, National Sports Campus for an Information Evening on either Thursday February 1 or Thursday 8, February at 7pm, to hear more about the medical roles available



Athlete Isaac Findley from Dublin high fives volunteer Catriona O'Dwyer at the 2014 Special Olympics Ireland Games in Limerick

- Register at [www.irelandgames.ie](http://www.irelandgames.ie) and click on the red button 'express your interest in volunteering.'

If you have any questions in advance of our Information Evening please email: [Annette.codd@specialolympics.ie](mailto:Annette.codd@specialolympics.ie) or Tel: 01-8691635.

## INMO participates in Canadian nurses union's conference

THE INMO recently participated in the FIQ (Federation Internationale de la Sante de Quebec) and also GNU (Global Nurses United) Conference, of which the INMO is a founding member, in Quebec, Canada. The INMO president noted that international nurses/midwives faced similar struggles to those in Ireland: nursing and midwifery shortages; violence in the workplace; achieving mandated staffing levels; the deprofessionalisation agenda; and pay.

Ms Harkin-Kelly addressed the FIQ Conference as part of an international panel discussion and explained the challenges faced by Irish nurses and midwives given the economic backdrop, and detailed the actions taken to ameliorate employer cut-backs, ie. greater involvement in national policy formulation.

Speaking after the conference she said: "These networks are vital as we learn from and support other national associations who are undertaking similar actions or work."

## Line up announced for Irish Skin Foundation's dermatology study day

THE Irish Skin Foundation has announced details of its third annual dermatology study day which takes place March 10, 2018 in the Galway Bay Hotel, Salthill, Galway.

Attendees can look forward to an incredible line up of expert speakers from the world of dermatology. The day will offer informative training for hospital, community-based, GP practice and public health nurses, pharmacists and others involved in providing skin care will cover psoriasis, lesion recognition, burn management, rosacea, acne, and common childhood skin problems.

The annual event provides an exciting opportunity to learn from the experts and bring new knowledge and skills back to the workplace. Attendees will also get the opportunity to meet and talk during the event with various exhibitors on new and existing products on the market.

The 2018 study day will be chaired by consultant dermatologist Dr Trevor Markham from University Hospital

Galway. Carmel Blake, advanced nurse practitioner and helpline clinical manager for the Irish Skin Foundation, will give the welcome address.

Speakers include Deirdre Conlon, advanced nurse practitioner in plastic surgery, University Hospital Galway, who will deliver a paper entitled 'An Overview on the Initial Management of Burns' and Dr Kashif Ahmed, consultant dermatologist, University Hospital Limerick, speaking on 'Recognition of Early Melanoma by Dermoscopy'.

The Irish Skin Foundation's professional study day promises to be an unmissable event so we advise people to get their ticket well in advance to avoid disappointment.

The registration fee for the professional study day is €75, which includes, tea/coffee and lunch. Tickets can be downloaded from: [www.irishskin.ie/dermatology-study-day-line-announced/](http://www.irishskin.ie/dermatology-study-day-line-announced/) For further Information go to: [www.Irishskinfoundation.ie](http://www.Irishskinfoundation.ie)

## February

### Saturday 3

**CNM/ CMM Section** AGM. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie for further details

### Saturday 3

**Radiology Nurses Section** AGM. INMO HQ. 11am. For further details contact jean.carroll@inmo.ie

### Saturday 3

**International Nurses Section** AGM. INMO HQ. 1pm. For further details contact jean.carroll@inmo.ie

### Saturday 3

**Midwives Section** AGM. CUMH. 1pm. Contact jean.carroll@inmo.ie for further details

### Monday 5

**INMO North Tipperary Branch** AGM. Community Hospital of Assumption, Thurles. 7.30pm. Contact Mary Fogarty INMO IRO, Tel: 061 308999 for further details

### Monday 5

**INMO Louth Branch** AGM. Link Room, Stroke Rehab Ward, Louth County Hospital. 5pm. Contact Noel Treanor INMO IRO, Tel: 01 6640600 for further details

### Tuesday 6

**INMO Monaghan Branch** AGM. Monaghan General Hospital, Conference Room. 5.30pm. Contact Noel Treanor INMO IRO. Tel: 01 6640600 for further details

### Wednesday 7

**INMO Meath Branch** AGM. Conference Room, Our Lady's Hospital, Navan. 5pm. Contact Noel Treanor INMO IRO, Tel: 01 6640600 for further details

### Wednesday 7

**CPC Section** AGM. INMO HQ. 11am. Contact jean.carroll@inmo.ie for further details

### Wednesday 7

**Research Nurses Section** AGM. INMO HQ. 1.30pm. For further details contact jean.carroll@inmo.ie

## March

### Friday 2 - Saturday 3

**Irish Student Health Association** Annual Conference. Sheraton Hotel, Athlone. Further info and booking at [www.isha.ie](http://www.isha.ie)

### Tuesday 13

**National Care of the Older Person Section** Conference. Midland Park Hotel, Portlaoise. For further details contact jean.carroll@inmo.ie

### Thursday 22

**RNID Section** Conference. Midland Park Hotel, Portlaoise. Contact jean.carroll@inmo.ie for further details. See also page 51

## April

### Tuesday 3

**Dublin East Coast Branch** Meeting. Clonskeagh Hospital. 7pm. Contact ann.obrien@inmo.ie, Tel: 01 6640600 for further details

### Tuesday 3

**Leinster Nurses Golfing Society** New members wanted. Annual membership is €30. Contact Margaret Sheridan, Tel: 087 2719885 or Anne Tynan, Tel: 086 1700028

### Saturday 14

**PHN Section** Meeting. INMO HQ 11am. Contact jean.carroll@inmo.ie for further details

### Saturday 14

**School Nurses Section** Meeting. Session on documentation. INMO HQ. 10.30am. For further details contact jean.carroll@inmo.ie

### Monday 16

**National Children's Nurses Section** Meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie for further details

### Tuesday 17

**Student Allocation Liaison Officers** Meeting. INMO HQ. 12pm. Contact jean.carroll@inmo.ie for further details

### Wednesday 18

**RNID Section** Meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie for further details

### Friday 20 - Saturday 21

**ODN Section annual conference** See page 24 for full details

### Thursday 26

**Retired Nurses Section** Meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie for further details

## May

### Wednesday 2 - Friday 4

**INMO Annual Delegate Conference**, The Clayton Hotel, Silver Springs, Cork. See page 20 for full details

**INMO Professional DEVELOPMENT CENTRE**

## Library Opening Hours

**February**  
Monday-Thursday: 8.30am-5pm  
Friday: 8.30am-4.30pm

For further information on the library and its services, please contact:  
Tel: 01-6640-625/614  
Fax: 01-01 661 0466  
Email: [library@inmo.ie](mailto:library@inmo.ie)

## INMO Membership Fees 2016

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

## Condolences

- ❖ The Limerick Branch of the INMO extends sympathy to Mary Notaro, INMO rep in St Senan's Centre, Foynes on the recent loss of her beloved sister Hazel, may she rest in peace
- ❖ The staff of Muiriosa Foundation wish to acknowledge the passing of a dear friend and colleague Helen Kelly RNID, CMN2, educator/trainer. The INMO and RNID Section wish to extend our sincere condolences to Helen's husband Joe, her daughter Alice, all her family, friends and colleagues. May Helen rest in peace
- ❖ The INMO and ODN Section extends deepest sympathy to Anne O'Brien, Temple Street Hospital, on the sudden passing of her beloved son Conor O'Brien. May he rest in peace
- ❖ Sincere condolences to Sandra Morton, ODN Section officer, on the passing of her aunt Joan Hayes of Randalstown. May she rest in peace