€5.75 Vol 27 No 1 February 2019

WIN

World of Irish Nursing & Midwifery

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

Latest INMO CPD education programme
Page 29

INMO prepares to strike for only second time in 100 years
page 8

Minister spins as health service burns
page 18

Emotional toll of nursing and midwifery
page 43

Pre-pregnancy diabetes care
page 48

Ready for action

INMO members resolute on pay issue

NEWS & VIEWS

FEATURES

CLINICAL

LIVING

JOBS & TRAINING

WIN – World of Irish Nursing & Midwifery is distributed by controlled circulation to **more than 37,000** members of the INMO. It is published monthly (10 issues a year) and is registered at the GPO as a periodical. Annual Subscription: €155 incl. postage paid. Editorial Statement: *WIN* is produced by professional medical journalists working closely with individual nurses, midwives and officers on behalf of the INMO. Acceptance of an advertisement or article does not imply endorsement by the publishers or the Organisation.

guaranteed irish™

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

(ISSN: 2009-4264)
Volume 27 Number 1
February 2019

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

medmedia publications

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

Production & news editor Tara Horan

Sub-editor Max Ryan

Designers Fiona Donohoe, Paula Quigley

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

Publisher Geraldine Meagan

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

INMO
Irish Nurses and Midwives Organisation

Editor-in-chief: Phil Ní Sheaghdha

INMO editorial board:
Martina Harkin-Kelly; Catherine Sheridan; Eilish Fitzgerald, Kathryn Courtney, Ann Fahey

INMO editors:
Michael Pidgeon (michael.pidgeon@inmo.ie)
Freda Hughes (freda.hughes@inmo.ie)

INMO photographer: Lisa Moyles

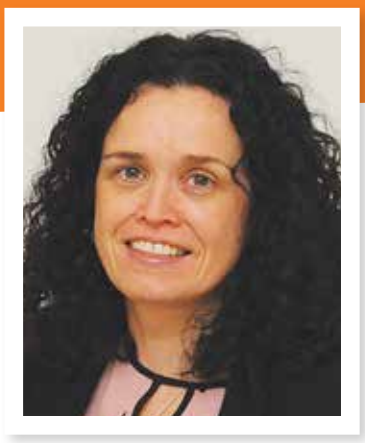
INMO correspondence to:
Irish Nurses and Midwives Organisation,
Whitworth Building,
North Brunswick Street,
Dublin 7.
Tel: 01 664 0600
Fax: 01 661 0466

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

www.facebook.com/irishnursesandmidwivesorganisation

twitter.com/INMO_IRL

Driven to strike by government inaction



AT THE time of print, we are preparing for the second national strike in the INMO's 100-year history. This is something we do with a heavy heart. Nursing and midwifery have always been caring professions and it is with great reluctance that we take these next steps.

But make no mistake – we have been driven here by a government that does not listen. Our professional goodwill is taken for granted, while conditions around us worsen and patients suffer. The idea that no matter how dire the conditions become, nurses and midwives will keep the system running, seems to have been the country's healthcare strategy for the past decade.

In the past 10 years, the conditions in our hospitals have deteriorated, and as a result the number of nurses and midwives in the public health service has fallen by more than 1,400 – a 4% drop. Our colleagues are leaving the country and the profession in huge numbers. Meanwhile, the population continues to grow and age, making the work more demanding and the hospitals more overcrowded.

These issues are well known, but the government has continued to dismiss our frontline concerns on understaffing, insisting that nurses and midwives are well paid and employed in sufficient numbers to run a safe health service.

The government's own research has shown what happens when you get staffing and skill mix right. Patients recover faster, staff are happier, the workforce stabilises and agency costs are reduced – the health service just works better.

This is not wishful thinking or just an opinion. These are the findings of government-sponsored trials, right here in Ireland.

But to fix anything in our health service, we simply need more nurses and midwives. That is at the root of what this strike is all about. Pay a better wage and you'll attract more to the work and keep more in the profession. It's as simple as that.

At the time of print, our meetings with the HSE and government have not led to any fresh proposals or sincere willingness to engage.

Whatever the government response, the days and weeks since the strike announcement have shown that there is huge public and political support for our cause. Patients, healthcare workers, friends, family members, neighbours and public representatives have all come out in support of nurses.

I recently sat in the Dáil with some fellow INMO members and students, listening to TD after TD praising our work and supporting our strike. It was heartening to see all parties stand with us – and disappointing to see the increasingly isolated government dig its heels in.

I have heard it said that the government is out of touch. Few nurses or midwives would disagree. Everyone who has seen the inside of Ireland's hospitals in the past 10 years knows that nurses and midwives are propping up a crumbling system.

Nurses and midwives do not accept that this is the best we can do, and we recognise that we owe it to ourselves, to our patients and to the future, to refuse to accept these conditions any longer.

There is simply no reason why Ireland cannot have a top-class health service, consistently delivering the standards of care which patients deserve.

To get there, we need the government to listen to the frontline, engage with us directly, and pay nurses and midwives a competitive wage. There is room to do so under the existing pay agreements.

None of us want to strike, but none of us can continue like this. Over the coming weeks, they will try to divide us: I ask for all members to take care of each other, be kind to each other, and stand proudly united in our union.

Phil Ní Sheaghdha
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

2019 will change the face of nursing and midwifery

AT THE time of going to print, it seems likely that 2019 will be the year where we take strike action for only the second time in our hundred-year history. However the year progresses, I think it is safe to say that it will be one that changes the face of nursing and midwifery in Ireland.

The government propaganda machine has gone into overdrive, spreading claims that the average nurses' salary is over €56,000 – a figure many thousands away from what even the most experienced nurses and midwives earn.

The government spin lumps in payments for overtime, night shifts, and holiday pay – as if this was just a basic part of the job, rather than an extra that is earned. Nurses and midwives have sacrificed many bank holidays and Christmases – as well as a normal sleep cycle – for their patients – and that work should be acknowledged.

The spin ignores that other allied health professionals – with similar qualifications – earn substantially more without having to work those extra hours.

The spin also tries to inflate the cost of resolving this issue. This is a tactic, to divide us from other workers and turn the public against us.

Throughout this period, I have been talking with fellow nurses and midwives. It's clear that whatever is happening on the airwaves, our workload has increased and care becomes more complex. The health service and its staff are under intolerable pressure, being hit again by flu and meningitis. There is no margin for error.

As I write, hundreds of very sick citizens languish on trolleys. Nurses and midwives run from Billy to Jack in an effort to give the care that they were trained to provide. But many of us are prevented by our working conditions from doing so. These are the conditions that are driving us towards strike action. It is not greed but rather moral conscience and concern for our patients.

If Ireland is going to offer a proper health service, then governments need to value nurses and midwives, we are the ones at the forefront of patient care.

Public backing

BUILDING public support is going to be key. This journal has many examples of the support we've received on and offline (*See pages 9 and 12-13)*. Former and current patients have spoken of the skill and kindness they received while under nurses and midwives' care, while Irish nurses working overseas, from Sydney to London, have stood together in support of their colleagues working in Ireland.

On January 21, I was proud to launch our petition to the government, where the public call on ministers to raise pay to ensure safe staffing. One day later, the petition already had over 12,000 signatures. I encourage all members and their families to sign, and for everyone to share it widely on social media. The petition can be found at **www.StandWithUs.ie.**

Centenary planning meetings

2019 will be the INMO's hundredth year. We're meeting regularly to plan how best to mark our union's centenary. The latest meeting of the group was on Jan 14 with a further meeting scheduled for Feb 4.

On February 28, 90 of our members will gather at the Mansion House for a reception hosted by the Lord Mayor of Dublin. The event will not only be a celebration, but a recognition of the work INMO members have given to the health service this past century. As we enter into a strike, the centenary is a celebration of our ongoing survival and perseverance in the face of adversity.

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

Thought of the month

We'll hold this line until Hell freezes over – Then we'll hold it on ice skates
Anonymous

Report from the Executive Council

COMMUNICATION is key in times of dispute. We held a press conference on January 8, following the Executive Council meeting. We set out the clear decision of the Executive for an initial 24-hour work stoppage on January 30, with other dates to follow.

The Executive did not make this decision lightly. For many of us, striking goes against the grain of our professions, but we have come to the end of the road – our goodwill has been expended.

Since that announcement many of you have become involved locally in strike committees and I want to thank you all for your outstanding work in these roles. You are daily showing resilience, strength and dedication.

Nationally, officers of the Executive have attended several contingency meetings with the HSE to ensure that services have been suitably minimised while ensuring safety. Separately, we are also meeting with the government in attempts to resolve this dispute.

Disappointingly, at the time of going to print, no meaningful proposals have been received and the dispute is proceeding. Whatever happens in the coming weeks, it's clear that nurses and midwives are strongest when we stand together.

Can I please remind all our members, who are working in conditions where they cannot provide safe care, to complete their disclaimer forms. This will be your only safeguard in the event of a near miss or an incident.

Get in touch

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

Strike action announced:
INMO officers, Executive Council members and activists gathered at the Organisation's HQ to announce strike action

Ball in government's court as nurses and midwives get set for strike

WITH no proposals on the table to avert action as we went to press, INMO members were set to begin strike action with a 24-hour nationwide stoppage on January 30.

This will see INMO members withdraw their labour for 24 hours, providing only lifesaving care and emergency response teams. Should no resolution be found, the INMO has scheduled five further 24-hour strikes on February 5, 7, 12, 13 and 14. This followed a 95% mandate from the membership for the Executive Council to organise strike action. While legally only required to give one week's notice, the union gave three weeks to allow the Department of Health and the HSE put safety planning in place.

The dispute centres on safe staffing in the public health service. The HSE has not been able to recruit and retain enough nurses and midwives on current wages.

The number of staff nurses fell by 1,754 (6%) between 2008 and 2018, despite an ageing and increasing population adding to the workload in the health service. This is only the second national strike in the INMO's 100-year history.

A number of talks in the run-up to the announced strike action with the HSE, the Department of Health and the Public Service Stability Agreement oversight body, failed to produced any proposals to avert the strike.

INMO general secretary Phil Ní Sheaghdha said: "Going on strike is the last thing a nurse or midwife wants to do. But the crisis in recruitment and retention has made it impossible for us to do our jobs properly. We are not able give patients the care they deserve under the present conditions. The HSE simply cannot recruit enough nurses and midwives on current wages. Until that changes, the health service will continue to go understaffed and patient care will be compromised.

"The ball is in the government's court. This strike can be averted. All it takes is for the government to acknowledge our concerns, engage with us directly, and work to resolve this issue, in a pro-active manner.

"We were due to meet with the government in the national oversight body in December, but the meeting was cancelled. Like many patients in Ireland's health service, we were left waiting. It's time for the government to get real and make serious proposals to resolve this."

INMO president Martina Harkin-Kelly said: "We entered these professions because we care for our patients. We'll be going on strike for the exact same reason. Ireland's patients deserve better than this understaffed health service. Nurses and midwives are now globally traded assets. The public health service no longer pays a competitive wage, so we can't get the necessary number of nurses and midwives."

Dispute centres on staff shortages due to low pay

THE INMO dispute centres on staff shortages caused by low pay, leaving the public health service unable to recruit and retain enough nurses and midwives to safely care for patients.

Nurses and midwives are the lowest-paid graduate professionals in the health service, earning thousands less than similarly qualified health professionals, despite having a longer working week.

Recent government proposals did not affect most nurses and midwives and were rejected as insufficient by 94% of INMO members in October.

INMO general secretary Phil Ní Sheaghdha said: "Ireland's nurses and midwives are speaking with one clear voice. This vote reflects a deep frustration in our professions, which the government cannot continue to ignore.

"Nurses and midwives simply want to do their jobs and care for patients properly. But low pay has led to staff shortages, compromising safe care. Ireland's current haphazard approach to nurse staffing is costly and bad for patient care, as confirmed by the Minister for Health's own taskforce on staffing and skillmix in nursing."

INMO president Martina Harkin-Kelly said: "I don't know a single nurse or midwife who wants to strike. We just want to get on with the job we love, but staff shortages have made that impossible. We've reached a breaking point.

"Nurses and midwives are united. We're standing up for safe staffing, fair pay and for our patients, who deserve better care. It's time for government to listen to frontline voices and fix this problem once and for all."

Pay comparisons of graduate professionals working in the public sector

Grade	After one year	After five years	After 10 years	After 15 years
Staff nurse	€31,110	€36,383	€43,070	€45,701
Occupational therapist/physiotherapist/ speech & language therapist	€37,784	€42,965	€48,595	€52,059
Radiographer	€36,228	€41,259	€46,746	€50,040
Respiratory technician	€37,423	€43,365	€49,848	€53,372
Teacher (post 1/1/2011 scale)	€37,804	€42,684	€50,499	€58,662
Garda (post October 2013 scale with LRA)	€31,695	€41,909	€48,270	€50,007

Public support a boost for members

AS WE went to press, the INMO was launching a public petition at **StandWithUs.ie**, calling on the government to raise nurses and midwives' pay to ensure safe staffing levels in the Irish health service.

The petition will allow members of the public to publicly back calls for improved pay and conditions for nurses and midwives.

Since the Organisation announced strike action in mid January it has been inundated with calls, tweets, comments, memes and emails from members of the public expressing their support for nurses and midwives.

Many messages have spoken personally of specific acts of kindness and dedication shown by nurses and midwives.

In further messages of support for nurses and midwives, a woman who had been a patient in the Mater Hospital earlier this month tweeted her support. "I spent some time in the Mater last week and the nurses were incredibly professional and kind. They provided impeccable healthcare, they listened and made me a lot less scared in a scary situation. They should be supported."

Another woman who had been on a trolley for more than two days said that despite the fact that her wife had her 20-week pregnancy scan scheduled for one of the proposed strike days, they had both agreed to join nurses and midwives on the picket line, commenting "Our family is important but so is theirs".

CervicalCheck scandal campaigners Vicky Phelan and Stephen Teap have also both tweeted their support.

In a very public show of support, on January 20, a group of Irish nurses and midwives working in Australia gathered on the steps of the Sydney Opera House to show their solidarity with INMO colleagues.

Powerful: *Around 300 Irish nurses and midwives working in the Sydney area gathered on the steps of the Sydney Opera House to show their support for their colleagues at home*

The powerful image shows a crowd of nurses and midwives along with a banner that reads '#Give us a reason to come home', driving home the message that nurses and midwives can earn significantly more working in Australia.

In a video posted online, Laura Phillips, one of the organisers, said: "We stand with the INMO and the PNA who are fighting for us".

"We will not come home until our skills are recognised and we are paid equally with other allied health professionals.

"It is not competitive pay rates that Ireland is offering and therefore there is a recruitment issue and a crisis in Ireland and at the end of the day this directly affects patient safety and that's why we're here.

"So we send a message to Leo, to Simon and all of the Irish government: give us a reason to come home."

The image of the nurses and midwives in Australia has been shared thousands of times as members of the public took the opportunity to voice their support for the strike.

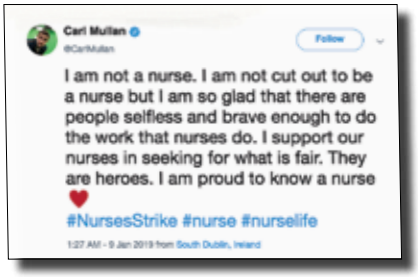
Speaking on the many messages of support, INMO president and Sligo-based nurse, Martina Harkin-Kelly said:

"We have been inundated with kind messages of support. Many have come from nurses in other countries, fellow trade unionists, and colleagues throughout the health service.

"But nurses and midwives have been especially touched by the kind words of current and former patients. Our working lives are dedicated to our patients, so it is deeply humbling and rewarding to know that patients have our backs when we need their support.

"The government may not be listening, but it's heartening to know that the public are.

"It's a challenging time for nursing and midwifery. I would encourage anyone who wants to stand with us to sign our petition at **StandWithUs.ie**," she said.



HSE's Service Plan for 2019 made no provision for safe staffing

THE HSE's National Service Plan 2019 has allocated no extra funds to provide safe staffing levels for nurses and midwives, according to the INMO.

The plan sets out the services the HSE will provide in 2019. It will see some services reduced, waiting times for some elective procedures lengthened, and delays in accessing nursing homes under the Fair Deal scheme.

The plan pledges, on page 92, to focus in 2019 on implementing the *Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals in Ireland* and the phase 2 *Framework for Staffing and Skill Mix for Nursing in Emergency Care Settings*. This would necessitate increasing the number of nurses in wards. However, the HSE Service Plan has no funding to implement this framework, despite stating it would be focusing on it this year.

Adopting the framework is government policy. Its pilot programme in three Irish hospitals found that the framework delivered:

- A 58% reduction in missed care
- A drop in patient mortality
- Improved patient satisfaction
- Lower staff burnout, less sick leave and reduced intention to leave the job
- Significant savings in patient costs due to quicker care
- Monthly net staffing savings of €2,905 per ward, due to reduced agency costs.

INMO general secretary Phil Ní Sheaghdha said: "You get what you pay for. Plans are well and good, but they're just words on paper without the money to back them up.

"The government's own safe nurse staffing framework makes patients safer, saves money, and makes sense. Yet the upfront investment is nowhere to be found.

"The evidence shows that extra nurses and midwives make a real difference. The government must confirm that the necessary investment in safe nurse staffing levels will be provided in 2019, and an implementation plan agreed."

HSE's long-awaited winter plan falls short

ON publication of the HSE's long-awaited *HSE Winter Plan 2018/2019* in the first week of December, the INMO was dismayed to find that the plan did not significantly increase health service capacity or deal with understaffing.

Winter plans aim to deal with expected spikes in demand on Ireland's hospitals in winter. Every winter in the past decade has featured significant overcrowding, and 2018 has seen new records set each month for the number of admitted patients on trolleys.

The number surpassed 100,000 for the year 2018 for the first time since INMO records began in 2006. Trolley watch analysis shows that overcrowding is typically bad in December, but worst in January and February.

The INMO criticised the HSE for the late publication of the plan, which is normally published well before December. In contrast the NHS's winter plan was published back in September.

INMO director of industrial relations Tony Fitzpatrick said: "Overcrowding isn't just a winter problem anymore, hospitals are over capacity every day of every season, and the problem is getting worse.

"It's clear from our initial consultation that the draft Winter Plan will not increase capacity at all this year and only modestly next year.

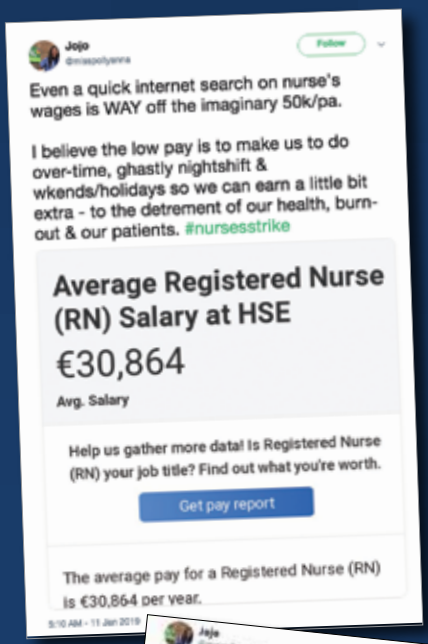
"The government accepts that we need to grow the health service's capacity, but extra beds require extra nurses. Without addressing pay, our health service will simply not be able to attract enough nurses and midwives."

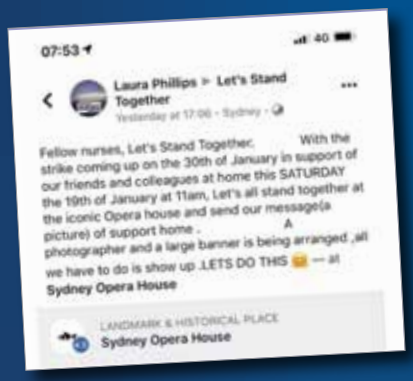
INMO members say strike act

Sean Shaughnessy was quoted in *The Irish Sun* on January 14, 2019
"We've spent the last three or four years trying to negotiate this, and every time we've been promised it'll be looked at. Now there comes a point in any relationship where there's a breakdown, and there's obviously a break down between everybody."

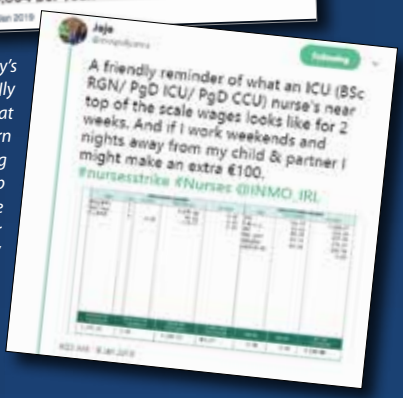
Ann Noonan spoke on *RTE News* and was also quoted in *The Irish Times* on January 8, 2019:
"Pay is the solution to this strike, but it is not the cause. The cause is the understaffed services we work in every day – where uncompetitive wages mean the public health service cannot recruit or retain enough nurses and midwives to work safely."

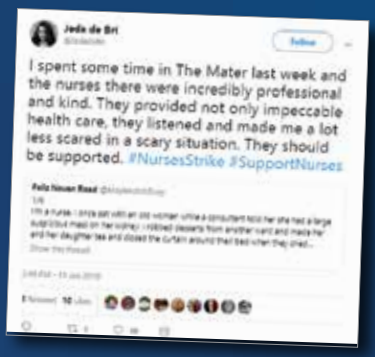
Cian Milofsky spoke to *RTÉ News* on January 8, 2019: *"The pay for nurses really isn't satisfactory when compared to other healthcare professionals and nurses working abroad."*





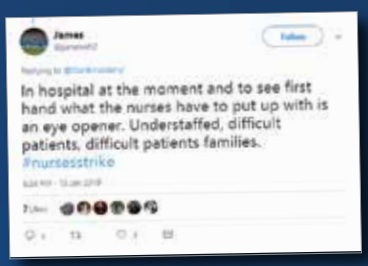
ICU nurse Joanna Hickey's tweets emphatically busted the myth that many nurses earn €50k/pa by sharing her payslip. The payslip showed she took home just over E1,120 for 'a near top of the scale' nursing job over a two-week period





Nurse Maylene McEvoy's Twitter thread on what it really is to be a nurse in Ireland at the moment went viral as it was shared both here in Ireland and internationally

Marie O'Brien was quoted in *TheJournal.ie* on January 9, 2019:
"We need to have pay restored and ensure that we have safety for our patients. Everything for us as nurses hinges around a safe environment and safety for our patients."



Patients and fellow healthcare professionals are sharing their support online for INMO members

ion now the only way forward

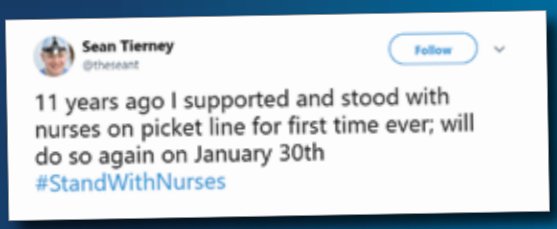
Strike announcement: *Flanked by INMO president Martina Harkin-Kelly and members of the Executive Council, INMO general secretary Phil Ní Sheaghdha addressed the media outside INMO HQ to announce the Organisation's planned strike*

'GOODWILL IS DRIED UP' Two Irish nurses explain how harsh reality of job is taking its toll on their lives as 40,000 to them prepare to go on strike

Margaret Frahill says more and more Irish nurses are quitting hospitals here because they are suffering from burnout

SOME 40,000 nurses are to stage a 24-hour strike on Wednesday, January 30, over what they claim are serious staffing issues that are impacting the workforce and patients more than ever.

Margaret Frahill was quoted in *The Irish Sun* on January 14, 2019
"I'm seeing nurses at the moment leaving the profession, much younger than me, because of the stress and burnout in it."
She also spoke to ***TheJournal.ie*** *on January 9: "Now I can see that there will be nobody nursing me unless we start paying a salary relating to the job we do," Frahill told* ***TheJournal.ie****, following an announcement by the Irish Nurses and Midwives Organisation (INMO) that its members will strike later this month. "Pay us now and reap the rewards of the future of nursing in this country."*



Sean Tierney
@theseant
Follow

11 years ago I supported and stood with nurses on picket line for first time ever; will do so again on January 30th
#StandWithNurses

Independent.ie

'There are far too many patients for one nurse to look after safely' - Nurse who wants to leave profession

Anne-Marie Walsh
9 January 2019 2:30 AM

'Looking for parity': Nurse Catherine O'Connor at INMO headquarters in Dublin. Photo: Colin O'Riordan

Catherine O'Connor was quoted in the Irish Independent on January 9, 2019:
"Pay is a factor because it's at the centre of the poor conditions that we're experiencing at the moment. I think if we had better pay for nurses that there would be more nurses on the wards, which would increase the quality of the conditions at the moment, which would then lead to a kind of snowball effect."

Overcrowding hit new high in 2018

INMO calls yet again for government to engage on underlying issues

OVERCROWDING in hospitals was at its worst ever in 2018, according to INMO trolley/ward watch analysis.

More than 108,000 patients went without hospital beds last year – the highest number since 2006, when INMO records began, and nearly double the number (55,720) in that year.

These figures are a 9% increase on 2017, which itself was a record high.

The months with the highest trolley figures were January (12,201), February (10,772) and March (10,511).

The hospitals with the highest trolley figures were:

- Limerick University Hospital, 11,437
- Cork University Hospital, 9,135
- Galway University Hospital, 7,452
- Midlands Regional Hospital, Tullamore, 5,831
- Tallaght University Hospital, 5,432.

Smaller hospitals also experienced record overcrowding, including South Tipperary General Hospital which saw 5,201 patients on trolleys in 2018.

The INMO blames this crisis on low bed capacity and understaffing. The Organisation has called on the government time and again to engage with the Organisation to develop real proposals to put an end to this crisis. However, the government's failure to engage on these and other issues drove 95% of members to vote in favour of strike action, which was due to begin on January 30 as we went to press *(see page 8)*.

INMO general secretary Phil Ní Sheaghdha said: "Despite government spin, 2018 was the worst year on record for overcrowding. Negative records were set throughout the year, with over 100,000 admitted patients forced to wait on trolleys and chairs, without a proper bed. We know that this dramatically worsens outcomes for patients.

"The HSE does not have enough beds to support our population. More beds means more nurses, but the HSE can't hire enough on current wages. It's beyond time for the government to engage with the INMO to resolve this crisis.

"Patients should be focused on recovering, but instead have to worry about waiting times, understaffing and a lack of beds. 2019 must see real changes in policy and funding to resolve this once and for all."

Table 1. INMO trolley and ward watch (Full year analysis 2006 – 2018)

Hospital	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
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	2,968
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	3,569
Mater 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	4,967
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	3,754
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	n/a
St James's 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	2,025
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	3,773
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	5,432
National Children's Hospital, Tallaght	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	85
Our Lady's Children's Hospital, Crumlin	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	579
Temple Street Children's University Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	749
Eastern total	**26,401**	**27,107**	**34,074**	**36,623**	**37,135**	**34,947**	**26,723**	**27,255**	**26,569**	**33,844**	**27,208**	**24,229**	**27,901**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	147	233	627	779	731
Cavan General Hospital	2,816	2,779	2,189	1,975	3,291	4,572	2,569	1,954	460	1,000	771	482	619
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	9,135
Letterkenny General Hospital	3,059	1,253	388	378	474	592	539	1,277	2,755	2,814	2,047	4,889	5,174
Louth County Hospital	200	88	152	146	25	n/a	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	1,998
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	2,681
Midland Regional Hospital, Mullingar	169	91	183	528	1,921	3,204	2,398	2,845	3,908	4,366	4,849	4,844	4,344
Midland Regional Hospital, Portlaoise	469	283	425	297	426	1,926	539	824	1,589	2,162	3,364	3,203	2,815
Midland Regional Hospital, Tullamore	64	34	95	77	766	1,857	1,303	1,156	3,746	2,758	4,748	4,774	5,831
Mid Wester Regional Hospital, Ennis	867	961	252	368	431	411	324	333	7	125	330	175	214
Monaghan General Hospital	106	287	293	119	n/a	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	81
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	2,233
Our Lady's Hospital, Navan	520	847	851	1,084	453	1,469	745	1,029	1,059	1,000	595	2,435	1,265
Portiuncula Hospital	403	281	306	605	840	941	821	813	912	1,100	892	1,569	1,302
Roscommon County Hospital	589	764	725	755	1,036	719	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sligo University Hospital	784	732	667	955	1,754	1,505	2,086	963	2,017	2,478	2,308	2,406	4,183
South Tipperary General Hospital	727	784	881	500	666	768	2,138	2,762	1,959	2,028	5,399	5,249	5,201
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	4,052
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	7,452
University Hospital Kerry	1,144	507	763	337	623	672	606	694	1,005	1,389	1,664	2,215	3,396
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	11,437
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	4,319
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	1,863
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**	**80,326**
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**	**108,22**

Tony Fitzpatrick, INMO director of industrial

Breaches to ED agreement pursued

THE INMO is continuing to pursue breaches of the 2016 Emergency Department Agreement with the HSE and the Department of Health through the auspices of the WRC.

Following our last update in *WIN*, at ED oversight meetings in November and December, the INMO highlighted the HSE's failure to provide agreed additional staffing to deal with the significant levels of overcrowding throughout 2018.

The INMO had secured 57 WTE additional staff to care for admitted patients within EDs, however funding for this had not been approved by the Department of Health at the time of meeting, and the HSE had failed to commence the recruitment process.

Significantly, the INMO secured agreement for five additional CNM2s for admitted patients in the hospitals that were escalated due to overcrowding since 2016 (namely University Hospital Kerry; Mercy University Hospital, Cork; St Luke's, Kilkenny; Sligo General Hospital; and Letterkenny University Hospital). Also, the HSE is to ensure that the agreed nine assistant directors of nursing (ADON) for patient flow posts are in place and working to the agreed job description.

Several items were agreed at the WRC meetings, including reaffirmation by Management that no staff should be redeployed out of the ED at times of escalation.

The HSE confirmed that approval had been sought for 57 WTE staff nurse positions for EDs in compliance with the recalibration process. The HSE said these posts were being considered as part of its service planning process. The HSE was to revert to the INMO by December 21 to confirm this funding and to proceed to advertisement.

Posts for care of admitted patients in EDs

On the 123 WTE posts to care for admitted patients in EDs, management confirmed that 105 of these had been filled. The INMO sought greater clarification and a site by site break down. When this detail was provided by the HSE on December 16, the INMO queried the numbers returned for Tullamore, Portlaoise, Kilkenny, Galway and Mayo. The HSE confirmed that Tullamore and Portlaoise recruitment processes were complete and posts would be offered in January 2019. On Kilkenny, approval had been given to fill the posts, but the hospital had not progressed the matter. More details were sought on Galway and Mayo. The INMO also pointed out that, for example, in Cork University Hospital, the nine individuals were not in post and that the HSE therefore needed greater clarification from the services.

Management reaffirmed that 15 WTE CNM2s for admitted patients were approved and funded with many posts filled. Any subsequent vacancy should be filled as funding is available. It was confirmed that CNM2s for admitted patients will be provided for Kilkenny, Letterkenny, Sligo, Mercy and Kerry university hospitals. The HSE Acute Hospital Division was to pursue the matter with the hospital groups. The HSE confirmed that the Mercy and Kerry had their business cases signed off and they were in the process of filling the CNM2 positions. Progress was also made with regards to Sligo and Letterkenny. It was advised that funding had been provided for a CNM2 for admitted patients in Kilkenny, however, the hospital had not submitted a case to fill the post so the HSE believed Kilkenny was not seeking to fill that position. The INMO said it would pursue the matter with local management.

Bursary for new ED recruits

As part of the ED Agreement, new recruits to EDs since January 2016 should be in receipt of a €1,500 education bursary. The HSE confirmed that monies were set aside for this provision but said there have been no claims for it so it is likely that no payments have been made. Both parties agreed to highlight the availability of this €1,500 bursary.

Patient flow

Management reaffirmed that the ADON patient flow posts should be appointed in compliance with the agreed job description. The INMO pointed out that ADON patient flow posts have been merged with operational ED ADON posts in several named locations. The HSE said it would ensure that the nine WTE ADON for patient flow posts are in place and working to the agreed job description and agreed that the ADON for patient flow should not take on an operational role.

St James's transition unit

Formal correspondence will issue from the Acute Hospital Division to the Dublin Midlands Hospital Group on plans emanating from St James's Hospital to use staff nurses and CNM2 for admitted patients to staff a transition unit. The parties agreed that this not an appropriate use of the resource purpose, to care. Any other plans to open a transition unit will be presented to the INMO and normal engagement should take place.

Other compliance issues

Following up an INMO request for detail on the number of times that the National Ambulance Service diversion policy had been used in response to hospital escalation, the HSE confirmed it had only been used on a few occasions. The INMO said it suspected that and the benefit of the policy is questionable, except for emergency and safety reasons. However, the point being highlighted is the failure of the HSE to comply with the escalation policy.

The Special Delivery Unit will provide to the INMO the audits completed as a result of the instigation of the full capacity protocol. Again, this is provided for in the Agreement.

Winter plan

While the HSE Winter Plan was yet to be announced at the time of meeting, the HSE provided broad details of it to the INMO. The HSE reaffirmed the need for all hospitals to engage with the INMO on all proposals around the winter plan. The INMO highlighted concerns it had with particular hospitals that were proposing to reduce bed capacity but extend AMAU services. The HSE indicated it was not in agreement with the reduction of bed capacity and would examine the specific matters in University Hospital Limerick.

The HSE confirmed that only a small number of beds were to come on stream in January with the majority indicated in the plan not being on stream until the summer or later. The HSE also identified that it had arrangements with the NTPF to operate a voucher system for the nine sites that have been identified as the target sites. The HSE also outlined

relations, reports on current national IR issues

that it had bought additional bed capacity, both acute and critical care, and was also using additional private diagnostic capacity.

The HSE said the use of isolation cubicles in ED, due to a lack of inpatient isolation capacity and the failure to complete laboratory reports quickly would be immediately addressed. Specific issues at Naas General Hospital would be addressed immediately with the group and the HSE would ensure that a 1.5-hour testing process would be implemented.

The HSE confirmed that the resource and authority to fill any vacant posts is approved at national level and there were no restrictions on directors of nursing filling vacant posts that arise in EDs.

With delayed discharges increased to 624 at the time of the meeting, the HSE said it was planning to provide additional home care packages and home help supports with the goal of reducing this figure to 480 by Christmas.

Bed capacity

Management outlined the need to open additional bed capacity. However, limited number of beds may be opened by January 1, 2019, to be announced as part of the Winter Plan. The HSE and the INMO will meet to agree the appropriate staffing for these beds, using the Department of Health's Safe Staffing and Skill Mix Taskforce report published in April 2018. However, the remaining beds are unlikely to open until late 2019 or early 2020. Both parties agreed that fundamentally, the lack of capacity is a major causative factor and needs to be addressed proactively in the coming year.

The INMO and HSE will meet again on February 11, 2019 at the WRC.

Intensive WRC talks on theatre issues

FOLLOWING the WRC on November 21, 2018 on the many matters that affect theatre services currently, a direct meeting between the INMO and HSE management and the Department of Health took place on December 18, 2018.

I attended along with the officers of the Operating Department Nurses Section. This meeting was plenary in nature and a further meeting, involving the theatre nurse reps, will take place before both parties reconvene at the WRC in February 2019.

The INMO outlined issues of concern about on call including:

- Excessive on call
- Non-compliance with 33/2003
- Inadequate sleep time
- Nurse staffing levels on call
- Inadequate controls out of hours
- Mixed arrangements with regards to night duty and on call
- National centres, regional centres and difference in the provision of on call
- Duality of surgical and obstetric services, with some hospitals having one team covering both and others having two separate teams
- Inadequate staffing levels and skill mix
- Staff turnover
- Care of ICU patients in recovery
- Education of theatre staff
- Standard of facilities for on call staff
- Excessive on call with part time staff doing same level of on call as full-time staff
- Lack of controls in the out of hours period
- Theatre over runs.

Talks on pension matters

A MEETING took place between the INMO and HSE on December 6, 2018 on several outstanding pension matters. The unions raised the fact that individuals are not receiving pension entitlements for up to four months after retirement. The HSE was to revert in January 2019 on whether interim payments can be made until entitlements are finalised.

No progress was made regarding senior staff nurse appointments. The HSE said it is acting under strict DPER circular instruction on this.

On the issue of certain allowances and on-call stand-by payments being pensionable, the HSE has issued correspondence to the system clarifying that this should be superannuable.

The issue of QROPS, where individuals can transfer their service from the UK to the HSE is to be clarified by the HSE/Department of Health in January 2019.

SATU policy

Engagement is ongoing with the Department of Health with regard to a defined policy for the provision of a sexual assault treatment unit (SATU) service and a request has been made to the department of health for a meeting in January 2018. Furthermore, correspondence has issued to the National Lead on SATU for engagement on outstanding IR matters including the appropriate payment for a SATU service, out of hours.

Developments in community nursing

WITH the ongoing resource challenges within community nursing, there are plans for significant developments within community nursing as a result of Sláintecare. The INMO is pursuing several of these matters, including:

- Filling director posts
- Reviewing the number of assistant directors of public health nursing posts
- Filling community nursing vacancies countrywide
- Increasing the number of PHNs and community RGNs to meet service demand
- Provision of additional administrative support
- Attracting more candidates for student PHN sponsorship
- Weekend working
- Governance of home helps
- Standard payment of allowances to PHNs and CRGNs.

The INMO has learned that an Ages and Stages Questionnaire (ASQ) is being rolled out by Nurture – the Revised Child Health Programme. However, there has been no consultation with the INMO on this. Following correspondence with the HSE, it was agreed that the matter would be delayed pending engagement between primary care and the Nurture Programme and subsequently with the INMO.

The INMO will brief all directors of public health nursing ahead of engagement with the HSE on this. Members should not engage with meetings or training on ASQ until instructed.

Dave Hughes, INMO deputy general secretary, calls on the government to stop hiding behind the veil of a Public Service Stability Agreement, which it has already failed to honour itself

Minister spins as health service burns

THE Minister for Finance used an article in *The Sunday Business Post* on January 6, 2019 in defence of the Public Service Stability Agreement (PSSA) to launch an attack on the right of nurses and midwives to use that agreement as it had been written in terms of recruitment and retention.

The only category mentioned were the professions of nursing and midwifery – other grades and groups in the public service who have already participated in industrial action and challenged or rejected the agreement in its entirety were not mentioned.

The *SBP* article made a number of exaggerated claims and inaccurate and misleading assertions in an attempt to set the dialogue in advance of the INMO Executive Council's consideration of its 95% mandate in favour of strike action.

The article starts with the Minister claiming that at €18.7 billion the public service pay bill amounts to one-third of public spending. In fact, it is less than a quarter, at 22% of public spending. He then proceeded to claim that 3,300 additional nurses have been recruited to the public health service since 2014 while omitting the fact that at that point, there were 5,000 less nurses in the system than there had been in 2010 and that while the numbers of nurses and midwives decreased by 1,418 or 4% since 2008, all other categories in the health service have increased by 39%-61%. Management grades in the HSE increased by a whopping 39% over the same period.

Dealing with the PSSA, the Minister asserted that it provided increases to nurses, midwives and other public servants when, in fact, for nurses and midwives the PSSA is only about pay restoration and they will not reach the rate of pay that they had prior to the recession until the end of 2020. Even at that point their net pay will be less than it was 10 years previously because the pension levy, unjustly imposed on them, has partially been replaced by an additional superannuation charge.

The Minister promotes the Public Service Pay Commission with selective quotes but fails to mention that he interfered with its terms of reference when he instructed it, as is recorded in its report, that it could not, in any circumstances, deal with the totality of nursing pay, despite the fact that the original agreement and terms of reference do allow it consider pay. The Minister's department also made a submission to the Pay Commission which ignored submissions made by the Department of Health/HSE confirming the crisis in recruitment and retention for nurses and midwives and instead promoted the idea that the crisis in nursing and midwifery was no worse than any other group or grade in the public service, with a few exceptions for specialist nurses and midwives. Such an assertion is far from the truth and can be seen by patients and staff in every service throughout the Irish public health service.

The accusation put forward by the Minister that the INMO is potentially in breach of the PSSA again is widely inaccurate and is more than a little tongue in cheek when one considers that the HSE itself has breached the PSSA by failing to produce a workplan for 2018 or 2019 and that the Minister's own department chose to prioritise clause 4 of the PSSA which did not provide for any payment during the lifetime of the agreement over clause 3 which dealt with recruitment and retention and specifically said that solutions required to deal with those difficulties in a particular grade or category could be put in place during the lifetime of the agreement. By prioritising clause 4 over clause 3 the Minister was pandering to a populous cause with regard to new entrant pay on the basis that it covered more grades than dealing with the real market problem faced by the health service in recruiting and retaining nurses and midwives.

Reneging

This is a departure from the agreement and a reneging by government on commitments given that the recruitment and retention issues facing nursing and midwifery would be properly examined and dealt with during the lifetime of the PSSA.

By contrast INMO members accepted, primarily based on clause 3, the PSSA, which itself is poor enough and have attempted to have their case promoted through procedure. The interference with that procedure and the assertion by government that concessions to nurses and midwives would lead to cross sectoral claims is contradicted by clause 3 itself, which every union in the public service signed up to not pursuing cross sectoral claims based on any such concessions.

Savings available

The INMO, on behalf of its 40,000 members, want the government to directly engage with the Organisation and, if it does so, we can demonstrate, based on the government's own research, that the funds necessary to recruit and retain can be recouped by the savings available by tackling the gross understaffing which is now occurring.

Currently Ireland is training nurses and midwives for export. This is a costly exercise for the taxpayer as many of these nurses do not come back and the evidence for this is demonstrated by the abysmal failure of the HSE's 'bring them home' campaign.

The consequence is that the HSE has tendered for a €10 million contract for an agency to engage in foreign recruitment with €10,000 per candidate recruited in agency search fees along with a further €11,000 in fees and costs related to orientation and adaptation of those recruited when they arrive in Ireland. An adequate recruitment and retention strategy with proper pay for nurses and midwives would both recruit and retain at a much higher level and reduce these excessive recruitment costs. The HSE currently spends €1.5 million a week employing agency nurses to fill gaps caused by the shortage of nurses and midwives on shifts. Additionally, the voluntary hospitals spend approximately €0.5m a week on the same exercise. This adds up to circa €100m a year spent filling gaps caused by the shortage and making millionaires out of agency owners who supply nurses and midwives, many of whom already work in the public health system.

Workforce stabilisation

Most importantly, the shortage of nurses and midwives and the failure to recruit and retain means that the current nursing and midwifery staff to patient ratios are out of kilter with other jurisdictions and fall well short of the proven requirements for Irish medical and surgical wards in the government's own policy.

Under its own taskforce, the government received positive proof that the reliance on and expenditure in relation to agency directly decreased by 95% when wards were properly staffed and resourced consistently. The stabilisation of the workforce led to reductions in absenteeism and turnover with improvements in patient care and reduced length of stay for patients. In respect of every nurse-sensitive indicator, the results were positive. Overall having the right skill mix in an inpatient medical or surgical ward which leads to improved outcomes and reduced length of stay was proven to provide savings of up to €2,397 per case. If the taskforce report was applied in a stable recruitment and retention situation, millions of euro could be saved for the health service.

But government would prefer to shelter behind the veil of a PSSA which, because of the interference with what was agreed, is no longer fit for purpose. The INMO is simply seeking that the agreement does what it said it would and that there is a need to address nursing/midwifery pay and conditions, which are inferior to all other comparable grades.

Since 2006 nurses and midwives are required to have an honours degree of four years duration before they can register in this country. Such is the quality of nurse and midwife education and training that the Irish nurse and midwife is highly sought after right across the English-speaking world. The professions have grown and adapted to advances in medical and nursing care and ever-increasing acuity in the client population. Nurses and midwives are making decisions and taking responsibility, with both accountability to their employer and the public through statutory regulation, yet the nurse attending the patient in the bed is often the lowest paid professional with whom they will have contact during their stay in hospital.

Healthcare assistants can be higher paid than the nurse with whom they work if the nurse has less than five years' service. Social care workers who report to, or work alongside, nurses are higher paid than the nurse. Also, the other health professional therapeutic grades who attend the same patient for short periods of time with their specialty, require the same level of education and qualification but work shorter hours and are paid €7,000 more than the nurse who is working with them.

Is it any wonder that nurses and midwives are attracted to Australia, the UK, Canada and the US, where they are properly valued and it can be no surprise given the lack of esteem shown to them that they have decided, by a 95% majority, to strike?

It is time for the Minister and Taoiseach to take their heads out of the sand and wake up to the reality that they are listening to the wrong voices. The public will be unforgiving if nurses and midwives are forced into strike action and this time, they will know who to blame – a government that failed to listen.

The reaction of the same government, through its failure to attract candidates for the CEO position in the HSE, makes a stark contrast to its reaction on the failure to recruit and retain nurses and midwives. When the HSE declared that it could not get suitable candidates for a CEO, government immediately responded by increasing the offer by €50,000 per annum. When the government is faced with a critical shortage of nurses and midwives, which impacts directly on patient care, it patronises the nurses and midwives and hides behind the veil of a Public Service Stability Agreement.

Staffing crisis continues at Tallaght paediatric ED

THE paediatric emergency department at Tallaght Hospital continues to struggle to recruit sufficient numbers of staff nurses, resulting in inadequate staffing and skill mix on duty.

A WRC agreement in May 2018 allowed the unit's staffing complement to increase from 25 to 34 WTE. This included agreement to recruit seven WTE CNM2 shift leaders. The shift leader posts are now in place, however, due to the ongoing recruitment crisis, the unit was depleted by eight WTEs. At a recent meeting with the INMO, management outlined its efforts to recruit staff. Despite this, staffing levels remain extremely concerning.

INMO IRO Joe Hoolan said: "Staffing levels in this department are a major concern. The unit sees the same volume of emergency presentations as OLCHC, and our members are struggling to maintain patient safety." Members were due to meet in January as we went to press to decide what action they wish to pursue in their efforts to secure a safe environment for emergency paediatric care.

Thumbs up from Mater nurses as work permit issues solved

Thumbs up as visa problems averted: *International nurses working at the Mater Hospital with INMO IRO Albert Murphy (back left) are (l-r): Arlene Diaz, overseas adaptation nurse coordinator/ clinical placement coordinator; Hannah Wei; Jackson Daniel James; Ace Marion Bayron; and Miguel Austin Gapuzan*

DUE to a backlog in the Department of Business Enterprise and Innovation (DBEI), there have been serious concerns for international nurses who are experiencing difficulties in securing letters of support from the department and subsequently appointments with the Garda National Immigration Bureau (GNIB).

International nurses concerned work under the Critical Skills Programme in a number of hospitals, including the Mater Hospital. This programme allows employees who have critical skills to work in the Irish economy.

In the case of the Mater Hospital, up to 35 nurses faced the threat of having to cease work because of the delays they were experiencing in securing the letters of support from the DBEI and other delays in relation to the GNIB process.

Arlene Diaz, CPC in the Mater Hospital, organised a group of the international nurses to help resolve this issue. The INMO contacted the Mater Hospital director of nursing office and HR department, and wrote to the DBEI about this issue. The INMO also highlighted the difficulties through a press release, which received wide coverage in the media in the run up to the Christmas period.

This exposed that the government was out of touch. On the one hand we had a situation where nurses were being told by their employer that they would have to cease work because they had no permit, while on the other, in sharp contrast, Taoiseach Leo Varadkar was calling for the Irish health system to work "at full whack over the Christmas period". The international nurses concerned were working in critical care areas in the Mater Hospital, including cardiology, theatre, special care units and other specialist areas.

However, following intervention by the INMO, the backlog has improved dramatically. The DBEI issued a statement, which can be viewed on its website, stating that no nurse who is experiencing difficulty, due to the backlog in the department, in receiving a letter of support would be asked to leave the country.

– Albert Murphy, INMO IRO

Nazareth House S39 pay restoration

FOLLOWING two recent WRC conciliation conferences, the INMO secured a significant step towards full pay restoration for members working in Nazareth House, Mallow. As a Section 39 organisation, this facility fell outside the prioritisation sites for the national pay deal.

However, following a 1% pay increase secured in the WRC, S39 members will receive €500 restoration in May 2019, a further €500 in May 2020, 1% in January 2021 and 1% in April 2021. This provides for significant pay restoration for S39 members, however the INMO is continuing its endeavours to secure the remainder of pay restoration as part of the national process for those outside prioritisation sites.

INMO IRO Liam Conway said: "This represents a significant improvement for these members. The lack of pay restoration had significantly impacted on recruitment of nursing staff in Nazareth. However, improved pay and a commitment to align to HSE pay scales will significantly improve this issue."

Back-dated allowance

A MEMBER recently received retrospective payment of the specialised qualification allowance back-dated to 2009. This person was working as a CNM2 in a specialised area with the relevant qualification. The matter was referred to third party but was settled ahead of a Labour Court referral. On receipt of a qualification in the area you are working which is NMBI Category 2 approved, members need to claim for this allowance, which currently stands at €2,791 per annum.

– Liam Conway, INMO IRO

Successful recruitment drive in Cavan

At your service: *At the INMO recruitment and information event in Cavan General Hospital were (l-r): Neal Donohoe, student and new graduate officer; Karen Eccles, Executive Council member; and David Miskell, IRO*

A SUCCESSFUL recruitment and information event was held in Cavan General Hospital to encourage new members to join the INMO and provide information on services available to existing members.

There was particular interest in the wide range of educational and professional development opportunities available to INMO members, in addition to nurses and midwives expressing interest in joining the Organisation.

Karen Eccles, local INMO representative and member of the Executive Council for the North East area, said that: "Such events are important as they provide an opportunity to engage with potential new members and provide useful information to existing members on the range of services provided by the INMO."

The INMO plans to hold such events more regularly at Cavan General, as well as at other workplaces around the country.

Meanwhile, a basic rep training course for members in the north east area who are interested in becoming INMO reps in their workplace will be held in Drogheda on March 19-20, 2019. For further information email: martina.dunne@inmo.ie

– David Miskell, INMO IRO

Ongoing issues at Cavan General referred to WRC

A NUMBER of ongoing issues at Cavan General Hospital have been referred to the Workplace Relations Commission recently relating to staff shortages and compliance with INMO agreements.

Among the matters referred is the significantly understaffed pre-discharge unit, which is currently catering for a patient cohort with high acuity levels and needs that are inconsistent with what might be reasonably expected on such a unit.

Additionally, staffing issues and practices in the endoscopy unit and the acute medical assessment unit (AMAU) have also been referred to the WRC, with a view to reaching an appropriate agreement for these areas.

Compliance with the National Emergency Department Agreement relating to the function of the CNM2 for admitted patients is also an issue that is currently being addressed through the IR process.

David Miskell, INMO IRO for the North East, said that these matters have been the subject matter of extensive local discussions however definitive resolutions have not been found.

While acknowledging management's efforts to achieve a resolution on some of the issues, he said that the issues will need to advance to the WRC for a more definitive resolution.

Mr Miskell also noted in particular the significant and ongoing efforts of local union reps for their advocacy on behalf of their colleagues and safe patient care.

Long-serving Louth County rep retires

ON Sunday, January 6, colleagues, family, friends, INMO representatives and members of the management team joined together in Louth County Hospital to honour long-serving INMO activist Aoife Carr on her retirement.

Aoife began her general and midwifery training in 1977 at the International Missionary Training Hospital, Drogheda, where she was encouraged to join the INMO (then the INO).

On completing her training, she took up a position in Louth County Hospital in 1982. Throughout her time in Louth County, Aoife has been an active and loyal member of the Dundalk Branch – from participating in a local work-to-rule in 1990, on foot of which significant improvements were made to staffing levels and working conditions, and taking to the picket lines in the strike of 1999.

She took an active part in the negotiations with management in 2010 when Louth County Hospital was transformed to a non-acute facility.

Having served as branch secretary and as a local rep, Aoife has supported and represented her colleagues in Louth County and more recently has assisted the Drogheda Branch.

Farewell Aoife: *Pictured at the celebration for Aoife Carr's retirement from Louth County Hospital were top (l-r): Mai Kearns McAdam, Group HR lead & Change Manager; Adrian Cleary, director of nursing; Aoife; and Yvonne Burke; and lower photo (l-r): David Miskell; Cathy Rabbat, Aoife Carr, Emma Ross, Colette Vize and Anita*

INMO IRO David Miskell extended his sincere thanks to Aoife for her support since he started working for the INMO and said it was a great pleasure to work with her. He wished her all the best for the future.

Thanking all the hospital staff for their good wishes, Aoife confirmed that despite her retirement, she intended to continue to support her colleagues in the INMO's challenging year ahead.

Retired Section diary dates

- Tuesday, February 26 – guided tour of Trinity College and visit to the Book of Kells. Meeting at 11am. Please contact Ger Sweeney at Tel: 087 2794701. Book tickets on arrival
- Thursday, March 28: Glasnevin and Botanic Gardens. Meeting at 11am. Please contact Ann Igoe at Tel: 087 7735735
- Sunday, April 7: Four night stay at the Park Hotel, Dungarvan, Co Waterford, €330 per person. The trip includes transfer to and from Dublin, dinner and bed and breakfast each day, and daily tour excursions by luxury coach. To book, contact Annette McGinley at Tel: 074 9135201 or email: jmgtravel@eircom.net

For any other queries contact Myra Garahan at Tel: 087 6305231.

The Retirement Section social calendar can be found in full at: **www.inmo.ie/retired_nurses_midwives**

Richmond hosts 48th FOHNEU board meeting

(Left) FOHNEU delegates from around Europe in attendance at the meeting (back, l-r): Gert van Gent; Styliani Tziaferi; Mary Doran; Gote Molleby; Mari Anne Anttila; Lotte Falck; Gemma Arevalo; (front, l-r): Una Feeney; FOHNEU president Henriett Hirdi; INMO president Martina Harkin-Kelly; Julie Staun; Valerie Vangulck; and FOHNEU treasurer Margaret Morrissey. (Right) Martina Harkin-Kelly addressing attendees at the board meeting

RETENTION and pay issues were the focus of INMO president Martina Harkin-Kelly's opening address at the 48th FOHNEU (Federation of Occupational Health Nurses in the European Union) board meeting in November last year.

Ms Harkin-Kelly was speaking at the meeting which was held at the Richmond Education and Event Centre, Dublin from November 14-16, and attended by delegates from nine European countries.

Una Feeney and Margaret Morrissey were the FOHNEU representatives from Ireland in attendance.

Topics covered at the meeting included:

- Nursing best practices in occupational health
- Comparisons of educational curricula
- Final preparations for the 7th FOHNEU International Congress in Budapest in April (for further details about Congress see **www.fohneu.org**)

Busy agenda for ODN Section's conference

THE Operating Department Nurses Section will host its annual conference at the Richmond Education and Event Centre for the first time next month.

The poster competition is open until March 1 and all section members are encouraged to enter this.

A prize fund of up to €1,000 is available to entrants and the overall winner of the competition will be invited to present at next year's annual conference.

Fee reduction

INMO members will also benefit from a discount in the conference fee. *Please see page 26 for full details.*

Topics

The topics that will be covered over the two-day conference include:

- INMO organisational updates
- Legal updates
- Neurology
- MDRO infection
- Sleep deprivation
- Difficult airways
- Essential information for new staff and students starting in theatre
- Emotional intelligence.

The Section is looking forward to seeing you all at the Richmond.

Please visit www.inmo.ie for details of your Section's AGM, including the date and venue Your attendance at these meetings is valued.

See Diary on *page 60* for details of upcoming Section meetings and conferences

Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Query from member

I am currently working in the public health service as a staff nurse having been appointed in early 2000. I would be interested in retiring at age 56 and would like to know how this will affect my pension and lump sum.

Reply

For nurses/midwives who entered the public sector pre-April 1, 2004, normal retirement age is 60. For nurses/midwives who entered post-April 1, 2004, it is 65.

On April 1, 2004 cost-neutral early retirement was introduced to allow public servants to retire early; if your normal retirement is 60 you can retire between the ages of 50 to 59. If your normal retirement age is 65 you can retire between the ages of 55 to 64.

If you decide to retire early, both your gratuity and pension will be subject to an 'actuarial reduction' to take account of the fact that your gratuity is being paid earlier than anticipated and that your pension will now have to be paid over a longer period. The reduced rate of pension applies throughout the lifetime of your pension (Department of Health Cir 10/2005).

All applications for cost neutral early retirement are considered based on business needs. Nurses and midwives opting for this scheme should contact their superannuation department.

Query from member

I am currently working 20 hours per week and have been asked to work additional hours. Are these extra hours reckonable for pension purposes?

Reply

Extra hours worked up to 39 hours are reckonable for pension purposes. It is vital that adequate records are maintained of all hours worked and that pensionable service is clearly identified. Also your contract should be adjusted to recognise the increase in hours.

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 or
Email: catherine.hopkins@inmo.ie/
karen.mccann@inmo.ie
Mon to Thur 8.30am-5pm/Fri 8.30am-4.30pm

INMO

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

Introducing Executive Council members

Breege Creavan

Staff nurse at
University Hospital Galway

BREEGE originally pursued a career as a professional Irish dancer, travelling the world while studying business for a few years. On returning to Galway, Breege undertook a pre-nursing course and absolutely loved the modules, particularly anatomy, physiology and holistic care for patients.

Her placement was at the hospice in Harold's Cross, Dublin. Seeing the care provided by nurses there convinced her to go into nursing. Realising there are many different career paths within nursing, Breege decided she wanted to help patients return to their optimum health and care for them in an empathetic manner in the acute hospital setting.

Breege loves working as part of a team and has expanded her role to include health promotion, education and research. She joined the INMO as a student nurse at UCD and became active when she returned to Galway and started working full-time. She wanted there to be good representation on her ward and throughout the hospital and for staff to know that the INMO was there working for them.

Breege was determined to amplify the voice that the INMO provides for nurses and midwives in Ireland so she became involved with the Galway Branch, where she was appointed education officer in 2017. She was elected to the INMO Executive Council in 2018.

Speaking about the crisis facing nursing and midwifery in Ireland, Breege said: "I want to be able to provide excellent patient care, but we need safe staffing to do that. Recruitment and retention are the most important issues for me. In my role as education officer it is important to promote continued professional development with colleagues and students. As part of the INMO I want to secure safe staffing levels both locally and nationally."

Frances Cullen

Senior staff nurse at St Joseph's
District Hospital, Ballina

FROM a young age Frances wanted to help the sick and the dying. She initially worked at the Marie Currie Foundation and later went into nursing as she felt she could be more productive in that role.

She trained in London before returning to Ireland, where she found work at the hospital where she was born. This meant a great deal to Frances. She had been doing the same work in London, but it delighted her to make a difference with people in her own home town. Frances joined the INMO and was always fascinated by the reps in her workplace, the support they gave and the knowledge they possessed.

When issues occurred at her workplace, Frances was represented by the INMO, who helped and guided her. When they won the case, she was asked to become a rep. She met like-minded professionals from other workplaces and heard about their experiences.

Frances brought this knowledge back to her own workplace and got other people involved in the union.

Frances is passionate about care of the older person and feels that all other disciplines encompass this area. She feels it is really important to preserve the role of the nurse, stating: "All workers should be in a union for fairness and equality and self preservation. If you're oppressed and not allowed your rights, go to the union and have your rights upheld. You have a collective voice – a voice of a group of people doing the right thing for the right outcomes.

"In the INMO we provide a collective voice, professional development, legal advice and industrial relations support and I'm proud to be a part of that."

Karen Eccles

Theatre staff nurse at
Cavan General Hospital

KAREN'S father was a GP in rural Fermanagh and her mother was a theatre nurse, so she always felt destined to follow them into healthcare. She has always been a member of a union since starting work and is a firm believer in the role of unions.

Karen became active with the INMO because of the financial crisis, starting in 2005, that resulted in what she refers to as 'the culling of nurses'. This led her to become active within her own department, and she subsequently became an INMO rep.

Later, Karen became involved at branch level and after two years, was elected to the Executive Council. This allowed her to explore her role within the union as well as the role of the union within nursing.

Most important to Karen is bringing members' concerns to the Executive. She feels the full support of the Theatre Nurses Section, but is also mindful that she represents all members equally, stating: "It's never been more apparent that unions are important. Unions are there to protect workers from poor decision making, whether it be as a result of profit, budgetary cuts or other measures.

"The INMO will be judged in years to come on the role it has played in maintaining safety within our health service. The Organisation is not necessarily tasked to do that. It is tasked with industrial relations, professionalism and professional development, but I, as a nurse, have felt the arm of support from the union really drilling down on safety issues and, without it, I don't know where the health service would be. The INMO has played a pivotal role in maintaining the service throughout the past five years."

Introduction of termination of pregnancy services

Edward Mathews discusses the impact the new legislation will have on members

THE introduction of termination of pregnancy services is a significant development in Irish health services and one which has been the subject of considerable reflection for our members from a wide variety of perspectives.

Members have considered this issue at two annual delegate conferences. At the first, delegates recognised the plurality of strongly held views among our membership and encouraged members to listen to all the arguments during the democratic process related to the referendum that followed. Furthermore, at the 2018 ADC a motion was proposed and adopted which dealt specifically with the issue of conscientious objection in the context of any proposed legislation to give effect to the repeal and replacement of the Eighth Amendment to the Constitution.

Having debated the issue of conscientious objection in full and having adopted the motion proposed to the Conference, the delegates have determined the policy of the Organisation on this issue in a democratic way. This resolution called on the Organisation to:

"...safeguard the individual nurses and midwives who hold differing, often strongly held, views on abortion, where issues of personal morality and professional ethics co-exist. The 2013 Protection of Life During Pregnancy Act makes provision for the statutory right of all healthcare staff to 'conscientious objection' to participate in abortion. If the eighth amendment is repealed this right to conscientious objection should be upheld and protected. No nurse or midwife should be vilified or coerced into compromise, because freedom of conscience is not respected or because staffing levels are at crisis point".

Implementation

The Executive Council considered this resolution immediately following the ADC and set about a programme of implementation. This programme of work following the conference was motivated both by the resolution from the ADC and by the NMBI Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives and led to engagements with the HSE concerning the introduction of the new service.

From a legislative viewpoint the Organisation has carefully monitored the relevant legislation following the constitutional amendment. In addition, the INMO has engaged with a wide range of members who have a variety of perspectives on the introduction of this new service and will be affected by it in different ways.

We have also been engaging intensively with the HSE, alongside other heath service trade unions, in the lead up to the introduction of the service, and that engagement is ongoing.

In the course of those engagements we have had to the forefront our minds the conscientious and ethical position of our members. Notable in our engagement with our members on this topic, irrespective of their viewpoint, was their agreement with the ethical position as enunciated in our Code that in the course of our work that the dignity of the individual must be of paramount concern. Therefore, in all our discussions with the HSE we have advocated that the introduction of this service must respect the dignity of the person seeking the service and also must be prepared for, organised and delivered in a safe and dignified manner.

Local level

In this regard we are continuing to liaise with management in relation to organisational arrangements at a local level, capacity issues, staffing issues, elements of the model of care and matters relating to funding of the service.

While some of these issues can be, and have been, clarified at a national level it is more likely that local engagement will be required concerning implementation and members should consult with their industrial relations officers in this regard.

Supporting members

In addition, we have been focused on the ethical and conscientious position of members in relation to participation in this new service. Firstly, members have contacted us in relation to what they believe is their duty to provide the service and again we have advocated that services should be provided in a dignified and safe manner respecting those availing of the service and those providing the service.

The HSE has agreed that no staff member providing a service can be subjected to any adverse treatment and we will support any member who feels they have been adversely treated in these circumstances.

Conscientious objections

Furthermore, we have been advocating on behalf of those who have an ethical or conscientious objection to being involved in the provision of this service.

On the issue of conscientious objection, we wish to advise our members as follows:

- It is agreed with the employer that no person exercising a conscientious objection will be subjected to adverse treatment
- Managers must treat the disclosure of a conscientious objection in a sensitive manner and in accordance with GDPR requirements relating to confidentiality
- There is an obligation on staff to inform their manager if they have a conscientious objection. The manager can be informed verbally or in writing
- As the service has been, or will shortly be, introduced, we advise that you inform your director of midwifery/nursing, or

their designate, as may be necessary. If informing a manager in writing, we advise that you simply state "In accordance with the NMBI Code of Professional Conduct and Professional Ethics for Registered Nurses and Registered Midwives I wish to inform you that I have a conscientious objection to being involved in service provision related to the termination of pregnancy"

- The Health (Regulation of Termination of Pregnancy) Act 2018 (the Act) refers to conscientious objection in section 22. This provides that no nurse or midwife shall be obliged to carry out, or to participate in carrying out, a termination of pregnancy. However, where there is an immediate risk to life, or of serious harm to the health, of a pregnant woman and it is immediately necessary to carry out a termination then conscientious objection does not arise
- The provisions of the legislation operate in tandem with the provisions of the Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (the Code). Principle 2, Standards Conduct 7 and 8 of the Code provide as follows:
  - 7. If you have a conscientious objection based on religious or moral beliefs which is relevant to your professional practice, you must tell your employer and, if appropriate, tell the patient as soon as you can. If you cannot meet the patient's needs because of this objection, you must talk with your employer and, if appropriate, talk to the patient about other care arrangements
  - 8. Even if you have a conscientious objection, you must provide care to a patient in an emergency where there is a risk to the patient's life
- The NMBI has also issued a statement indicating that an addendum has been made to the Code as follows: It is not a breach of the Code to provide services under the Health (Regulation of Termination of Pregnancy) Act 2018.

Range of duties

Members have asked us what range of duties is comprehended by the Code and legislation in the area of conscientious objection. Regrettably, these are not questions that can readily be answered in the absence of any explanatory documentation for the Code or the legislation. Therefore, we are advocating that when employers and managers are informed of such an objection that they respect the conscience of their staff members and plan accordingly. In tandem, we are also asking managers and our members to respect the conscience of staff who participate in the delivery of this service. We will of course assist any of our members who encounter difficulties in this area, and you can seek support from your industrial relations officer.

As a final point, members have raised with us the interrelationship between service provision in this area and other obligations that exist under legislation and policy relating to safeguarding and child protection. Our understanding is that any obligations that nurses or midwives have towards vulnerable persons or minors are unaffected by the introduction of this service.

This is a new service and, as with any new service, there will be further developments as the service progresses. We will keep members updated on all developments.

Edward Mathews is INMO director of regulation and social policy

Shaping the future and bringing change

INMO student and new graduate officer, **Neal Donohue**, discusses how you could play a part in shaping Organisation policy by getting involved

THE main objectives of the INMO are to organise registered nurses and midwives and regulate relations between members and employers and other unions. Although we may all have different cultures, beliefs, interests and ideals, what brings us together is our common interests in our profession. It is within the interest of all nurses and midwives to connect under the umbrella of the INMO where unity, and the resulting collective power, creates the opportunity to affect change.

Getting organised

The INMO is a democratic organisation and all members can influence the direction of the union. All students can sign up for free membership with the Organisation and have the opportunity to become a representative and get involved in the INMO Student Section. All members under the age of 35 also have the opportunity to get involved in the Western, Cork or Dublin Youth Forums.

All members should be in close contact with their INMO representatives. Advice for all student and new graduate members is issued frequently, however, if your class does not have an INMO representative you will find yourselves at a disadvantage. If you wish to receive support and advice for your cohort you will need a representative who will remain in contact with the INMO student/new graduate officer.

If you would like to be a representative please get in touch with me, Neal Donohue, via the contact details at the end of this article, for full details on the role.

Influence change

Through the Student Section and Youth Forums members can discuss issues and decide on ways to affect change. This happens through a structured process. Every year in May the INMO holds an annual delegate conference (ADC) where issues from all areas of nursing and midwifery are debated among some 350 delegates. From these debates the INMO is given a mandate to pursue the interests of its members.

Early in 2019 the Student Section and Youth Forums will hold their annual general meeting (AGM). At this meeting officers will be elected for the Student Section and for each of the Youth Forums (Western, Cork and Dublin) and they will serve a 12-month term. At the AGM each group will also nominate two delegates to attend the INMO ADC, which will take place in Trim, Co Meath this year.

The Student Section and Youth Forums will each propose one motion for ADC. These motions are debated and delegates vote on whether the motion will be adopted as organisational policy.

For many of the students and new graduates the prospect of attending meetings and conferences is quite daunting. Everyone has a busy schedule with exams, work and other commitments, but if you want to influence the future you must participate. If you have a reason to complain then you have a reason to campaign for change, and you will find an abundance of support in doing so.

In 2018 the Student Section brought forward a motion relating to mental health support for student nurses and midwives. The issues relating to mental health and the inadequacies of the current support structure for students were debated and members voted that the motion carry.

Since ADC in May 2018 the INMO has been collaborating with Jigsaw, an organisation that supports and educates young people and communities on matters relating to mental health.

We are in the process of creating a bespoke mental health programme for student nurses and midwives focusing on mental health literacy, self-care and help seeking behaviours. We invited students and new graduates to a focus group in early January to discuss the issues they experience and to offer the opportunity for those present to advise on what they believe they need in terms of support. It is this first-hand information that will influence the overall design of the programme.

We plan to roll out the programme in 2019 starting with a group of students in Dublin, and our overall goal is to continue to develop this programme and build it into the undergraduate curriculum.

This is just one example of how members can positively influence their profession through connecting with the INMO, attending meetings and using the existing processes and supports to bring about change.

The 2019 INMO ADC will be held on May 8-10 in Trim Co Meath. Delegates who attend ADC may claim expenses for travel, and hotel accommodation will be arranged by the INMO. Graduates who are working may apply for union leave with their employer by completing a request form (HR 108 q).

Anyone who is interested in getting involved in the Student Section/Youth Forum can contact me and I will explain to them about what is involved. You will be supported and empowered and you will have the opportunity to influence change and create a more positive working/studying experience for yourself and your colleagues.

Neal Donohue is the INMO's student and new graduate officer. If you have a question about the above article, or need support or information, you can contact him at email: neal.donohue@inmo.ie or Tel: 01 6640628

Quality & Safety

A column by Maureen Flynn

Using clinical decision support tools to manage sepsis in ED

WE OPEN 2019 with part one from a series on sepsis and the clinical decision support tools available to nurses and midwives. This months focus is on care in the emergency department (ED)

Sepsis

In 2016 the Surviving Sepsis Campaign defined sepsis as life-threatening organ dysfunction caused by a dysregulated host response to infection. Sepsis is complex and evolves over time and the pattern of evolution is extremely variable depending on the patient's general health status, their genetic response to infection and the characteristics of the infecting microbe.

In 2017 in Ireland there were 15,341 cases of sepsis documented, a 16.6% increase over 2016, with an in-hospital mortality of 17%, representing a 2.5% decrease in mortality. Prevention is the most effective way to reduce mortality from infection/sepsis, ie. good sanitation, personal hygiene, eating healthily and exercising moderately, breast feeding, avoiding unnecessary antibiotics and vaccination for vaccine preventable infections. The next most effective way is early recognition and appropriate timely management.

The Irish sepsis database identifies three patient groups that have a mortality risk of > 20% if diagnosed with sepsis and recommends that these patients receive the sepsis 6 bundle if they present unwell or deteriorate with an infection. These include:

- Patients at risk of neutropenia, due to bone marrow failure, autoimmune disorder or treatment including but not limited to, chemotherapy and radiotherapy
- Patients who present with clinically overt new onset organ dysfunction
- Patients who present with a SIRS response due to infection who have one or more co-morbidity associated with increased mortality from sepsis.

The National Sepsis Programme provides clinical decision support tools (CDSTs) that facilitate:

- Recognition of 'at risk' patients prompting escalation to medical review
- Correct risk stratification prompting appropriate and timely treatment
- Correct diagnosis and documentation of sepsis and septic shock.

The CDSTs provide guidance for nurses and doctors enabling them to adopt a standardised approach thereby ensuring they are afforded the best possible chance to survive sepsis and/or prevent the associated long-term sequelae. CDSTs specifically prepared for use in ED are available, eg:

- ED sepsis triage algorithm
- ED sepsis management algorithm
- Sepsis Form: emergency adult
- Fluid resuscitation algorithm
- ED sepsis educational tool – prompt card.

Benefits of using the Sepsis Form

National audits identify that when the Sepsis Forms are used, diagnosis and treatment are twice as likely to be correct than when no form is used. Additionally, HIPE coding is based on documented diagnosis in the healthcare records and reflects the incidence of sepsis as determined by their treating clinicians. HIPE Coders can code from the Sepsis Form when signed by the treating clinician, promoting learning and improvements in care.

Trigger for screening at ED triage

Patients presenting to the ED with a history suggestive of infection should be screened for sepsis at triage using the sepsis screening algorithm. If there is a suspicion of infection and the patient belongs to one of the 'at risk' groups they are assigned triage 'category 2' and the Sepsis Form is commenced.

Medical review – the nurse's role

Sepsis is a time dependant medical emergency and it is important that management is as per the one-hour and three-hour sepsis bundles providing the best possible outcome for patients.

Medical review should occur within 30 minutes of trigger. History and examination confirms the need for Sepsis 6 indicating time zero. Sepsis 6 is completed within one hour of time zero.

The three-hour bundle assesses the patient's response to initial therapy. The infection aetiology and sepsis diagnosis are reviewed with the results of available tests and investigations and the treatment plan amended accordingly.

If infection is ruled out as part of differential diagnosis the Sepsis Form is terminated in section five of the Sepsis Form and signed at the bottom.

If infection is suspected but the patient is not deemed to belong to an 'at risk' group, the Sepsis Form is terminated and signed and usual treatment pathway for that infection is followed. The 'ED Sepsis Algorithm' outlines the three-hour bundle and the Fluid resuscitation algorithm provides guidance on administering fluid bolus.

Get involved

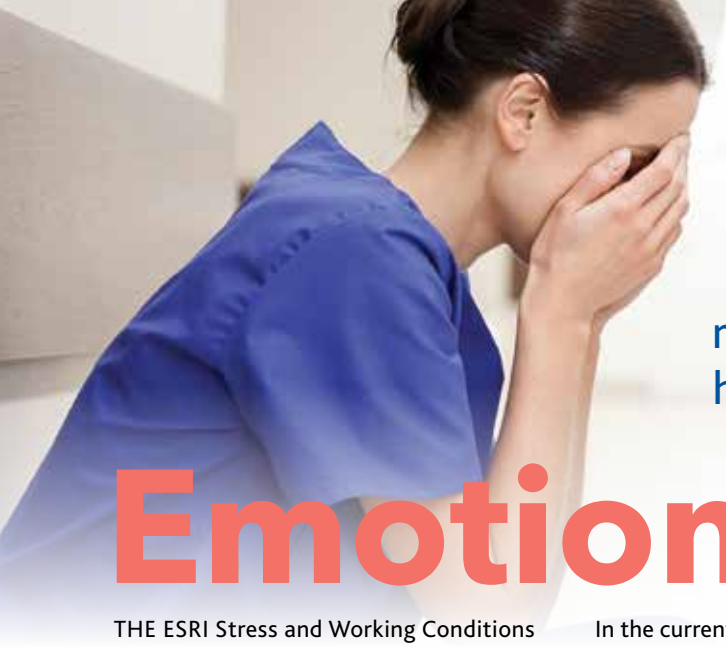
At your next unit/team meeting talk about and encourage the use of the clinical decision support tools.

Further information

More information is available on the website www.hse.ie/sepsis. Sepsis eLearning is available at www.hseland.ie

Maureen Flynn is the director of nursing ONMSD, QI Connections Lead, HSE National Quality Improvement Team

Acknowledgement: Thank you to the Sepsis Programme team and in particular Celine Conroy, IEHG group assistant director of nursing – sepsis for assistance in the preparation of this column



Employers need to recognise the toll of emotional labour and ensure resources and support are available to help deal with it, writes **Steve Pitman**

Emotional labour

THE ESRI Stress and Working Conditions Survey 2018 reported that job stress had doubled between 2010-2017, from 8% to 17%.[1] Workers in the health sector reported the highest levels of stress. The survey identified that stress was higher in workers who experienced high levels of the following work demands:

- Emotional demands
- Time pressure
- Bullying, harassment, violence and discrimination
- Long working hours.

While no specific professional group was identified in the report, the four work demands have been previously associated with the experience of nurses and midwives.

This article focuses on the issue of emotional demands. The ESRI identified that workers who experience high levels of emotional demands are "21 times more likely to experience job stress than those with the lowest levels".[1] Nurses and midwives can be described as 'emotional labourers', as caring and compassion are fundamental to the nature of the professions.

Pandey and Singh argue that emotional labour is a requirement to deliver effective and efficient healthcare.[2] Expressing appropriate emotions is part the role of the nurse and midwife, to deliver service 'with a smile'.[3] However, while there can be no doubt that compassionate care has a positive impact on patients, "it can be emotionally demanding for healthcare staff".[4] When demands are high, and resources are low this labour takes its toll on individual nurses and midwives.

The imbalance between demands and resources – physical, personal and social – is seen as a predictor of workplace stress and burnout.[5] Stress has been identified as an important factor in predicting job turnover among nurses,[6] job satisfaction, organisational commitment,[7] burnout[8] and work engagement.[9]

In the current challenging environment of working within the Irish health system there can be no doubt that stress and emotional labour are contributory factors to the difficulties in recruiting and retaining nurses and midwives.

What is emotional labour?

The ESRI defines emotional demands as dealing with angry clients or having to hide emotions while at work.[1] Emotional labour is seen "as the emotional regulation required of the employees in the display of organisationally desired emotions".[10]

Nurses and midwives are required to manage their emotions to ensure that they display emotions that are organisationally and professionally expected. This can be described as wearing a mask that hides the true feeling of the individual and requires the nurses or midwife to act or pretend in the desired role.[11]

This requires what Hochschild describes as the need for "one to induce or suppress feelings in order to sustain the outward countenance that produces the proper state of mind in others".[12] Essentially, the nurse or midwife can experience dissonance or mismatch between their surface-level emotions, which are outwardly expressed or displayed, and their deep-level emotions, which is what they really feel.

What is different about nurses and midwives?

Nurses and midwives are privileged in experiencing the high and low points in the lives of patients and their families, however this unique experience can come at a cost. Almost 60 years ago Menzies argued that "Nurses are confronted with the threat and the reality of suffering and death as few lay people are. Their work involves carrying out tasks which, by ordinary standards, are distasteful, disgusting and frightening".[13]

Nursing and midwifery is challenging, hard and emotional, a factor usually not considered or recognised in management practice.[14] The emotional labour of the nurse and midwife is experienced each day when confronted with the pain and suffering of patients in clinical practice but confounded when faced with the inadequacies within the health services.

The emergency department nurse who faces patients and their families, on a continual basis, waiting on a trolley for a hospital bed, is frustrated in the knowledge that care is delayed and patients suffer. There is a personal cost to the nurse who experiences this frustration daily.

What can be done?

Bakker and Demerouti's 'job demands -resource model' describes the need to counterbalance increasing demands in the workplace – including pressure on resources, patient waiting times, staffing, trauma, death, dying etc – with resources.[5]

These resources can be in the form of tangible improvements in skill mix, availability of beds and equipment but also personal coping strategies and social support.

Riley and Weiss highlight the need to recognise and value the role of emotional labour in the workplace and to ensure that "support and supervision is in place to enable staff to cope with the varied emotional demands of their work".[15]

The support of colleagues is seen to have a buffering effect that helps an individual to share their experiences and draw on the emotional support and understanding others. Other approaches include developing the ability to engage in an appropriate level of detachment yet continuing to fulfil the role as a compassionate and caring professional.

The key message is that emotional labour comes at a cost. Healthcare employers need to recognise the challenges of emotional labour and ensure adequate resources are in place to support nurses, midwives and other healthcare professionals.

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

In next month's issue we will explore how to manage emotional labour

References available on request by email to: nursing@medmedia.ie (Quote: Pitman S. WIN 2019; 27 (1): 43)

Standards in midwifery

Deirdre Munro discusses the second theme of the new Midwifery Unit Standards which focuses on equality, diversity and social inclusion

THE creation of the Midwifery Unit Standards is the first joint output collaboration between Midwifery Unit Net and European Midwives Association. They were developed to guide midwives, managers and commissioners across Europe in creating and developing midwifery units. Focusing on philosophy of care and the organisation of services, the aim of the Midwifery Unit (MU) Standards is to improve the quality of maternity care, reduce variability of practices and facilitate a biopsychosocial model of care.

Addressing the gap in implementation of midwifery units (in hospitals and primary care settings), the Standards focus on philosophy of care, organisation of services and are intended to be used alongside clinical guidelines. An MU is a location offering maternity care to healthy women with straightforward pregnancies in which midwives take primary professional responsibility for care. MUs may be located away from (freestanding) or adjacent to (alongside) an obstetric service.

Philosophy of care at midwifery units

Researchers demonstrate how midwifery units adopt and promote a biopsychosocial model of care addressing physical, psychological and social needs, referred to as a social model of care.[1]

The model promotes:

- Equality between women and their carers
- Bodily autonomy
- Informed decision making.[2-6]

Services are organised around the social needs of women and families, so aim to provide a comfortable, homely atmosphere, rather than a clinical environment, which can seem impersonal, cold and frightening.

Services aspiring to work within this philosophy of care seek to respect and empower women during pregnancy and birth, as well as facilitating a positive transition to parenthood. In order to deliver such a service, it is vital to offer an empowering working environment for midwives and maternity support workers to ensure that the team embraces a positive working culture which fosters learning and continuous development.[6,7,8]

Midwifery Unit Standards	Theme 2:	Equality, diversity and social inclusion
Standard 2: The midwifery unit has a policy relating to respect, diversity and inclusion		

Theme 2

The second theme centres on equality, diversity and social inclusion, which are key indicators of good quality maternity care.[9] When services are proactive in planning ways to reach and engage all women, to ensure that each is able to access the model of care that suits their personal circumstances, this can be very successful in addressing existing inequalities.

MUs can provide a salutogenic health promoting environment in which women who are marginalised, discriminated against or in vulnerable situations, and their babies, can thrive.[5]

Standard 2

The midwifery unit has a policy relating to respect, diversity and inclusion.

a) Each MU has an analysis of use by socio- economic status and ethnicity of service users and will assess this against local population analysis and review the extent to which it is serving the diverse population

b) Each MU will periodically review the needs profile of its local population, in order to inform and align the services it offers with those needs

c) Before, and regularly after, the opening of a MU, managers and MU staff engage the local community and involve community leaders to understand population experiences and needs

d) The MU aims to maximise access to care with specific focus on accessibility for women in vulnerable situations and improving timely and appropriate access to care

e) The MU has language and communication support available as required for people who have language and/or communication needs to ensure that they can understand information, be understood by staff and make fully informed decisions about their care, this can include cultural mediation

f) The structure of the MU respects minority rights and works in partnership with local networks which support socially disadvantaged families and children'.

We hope these Standards will stimulate reflection and debate about improving service provision for women and families and developing opportunities for midwifery care. Services may differ from these Standards in ways that make sense within their own context.

Not all Standards will be currently achievable or entirely relevant in all countries, but we hope that whatever the current provision, positive changes can be made in relation to the key themes.

For more details visit the Midwifery Unit Network at **www.midwiferyunitnetwork.org/** and for the full list of MU Standards visit: **www.midwiferyunitnetwork.org/wp-content/uploads/PDFs/LY1309BROMUNEt-Standards-PRINT-opt.pdf**

Deirdre Munro is International officer for the INMO Midwives Section and a researcher for the MU Standards

References

1. Walsh D and Newburn M. 2002. Towards a social model of childbirth. British Journal of Midwifery, 10, 9, pp. 540–544
2. Macfarlane A J, Rocca-Ihenacho L and Turner LR. 2014. Survey of women's experiences of care in a new freestanding midwifery unit in an inner city area of London, England: – 2: Specific aspects of care. Midwifery, 30(9), pp.1009-1020
3. MacFarlane et al. 2016. Wide differences in mode of delivery within Europe: risk-stratified analyses of aggregated routine data from the Euro-Peristat study. BJOG: An International Journal of Obstetrics & Gynaecology, 123(4), pp.559-568
4 McCourt et al. 2012. Organisational strategies and midwives' readiness to provide care for out of hospital births: An analysis from the Birthplace organisational case studies. Midwifery 28(5), pp.636-645
5. Overgaard et al. 2012. Freestanding midwifery units versus obstetric units: does the effect of place of birth differ with level of social disadvantage? BMC Public Health, 12(1), p.478
6. McCourt et al. 2014) An ethnographic organisational study of alongside midwifery units: a follow-on study from the Birthplace in England programme. Health Services and Delivery Research, 2(7)
7. McCourt et al. 2011. Birthplace a qualitative organisational case studies: how maternity care systems affect the provision of care in different settings. Birthplace in England research programme. Final report part 6. London. NIHR Service Delivery and Organisation programme
8. Rocca-Ihenacho, Newburn and Byrom. 2017.The MUN: creating a community of practice to enhance maternity services. The Practicing Midwife 20(6):24-27
9. WHO 2018. WHO recommendations: intrapartum care for a positive childbirth experience. Geneva, Switzerland

COPD update: Changes to GOLD guidelines for 2019

The updated GOLD guidelines for 2019 include an important refinement of the ABCD assessment tool, which now separates initial treatment from follow-up treatment

THE Global Initiative for Chronic Obstructive Lung Disease (GOLD) has published updated guidelines for 2019, as well as a quick-reference pocket guide for healthcare professionals with the key information about patient management and education.

Chronic obstructive pulmonary disease (COPD) is on course to be the third leading cause of death worldwide by 2020. It is a significant cause of mortality in Ireland and has shown no major decline in recent years. In fact, Ireland has one of the highest age-standardised death rates from COPD among European countries, as well as the highest rate of hospital admission with COPD of any country in the OECD. In 2017, the Irish National Healthcare Quality Reporting System recorded over 15,000 inpatient hospitalisations with a primary diagnosis of COPD.[1]

The GOLD guidelines are used worldwide as a strategy document for healthcare professionals and governments to implement effective COPD management programmes, based on the best and most up to date scientific evidence available. Since its first set of guidelines in 1998, GOLD has issued major revisions of its guidelines every five years or so, as well as annual updates. It was the 2011 GOLD update that introduced the ABCD assessment tool, which was considered to be a major advance on the simple spirometry grading system of the earlier versions of the guidelines, because it incorporated multimodality assessment, symptom burden and highlighted the importance of exacerbation prevention in the management of COPD. However, there were some limitations to this scheme in that the ABCD assessment tool was no better than its predecessor at predicting mortality and other important health outcomes. To address this, the 2017 revision refined the ABCD system by separating spirometry from the 'ABCD' groups, which analyse a patient's history of symptoms and exacerbations, and base recommendations for pharmacotherapy primarily on the patient's needs, ie. to reduce symptoms and/or to prevent exacerbations.

Table 1: Refined ABCD assessment tool

Spirometrically confirmed diagnosis	Assessment of airflow limitation		Assessment of symptoms/risk of exacerbations	
			Moderate or severe exacerbation history	
Post bronchodilator FEV < 0.7	Grade	FEV (% pred.)	≥2 or ≥ 2 leading to hospital admission	0 or 1 (not leading to hospital admission)
	GOLD 1	≥ 80	C	D
	GOLD 2	50-79		
	GOLD 3	30-49	A	B
	GOLD 4	< 30		
			nMRC 0-1 CAT < 10	nMRC ≥ 2 CAT ≥ 10
			Symptoms	

The GOLD committee felt the separation of airflow limitation from clinical parameters makes it clearer what is being evaluated and ranked. It believes this will enable more precise recommendations on treatment, based on parameters that are driving the patient's symptoms at any given time.

Acknowledging the limitations of FEV1 in influencing some therapeutic decisions for individualised patient care, the revised ABCD assessment tool introduced in 2017 highlights the importance of patient symptoms and risks of exacerbation. However, spirometry remains key in the diagnosis, prognostication and treatment with non-pharmacological therapies.

Following feedback from users of the 2017 revised tool, the committee found there was some misinterpretation of the ABCD system. Therefore, in this year's revision, initial treatment based on ABCD is separated from follow-up treatment, which is based on the patient's major treatable traits and current drug therapy.

In addition, the 2019 guidelines introduce the blood eosinophil count as a biomarker for estimating the efficacy of inhaled corticosteroids (ICS) for the prevention of exacerbations.

Revised ABCD assessment tool

In the revised assessment scheme ***(see Table 1)***, patients should undergo spirometry to determine the severity of spirometric grade. Secondly, they should undergo assessment of either dyspnoea using the Modified British Medical Research Council

(mMRC) questionnaire or symptoms using the COPD Assessment Test (CAT). Thirdly, their history of moderate and severe exacerbations (including prior hospitalisations) should be recorded. The number in the assessment tool provides information on severity of airflow limitation (spirometric grade 1 to 4) while the letter (groups A to D) provides information on symptom burden and risk of exacerbation, which can be used to guide therapy.

GOLD considers FEV1 to be a key parameter at the population-level in predicting important clinical outcomes such as mortality and hospitalisations, or prompting consideration of non-pharmacological therapies such as lung volume reduction or lung transplantation. However, according to GOLD, at an individual patient level, FEV1 loses precision and therefore cannot be relied upon on its own to determine all therapeutic options. On the other hand, in circumstances such as during hospitalisation or emergency presentations, the ability to assess patients based on symptoms and exacerbation history, independent of the spirometric value, allows the medical team to initiate a treatment plan based on the revised ABCD scheme alone. This approach acknowledges the limitations of FEV1 in making treatment decisions for individual patient care and highlights the importance of patient symptoms and exacerbation risks in guiding therapies in COPD.

Blood eosinophil count

Another significant update to the guidelines for 2019, is a result of GOLD taking cognisance of a number of recent studies that have shown that blood eosinophil counts predict the magnitude of the effect of inhaled corticosteroids (ICS), added to regular maintenance bronchodilator treatment, in preventing exacerbations ***(see Table 2)***. GOLD notes that there is a continuous relationship between blood eosinophil counts and ICS effects; no or small effects can be seen at lower eosinophil counts, with increasing effects seen as eosinophil counts get higher.

Data indicates that treatment regimens containing ICS have little or no effect at a blood eosinophil count < 100 cells/µL, therefore ICS regimens are unlikely to be of significant benefit in the treatment of patients below this threshold. On the other end of the scale, a blood eosinophil count > 300 cells/µL has been found to be the upper threshold of the continuous relationship between eosinophils and ICS, and can therefore be used to identify patients with the greatest likelihood of treatment benefit with ICS.

In summary, blood eosinophil counts are helpful in estimating the likelihood of a beneficial response by the addition of ICS to regular bronchodilator treatment, and thus can be used as a biomarker in conjunction with clinical assessment when making decisions regarding the use of ICS.

Improved clarity

The 2019 updates were made to reflect key evidence from peer-reviewed publications between January 2017 and January 2018, as well as to improve the clarity of figures and tables. As well as the new section on blood eosinophil count and updated sections on pulmonary rehabilitation and self-management, *Chapter 3* has more discussion on the evidence around the use of combination therapies in patients with a history of exacerbations.

Chapter 4 includes updated algorithms for the initiation of and follow-up management of pharmacological treatment, and clearer diagrams that bring them into line with the latest evidence. It also discusses the initiation of therapy and follow-up treatment, including escalation and de-escalation strategies.

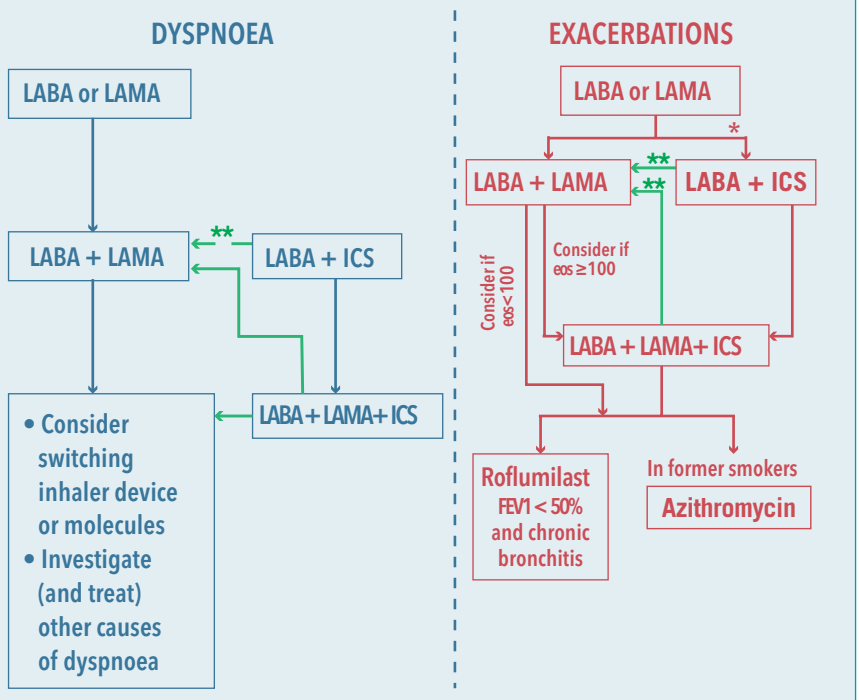
– Tara Horan

Table 2: Initial pharmacological treatment[2]

≥ Two moderate exacerbations or ≥ one leading to hospitalisation	**Group C:** LAMA	**Group D:** LAMA or LAMA + LABA* or ICS + LABA**
Zero or one moderate exacerbations (not leading to hospital admission	**Group A:** bronchodilator	**Group B:** Long-acting bronchodilator (LABA or LAMA)
	mMRC 0-1 CAT < 10	mMRC ≥ 2 CAT ≥ 10

**Consider if highly symptomatic (eg. CAT ≥ 20)*
*** Consider if blood eosphonil count is ≥ 500 cells/ µL*

Table 3: Follow-up treatment[2]



*Consider if eosinophil count ≥ 300; or eos ≥ 100 and ≥ two moderate exacerbations/one hospitalisation
**Consider de-escalation of ICS or switch if pneumonia, inappropriate original indication or lack of response to ICS

References
1.Department of Health. National Healthcare Quality Reporting System Annual Report 2018
2. Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease (GOLD). 2019 Report

Pre-pregnancy care in diabetes

Pre-pregnancy care presents an opportunity to optimise potential future pregnancy outcomes, writes **Rita Forde**

PRE-PREGNANCY care strategically targets a woman's health before conception. Through prevention and management, pre-pregnancy care aims to identify and modify biomedical, behavioural and social healthcare risks.[1,2] The provision of this is care also strives to ensure that the woman is aware of any potential hazards, so that she can make an informed decision about pregnancy and her modifiable and non-modifiable risks.

Pre-pregnancy care is essentially an opportunity to optimise future pregnancy outcomes, particularly in the presence of known risk factors.

Diabetes and pre-pregnancy care

Diabetes is one of the most common medical conditions affecting pregnancy and is associated with adverse maternal, foetal and infant outcomes.[3] The risk of congenital malformation in the infants of women with diabetes is twice that of the background population, there is a five-fold increase in stillbirth and a three-fold increased risk in perinatal mortality.[3,4,5,6] Pre-existing diabetes exerts an influence on all stages of pregnancy, consequently these pregnancies are considered high-risk.

The first trimester of pregnancy is particularly crucial as this is the period of organogenesis, and it is known that exposure to hyperglycaemia and many of the medications prescribed for the treatment of diabetes can be hazardous during this early developmental phase.[6,7,8,9] Indeed the negative impact of these can be realised even before the woman is aware she is pregnant.[10]

To reduce these risks, women with diabetes need effective pre-pregnancy care, either to prevent pregnancy or to reduce diabetes-related risk factors prior to conception.[11] It is therefore essential that women have an awareness of their need for pre-pregnancy care and know how to access it. Internationally, clinical guidance recommends that a focus on pre-pregnancy care be incorporated into diabetes consultations with women from adolescence and throughout their reproductive years.[3,12,13]

Pre-pregnancy guidance

The key elements of pre-pregnancy care for women with diabetes include, the need to optimise their glycaemic control (HbA1c < 48mmol/mol); appropriate medication management to prevent foetal exposure to teratogenic agents; the introduction of high dose folic acid (5mg); and screening for and treatment of diabetes complications.[3,13]

Individualised dietary advice is advocated and where necessary women should be supported to achieve a healthy weight. Importantly, reliable contraception is essential and this should only be discontinued once the woman has attained the recommended targets and is ready to conceive.[3,13] Furthermore, once pregnant, women with diabetes are advised to attend antenatal care as early as possible in their pregnancy, ideally before eight weeks gestation.

Pregnancy preparation

The importance of pre-pregnancy care for women living with diabetes has been appreciated for several decades, and the positive results of this care have been replicated in many studies.[14-18] Generally, these studies have demonstrated that women who have received pre-pregnancy care are more likely to have optimised their glycaemic control prior to conception; have an increased uptake of high-dose folic acid; and are less likely to be taking medications unsuitable for pregnancy around the time of conception compared with those who have not received it. Recipients of pre-pregnancy care are also more likely to attend for antenatal care at an earlier gestation than those who have not received it. Nevertheless, despite these benefits the majority of women with diabetes still do not receive pre-pregnancy care.

In a recent large national cohort study in the UK (n = 3,036) during 2016 only 14% of women with type 1 diabetes and 37% of those with type 2 diabetes achieved the recommended glycaemic control target of 48mmol/mol prior to pregnancy. During the same period the uptake of 5mg folic acid was similarly disappointing at 46% among those with type 1 and 23% of women with type 2 diabetes.[19] The Irish national diabetes in pregnancy audit data during 2015, although having a much smaller number of participants (n = 185) were somewhat better as almost 20% of those with type 1 and 46% of those with type 2 diabetes had a first trimester HbA1c of < 48mmol/mol and the uptake of 5mg folic acid was almost 45% and 34% for those with type 1 and type 2 diabetes respectively.[20]

Significantly, the UK cohort study revealed for the first time that there were as many women with pre-existing type 2 diabetes in pregnancy as those with type 1 diabetes. In the last decade the number of women with type 2 diabetes prior to pregnancy has greatly increased, while in the CEMACH report 2007 only a third of those included had type 2 diabetes.[21]

Worryingly, while there is a growing population of women with type 2 diabetes during pregnancy, this group continue to be much less well-prepared for pregnancy compared with women with type 1 diabetes. Women with type 2 diabetes tend to present for antenatal care at a later gestation than women with type 1 diabetes (by which time the foetus may have already been compromised); women with type 2 diabetes are also less likely to have taken appropriate folic acid supplementation prior to conception, and are more frequently taking teratogenic medications.[14,17,22,23]

A synthesis of the experiences of women with type 2 diabetes and healthcare professionals has suggested that the uptake of pre-pregnancy care is informed by several elements including:

- The personal orientation of women towards their own reproductive healthcare needs
- How well women interact with their healthcare providers
- How they are supported to navigate care within the healthcare system
- The awareness and understanding of healthcare professionals about the need for this care.

Essentially, how women are facilitated to have an awareness of and access to pre-pregnancy care impacts the uptake of it.[24]

Pre-pregnancy care studies

Studies from Ireland and the UK have used a regional approach to the provision of pre-pregnancy care to women with diabetes. These groups have proactively identified women from their diabetes databases and provided postal information about the availability of pre-pregnancy care services, together with an invitation to participate.[5,17,18]

A common feature of these studies was the dual approach to concentrate on both the healthcare professionals and the women living with diabetes. The interventions for healthcare professionals predominantly comprised of education sessions, development of specific clinical practice guidelines, clinical practice proformas and information leaflets for women with diabetes. The provision of pre-pregnancy care tended to be in specialist centres within these select geographical regions.

While the impact of the individual elements of these interventions were not evaluated, collectively they did show the positive influence on the maternal and foetal outcomes among those women with diabetes who received pre-pregnancy care. However, these targeted interventions have also exemplified that enhancing the uptake of pre-pregnancy care is challenging as the overall uptake was reported as 27% of participants in the UK study[17] and 36% in the Irish study.[23]

Community-based pre-pregnancy care

More recently, a community-based approach to pre-pregnancy care has been evaluated.[25] This mode was adjunct to an existing regional service providing pre-pregnancy care via secondary care in the UK.[17] Within this study, 422 primary care centres were identified of which almost 73% (n = 306) agreed to participate and collectively they distributed 4,558 information leaflets to women with diabetes, aged 16-45 years. Online education modules for healthcare professionals were provided along with regional meetings and data collection supports.

This approach demonstrated favourable results with women attending for antenatal care earlier than previously with over 67% (n = 138) of women with type 1 and 40% (n = 53) of those with type 2 diabetes booking prior to eight weeks gestation. They also showed an increase in women with both type 1 and type 2 diabetes reaching the recommended glycaemic control targets, taking high-dose folic acid and a reduction in the use of teratogenic medications.

This community-based approach saw significant improvements in individual elements of pre-pregnancy care such as 50% of women taking folic acid prior to conception. Collectively however, only 16.3% of women with type 1 and 15.1% of those with type 2 diabetes were considered optimally prepared for pregnancy, which was defined as when a woman attained all the elements of pre-pregnancy care (initial HbA1c ≤ 48mmol/mol [6.5%], taking folic acid 5mg daily prior to last menstrual period; booking to antenatal care at ≤ eight weeks gestation; and not taking any teratogenic medications prior to last menstrual period).

Therefore, while we have a comprehensive understanding of what care is needed, and when this should be delivered, the challenge remains about how best to enhance the uptake of pre-pregnancy care for women with diabetes.

Technology and pre-pregnancy care

Alternative strategies to facilitate behaviour change and improve pregnancy outcomes are emerging. There is a more recent increase in studies which have focused on the use of multimedia technologies, namely interactive CD-ROM and DVDs.[26,27]

These approaches have resulted in significant improvements in knowledge and perceived benefits of pre-pregnancy care,[28,29] reduced barriers to seeking this care and increased intention to initiate a discussion about pre-pregnancy care with healthcare professionals[28,30] and an increase in the perceived benefits and attitudes to contraceptive use.[29,30] Although

data on the impact of these resources are limited, women were more likely to have prepared for pregnancy following exposure to DVDs about pre-pregnancy care.[31]

Mobile health (mHealth) technology is another important strategy. It has been estimated that 90% of the world's population has access to mobile networks, with smartphones accounting for a substantial proportion of mobile devices[32-35] that have the capacity to run applications (apps). These advances have resulted in a proliferation of healthcare education, decision-making support, and self-care monitoring apps.[34]

In relation to pre-pregnancy care the potential reach of this technology has important implications for awareness-raising and engagement with this care. An evaluation of the awareness and use of a locally developed Danish pregnancy in diabetes app reported that of the 139 pregnant women included, while almost all had a smartphone, 75% had downloaded an app, with almost half of women having actively engaged with the functionality of it before pregnancy.[36] Therefore, seizing on this shift towards technology, awareness raising about pre-pregnancy care has advanced.

Despite the overwhelming evidence supporting the benefits of pre-pregnancy care and the creative methods used to enhance the delivery and uptake, we have not succeeded in significantly engaging and activating women with diabetes to prepare for pregnancy. Therefore, we need to consider a robust programme for awareness-raising and education for women living with diabetes and healthcare professionals, so that there is a systematic integration of pre-pregnancy care into the routine care for all women with diabetes during their reproductive years.

Rita Forde is a research fellow at the Faculty of Nursing, Midwifery and Palliative Care, King's College London and an advanced nurse practitioner in diabetes

References

1. Seshadri S, Oakeshott P, Nelson-Piercy C, Chappell LC. Prepregnancy care. BMJ 2012; 344
2. van Voorst S, Plasschaert S, de Jong-Potjer L, Steegers E, Denkta S. Current practice of preconception care by primary caregivers in the Netherlands. Eur J Contraception & Reproductive Health Care 2016; 1-8
3. National Institute for Health and Care Excellence (NICE). Diabetes in pregnancy: management from preconception to the postnatal period. London: NICE; 2015
4. Egan AM, Murphy HR, Dunne FP. The management of type 1 and type 2 diabetes in pregnancy. QJM: Int J Med 2015;108(12):923-7
5. Dunne FP, Avalos G, Durkan M et al. ATLANTIC DIP: pregnancy outcome for women with pregestational diabetes along the Irish Atlantic seaboard. Diabetes Care 2009; 32(7):1205-6
6. Macintosh MC, Fleming KM et al. Perinatal mortality and congenital anomalies in babies of women with type 1 or type 2 diabetes in England, Wales, and Northern Ireland: population based study. Br Med J 2006; 333(7560):177
7. Cooper WO, Hernandez-Diaz S, Arbogast PG et al. Major congenital malformations after first-trimester exposure to ACE inhibitors. N Engl J Med 2006; 354(23):2443-51
8. Godfrey LM, Erramouspe J, Cleveland KW. Teratogenic risk of statins in pregnancy. Ann Pharmacother. 2012;46(10):1419-24
9. Berry DC, Boggess K, Johnson QB. Management of pregnant women with type 2 diabetes mellitus and the consequences of fetal programming in their offspring. Current Diabetes Reports 2016; 16(5):36
10. Toivonen KI, Oinonen KA, Duchene KM. Preconception health behaviours: A scoping review. Prev Med 2017;96:1-15
11. Murphy HR, Bell R, Dornhorst A, Forde R, LewisBarned N. Pregnancy in Diabetes: challenges and opportunities for improving pregnancy outcomes. Diabet Med 2018; 35(3):292-9
12. American Diabetes Association. Management of Diabetes in Pregnancy: Standards of Medical Care in Diabetes – 2018. Diabetes Care 2018; 41(Supplement 1):S137-S43
13. HSE. Guidelines for the Management of Pre-gestational and Gestational Diabetes Mellitus from Pre-conception to the Postnatal period. 2010
14. Willhoite MB, Bennert Jr HW, Palomaki GE et al. The impact of preconception counseling on pregnancy outcomes: The experience of the Maine diabetes in pregnancy program. Diabetes Care. 1993;16(2):450-5
15. Fuhrmann K, Reiher H, Semmler K, Fischer F, Fischer M, Glockner E. Prevention of congenital malformations in infants of insulin-dependent diabetic mothers. Diabetes Care 1983; 6(3):219-23
16. Temple RC, Aldridge V, Stanley K, Murphy HR. A study of the effect of glycaemic control and prepregnancy care on risk of pre-eclampsia in women with type 1 diabetes. Diabetologia 2005; 48:A315-A
17. Murphy HR, Roland JM, Skinner TC et al. Effectiveness of a regional prepregnancy care program in women with type 1 and type 2 diabetes: benefits beyond glycemic control. Diabetes Care. 2010;33(12):2514-20
18. Owens LA, Avalos G, Kirwan B, Carmody L, Dunne F. ATLANTIC DIP: Closing the Loop A change in clinical practice can improve outcomes for women with pregestational diabetes. Diabetes Care. 2012;35(8):1669-71
19. Murphy HR, Bell R, Cartwright C et al. Improved pregnancy outcomes in women with type 1 and type 2 diabetes but substantial clinic-to-clinic variations: a prospective nationwide study. Diabetologia 2017; 60(9):1668-77
20. Dunne F. The Irish National Diabetes in Pregnancy Audit. Presented at The management of diabetes in pregnancy: a multidisciplinary team approach; 2018; Dublin, Ireland
21. Confidential Enquiry into Maternal and Child Health (CEMACH). Saving Mothers' Lives: Reviewing Maternal Deaths to Make Motherhood Safer-2003-2005. The seventh report of the Confidential Enquiries into Maternal Deaths in the United Kingdom. CEMACH. London 2007
22. National Health Service (NHS) Digital. National Pregnancy in Diabetes (NPID) Audit Report 2016. 2017
23. Egan AM, Danyliv A, Carmody L, Kirwan B, Dunne FP. A prepregnancy care program for women with diabetes: effective and cost saving. J Clinical Endocrinology Metabolism 2016; 101(4):1807-15
24. Forde R, Patelarou EE, Forbes A. The experiences of prepregnancy care for women with type 2 diabetes mellitus: a meta-synthesis. International Journal of Women's Health 2016; 8:691
25. Yamamoto JM, Hughes DJF, Evans ML et al. Community-based pre-pregnancy care programme improves pregnancy preparation in women with pregestational diabetes. Diabetologia 2018; 61(7):1528-37
26. Charron-Prochownik D, Hannan MF, Sereika SM et al. How to Develop CD-ROMs for Diabetes Education: Exemplar 'Reproductive-Health Education and Awareness of Diabetes in Youth for Girls' (READY-Girls). Diabetes Spectrum.2006; 19(2):110-5
27. Spence M, Harper R, McCance DR et al. The systematic development of an innovative DVD to raise awareness of preconception care. European Diabetes Nursing 2013; 10(1):7
28. Fischl AF, Herman WH, Sereika SM et al. Impact of a preconception counseling program for teens with type 1 diabetes (READY-Girls) on patient-provider interaction, resource utilization, and cost. Diabetes Care 2010; 33(4):701-5
29. Holmes VA, Spence M, McCance DR, Patterson CC, Harper R, Alderdice FA. Evaluation of a DVD for women with diabetes: impact on knowledge and attitudes to preconception care. Diabet Med 2012; 29(7):950-6
30. Charron-Prochownik D, Sereika SM, Becker D et al. Long-term effects of the booster-enhanced READY-girls preconception counseling program on intentions and behaviors for family planning in teens with diabetes. Diabetes Care 2013; 36(12):3870-4
31. Hamill L, McCance D, Deery M et al. Impact of a preconception counselling resource (DVD) on preconception folic acid intake in women with diabetes. Proc Nutr Soc 2014; 73:E64
32. Silva BMC, Rodrigues JJPC, de la Torre Díez I, López-Coronado M, Saleem K et al. Mobile-health: A review of current state in 2015. J Biomedical Informatics 2015; 56(Supplement C):265-72
33. Derbyshire E, Dancey D. Smartphone Medical Applications for Women’s Health: What Is the Evidence-Base and Feedback? Int J Telemedicine and Applications 2013; 2013:10
34. Klasnja P, Pratt W. Healthcare in the pocket: Mapping the space of mobile-phone health interventions. Journal of Biomedical Informatics 2012; 45(1):184-98
35. International Telecommunication Union. The world in 2010: ICT facts and figure [Available from: https://www.itu.int/en/ITU-D/Statistics/Documents/facts/ICTFactsFigures2010.pdf
36. Reinhardt Mathiesen E, Ladefoged Nichum V, Barfred C et al. The smartphone application "Pregnant with Diabetes" communicates antenatal health information and reaches pregnant women with diabetes and those planning pregnancy. Eur Assoc for Study of Diabetes; Lisbon2017

Managing the societal impact of chronic pain

New recommendations call on European countries to address the way in which chronic pain is measured and monitored

NEW recommendations have called on the European Commission (EC) and EU member states to address the inconsistencies in funding for pain research, in order to improve clinical outcomes for patients.

Chronic pain is among the most prevalent co-morbidities associated with other long-term illnesses. It can affect a person's general functioning, quality of life and mental wellbeing.

According to the recommendations, published in November 2018 by the Societal Impact of Pain (SIP) platform, there are 150 million people in Europe experiencing chronic pain – that's more than the populations of France and Germany combined. This number represents a substantial burden on the healthcare systems and economies of European countries; pain complaints account for a large proportion of GP visits every year and almost half of all absences from work lasting three or more days.

The recommendations, supported by Chronic Pain Ireland, focus on four main categories: health indicators, research, education and employment.

Health indicators

In June 2018, chronic pain was included as a separate entry for the first time ever in the World Health Organization (WHO) 11th revision of the International Classification of Diseases (ICD-11).

The SIP recommendations, having identified a 'data gap' in how pain is measured and monitored across Europe, call on the EC to extend this classification to a European context under the European Core Healthcare Indicators project, and promote the implementation of ICD-11 at a national level within each of its member states.

Research

The recommendations also call on the EC to address the disparity between pain research funding at EU and member state level. SIP proposes the development of 'pain centres of excellence' to further the public's understanding of pain, inform evidence-based policy making and improve clinical outcomes for people living with chronic pain.

The recommendations highlight the responsibility member states have towards investing in clinical, scientific pain research, suggesting that extra funds be made available through health policy, employment in the area of pain management, and research and innovation programmes.

Education

The absence of dedicated pain management programmes in the education of healthcare professionals in Europe needs to be addressed, according to the recommendations.

In order to fill this gap in a clinical context, SIP has recommended that the EC and member states offer better access to pain programmes in healthcare professional education, promoting the delivery of pain management in the planning of the future health workforce.

In a broader community context, the recommendations call on the EC to support campaigns that are designed to raise awareness of pain and keep stakeholders, such as policymakers and patients, better informed about the impact that pain has on society.

Pain and employment

Chronic pain has become an increasingly common contributing factor in premature retirement, disability retirement and workplace absenteeism, with more than 40 million workers in the EU living with musculoskeletal disorders caused by the nature of their work.

To combat these issues and ease the impact of pain on the workforce, SIP recommends that the EC aligns its policies to reflect the link between pain and employment. Improving European health and safety regulations, and identifying work-related health problems and how to better prevent them will be key in achieving this aim, according to the recommendations.

Further resources

The SIP platform is a joint initiative, established in 2009 by the European Pain Federation (EFIC) and pharmaceutical company Grunenthal with the aims of:

- Raising awareness of the impact that pain has on our societies, health and economic systems
- Exchanging information and share best practices across EU member states
- Developing Europe-wide policy strategies for improved pain care.

A full list of recommendations for policy action, as well as the SIP framing paper, is available at **www.sip-platform.eu**

Survey

One in five people in Europe experiences chronic pain. To give these people a voice, Pain Alliance Europe (PAE) recently launched a survey, which is open for completion until March 1, 2019. The stated aim of the survey is to work toward establishing a better definition for pain, the stigma associated with it, and the burden it represents. For more information, and to complete the survey, visit **www.pae-eu.eu**

– Max Ryan

References

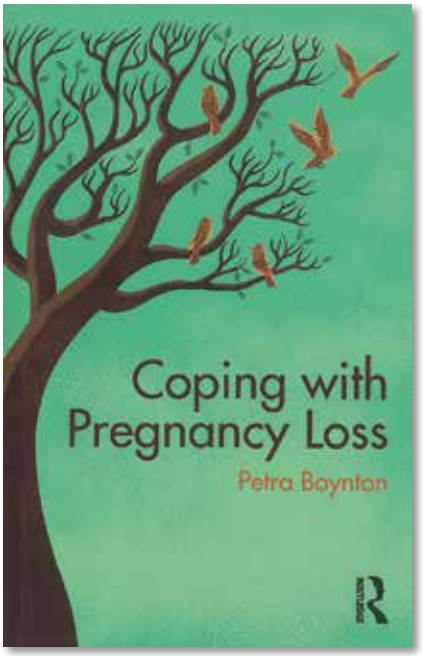
1. Societal Impact of Pain Joint Statement: Recommendations for Policy Action, Nov 2018. https://www.sip-platform.eu/files/editor/media/EU%20Initiatives/SIP%20Thematic%20Network/SIP%20Thematic%20Network%20-%20The%20Societal%20Impact%20of%20Pain%20Joint%20Statement_09%2011%202018.pdf

2. Thematic Network on the Societal Impact of Pain Framing Paper, Nov 2018. https://www.sip-platform.eu/files/editor/media/EU%20Initiatives/SIP%20Thematic%20Network/Framing%20paper%20SIP%20-%205112018_for%20website_update.pdf

Support at a time of loss

ONE in four pregnancies ends in miscarriage, yet pregnancy loss remains an isolating issue that can be hard to talk about. Drawing on her background as an academic working in sexual health with personal experience of miscarriage, social psychologist Petra Boynton has written *Coping with Pregnancy Loss* to help those affected by miscarriage, ectopic pregnancy or stillbirth to find their own paths through the labyrinth of questions, feelings and challenges that often follow the experience of losing a pregnancy.

Loss of a pregnancy affects people in different ways, yet it remains a sensitive topic and information can be hard to find. Insightfully shifting the focus across different areas of mental and physical health, social and sexual issues, this book aims to provide a practical tool kit for those affected and to offer a self-help resource that combines both personal empathy and detailed research-based information. It aims to equip those affected by loss with insights and strategies for self-care, with the tone of a trusted friend to talk things through with.



Based on scientific evidence, including research conducted by Petra Boynton herself, the book reveals some of the most common feelings and concerns and offers practical ways to help navigate mental, physical and emotional health. It also emphasises how those experiencing pregnancy loss are not alone and aims to create greater understanding around the impact of baby loss in the healthcare system and across society generally.

The book offers practical advice and self-care strategies to help people cope during or after loss, alongside ideas that will enable them to make sense of what has happened – including understanding their feelings and choices; outlining what they can expect during and after their loss; ways to navigate physical and mental healthcare, where needed; and thinking about how to remember their lost baby.

As well as being for people directly affected – currently or in the past, this book is also for midwives, nurses and other healthcare professionals, therapists, charities and support groups who want to provide support and care.

Everyone reacts and copes with pregnancy loss in different ways and this book is an invaluable resource when it comes to getting information, help and support.

Coping with Pregnancy Loss by Petra Boynton is published by Routledge. ISBN: 9781138047730. RRP STG£11.99

CROSSWORD Competition

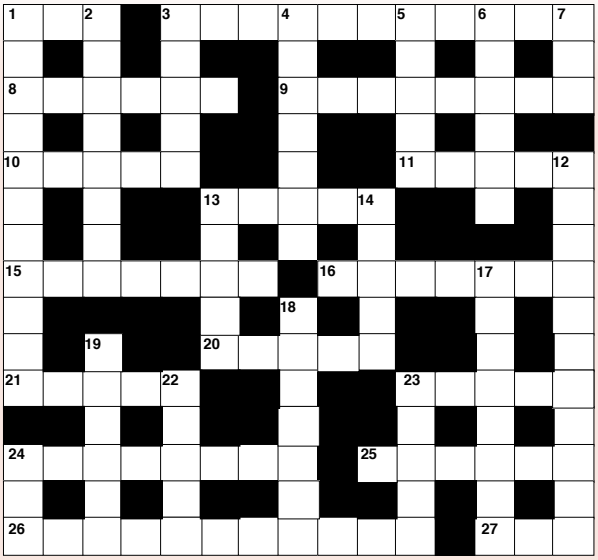
WIN a €30 gift voucher

Across

1 Equip with weapons (3)
3 Essay about an icon (imps too) (11)
8 Melancholy, gloomy (6)
9 Pulsated (8)
10 & 3d The first woman to win a Nobel Prize (5,5)
11 Walk vainly (5)
13 Traditional French headgear (5)
15 Ceded up, gave way (7)
16 No tests may be used in the manufacture of headgear (7)
20 Wheat found in a Hindu rummage sale (5)
21 Money in paper form (5)
23 Might, force (5)
24 & 2d Manic barmen empty out part of the ear! (8,8)
25 & 4d Fraternal plot to recreate a flowery design (6,7)
26 Bop us sots, and find a Pantomime title! (4,2,5)
27 An explosive sound from Dad (3)

Down

1 Representing his constituents at Stormont, he will slam my beans around (11)
2 See 24 across
3 See 10 across
4 See 25 across
5 Icons of solid disposition (5)
6 Innate, of one's nature (6)
7 Signal agreement (3)
12 The sound made by Iceland soccer supporters makes a pedant lurch about (11)
13 Produce offspring (5)
14 & 23d Native American structures (5,5)
17 Flower that appears in late winter or early spring (8)
18 Member of the Marx Brothers characterised by a moustache and cigar (7)
19 Perplexes with items of cricket equipment (5)
22 I swam around to a mentor (5)
23 See 14 down
24 Spinning toy (3)



December crossword solution

Across: 1 Danish pastry 7 Age 9 Cyan 10&15 Gin and tonic 11 Gnus 14 Phial 16 Lean 18 In-off 21 Azure 22 Rabbi 23 Wheat 24 Toys 25 Moral 26 Clean 29 Ogle 33 Donate 34 Tail 36 Sou 37 Dress the tree

Down: 1 Dry 2 Nuns 3 Sign 4 Punch 5 Santa 6 Yarn 8 Essential oil 9 Contractions 12 Injury 13 Screw 14 Pride 17 Embark 19 Often 20 Frame 27 Lions 28 Await 30 Loud 31 Gene 32 Star 35 Ice

(Apologies for error in printing of grid last month and a special well done to those who overcame the problem)

The winner of the December crossword is: Mary Jarvis Clones, Co Monaghan

You can now email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included.
Closing date: Monday, February 18, 2018
If preferred you can post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin, A96E096

Name:
Address:

Comparing the market

It is important to shop around for the best health insurance deal, writes **Dermot Wells**

INMO members now have the opportunity to compare the many health insurance products on the market with Cornmarket's health insurance comparison service. Some 45% of the population will renew their health insurance within the first three months of 2019 with 25% renewing in January alone.[1] With more than 325 plans available across the market, comparing like for like cover on your own can be difficult.

Usually at this time of the year, the media is focused on health insurance premium increases, but there is good news this year as insurers have frozen prices across the majority of their schemes, with some plans reducing in premium compared to last year.

Our message is always the same: don't renew until you review! If you have been insured under the same plan for two years or more you need to review your cover.

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

Here are a few things to consider to 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 different plans yet remain on the same policy? This allows you to choose separate plans depending on each family member's individual needs which could help to reduce your costs.

Avail of offers for children

It's important to remember that young children won't be treated in hi-tech hospitals such as Blackrock Clinic or 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. It's worthwhile shopping around as some of the insurers provide preferential or half price offers for kids 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 doesn't 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 offer 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 visits per year, then it may make financial sense to include this type of cover on your plan. You should sit down and do the calculations 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.

Ask about corporate plans

These are developed specifically for large company schemes, however any individual can avail of these plans. 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.

Many corporate plans also build in the ability to claim back on everyday medical expenses such as the GP, physiotherapist and dentist. 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.

Cut out unnecessary cover

Health insurance plans vary considerably in the level of cover that they provide. Not all benefits may be of relevance to you, therefore it's 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's 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 between 18 and 25 years of age or if you have a dependent that 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.

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. If you would like to avail of this service, contact Cornmarket at: Tel: 01 4086212 or visit: **cornmarket.ie/inmo**

Dermot Wells is the General Manager of Cornmarket's Health Insurance Division.

Reference
1. Source,HIA 2018

Survey on number of clinical research nurses and midwives

THE Irish Research Nurse Network (IRNN) launched a survey in January to measure the clinical research nurse and midwife workforce in Ireland.

'Count Me In' is a national survey of clinical research nurses and midwives based in a variety of settings.

The IRNN is a voluntary group that provides resources and support to clinical research nurses (CRNs) and midwives.

Currently, the number of CRNs working in Ireland is unknown, but is estimated to be in the region of 200.

Many CRNs are based in established healthcare institutions and research centres/facilities, however the posts are filled on a sporadic and ad hoc basis. CRNs may also be employed by commercial organisations or medical research charity groups.

CRN job titles, roles and responsibilities and terms of employment may vary between organisations and even from one post to another within the organisation.

A consequence of the lack of standardisation is an absence of job security. Furthermore, there is little professional support and no clear or defined career pathway for CRNs. Given these factors, nurses may be less inclined to consider the CRN role as a career prospect.

The aim of the 'Count Me In' survey is to reach all CRNs in the country to discover:

- How many research nurses/midwives are currently working in Ireland
- Where they are located
- The terms of employment
- The roles and responsibilities.

This will not only involve contacting research nurses already associated with IRNN, but also stakeholders within organisations nationwide. The success of the survey will be very much reliant on the Irish research community.

The data will be collated into a report that will be disseminated to stakeholders, such as the Health Research Board (HRB) and the Health Service Executive (HSE).

Findings will be used to advocate for increased recognition of the research nurse workforce, and to justify the development of formalised job descriptions, education and integration within academic and healthcare institutions.

On completion of the survey it is hoped to retain a database of research nurses/midwives who have provided consent for future communication. This will be in adherence to the General Data Protection Regulations.

Please contact the project manager Carole Schilling (caroleschilling@rcsi.ie) if you are:

- A research nurse/midwife willing to participate in the survey
- An employer or manager of research nurses/midwives who can provide information about research nurse posts in your organisation
- Available as a point of contact for your organisation, research area or region.

Nurses recognised at awards night

Nursing departments among winners at St Luke's awards ceremony

WITH 10 winners and runners-up , the nursing departments at St Luke's Radiation Oncology Network (SLRON) enjoyed great success at the inaugural Quality Excellence Awards in November 2018.

The awards, sponsored by Elekta, were held to acknowledge the achievements of individuals and teams under a number of categories including:

- Quality improvement
- Improvement initiative
- Best poster
- SLRON healthcare champions; one nominated by a patient or visitor and the other nominated by a fellow staff member.

St Luke's has been caring for cancer patients since opening in Rathgar in May 1954. St Luke's Radiation Oncology Network was established in 2011 with two additional centres opening in St James's Hospital and Beaumont Hospital.

The Network's primary role is in radiotherapy, and it is also the national centre for specialist techniques such as total body irradiation, stereotactic treatment for the lung and brain, and treatment of paediatric patients.

The nursing departments, across the three centres, were involved in many of the projects and enjoyed great success at the award ceremony.

The winners of the quality improvement award were the day ward staff at the Hospital with their initiative entitled 'You've gotta PICC a patient or two'. Their initiative involved the use of Site-Rite ultrasound system to confirm the placement of PICC lines to reduce infection, complications and cost while improving patient comfort.

Pictured at the Awards ceremony were nurse department award winners (l-r): Agnes Murray; Michelle Danagher; Frances Kingston, Antoinette Kirwan; Áine Lavelle and Fiona Liston

The winner of best visual poster went to registered advanced nurse practitioners Áine Lavelle and Claire Farrell for 'Virtual prostate follow-up', which describes the use of virtual telephone clinics to reduce waiting time, travel and cost for prostate patients.

This initiative allows for improved deployment of resources and has a psychosocial, logistical and financial benefit for the patients.

Fiona Liston, clinical specialist nurse, finished as runner-up for the patient-nominated SLRON healthcare champion award, an award to recognise staff who 'go the extra mile'.

Fiona has been working in radiation oncology since 2003; her main areas of interest are breast and lung cancer.

Speaking on the night, Antoinette Kirwan, director of nursing, SLRON said: "This occasion has highlighted the tremendous commitment each staff member gives each day to assist our patients on their journey with us.

"We are so proud that their efforts are recognised here today and I am delighted to be part of this wonderful team of dedicated staff. Sincere congratulations to everyone involved."

Colorectal study day

THE colorectal surgery department at University Hospital Waterford has developed a regional colorectal study day for general nurses, after identifying the need for further education in this specialty. The study day has already been run twice and on both occasions received positive feedback. The next date for the study day is May 20, and will cover a number of topics including colorectal cancer, IBD, pain management, dietetics, colorectal surgery and stoma care.

The hospital currently holds a regional weekly GI cancer multidisciplinary meeting (MDM) and every Monday morning, holds a local MDM where decisions regarding inpatient care can be discussed by clinical staff. Bookings for the next study day can be made at: **www.surveymonkey.com/r/XC5TFTF**

Charities benefit from ADC 2018

Funds were raised at the INMO ADC in May 2018 for Brú Columbanus and the Simon Community through a table quiz and raffle organised by members and staff. The event raised €3,000, which was evenly shared between both organisations. Members also organised a coffee morning at the ADC as part of National Alzheimer's Tea Day and raised €303, which was presented to the Alzheimer's Society of Ireland. All of these fundraisers were organised by the ADC organising committee, made up of the two Cork Branches: the Cork Voluntary and Private Branch and the Cork HSE Branch). The INMO would like to extend its thanks to all the delegates for their amazing generosity. All three charities were very grateful for the donations. Pictured at the cheque presentation to Brú Columbanus were (l-r): Eileen O'Keeffe; Eilish Fitzgerald, INMO second vice-president; Anne Marie O'Connor, fundraising manager of Brú Columbanus and Gobnait Magner

February

Friday 1
Nurse/Midwife Education Section meeting. INMO HQ. From 11.30am. Contact jean.carroll@inmo.ie for further details

Friday 1
Assistant Directors Section INMO HQ. From 11.30am. Contact jean.carroll@inmo.ie for further details

Saturday 2
Midwives Section AGM and meeting. CUMH. Contact jean.carroll@inmo.ie for further details

Saturday 2
School Nurses Section AGM and sepsis information meeting. INMO HQ. From 10.30am. Contact jean.carroll@inmo.ie for further details

Saturday 2
ODN Section AGM. Mater Hospital. From 11.30am. Contact jean.carroll@inmo.ie for details

Monday 4
National Childrens Nurses Section meeting. INMO HQ. From 11am. Contact jean.carroll@inmo.ie for further details

Monday 4
CPC Section Annual General Meeting. Richmond Education and Events Centre. From 10.30am. Contact jean.carroll@inmo.ie for further details

Monday 4
International Nurses Section meeting. INMO HQ. From 5.30pm. Contact jean.carroll@inmo.ie for further details

March

Tuesday 5
Care of the Older Person Section conference. INMO Richmond Education and Event Centre. Contact jean.carroll@inmo.ie for further details

Friday 29/Saturday 30
ODN Section conference. Richmond Education and Event Centre. Contact jean.carroll@inmo.ie for further details. *See page 26*

April

Sunday 7 - Thursday 11
Retired Section tour. The Park Hotel, Dungarvan, Waterford. Contact jmgtravel@eircom.net for further details or *see page 23*

May

Wednesday 8 - Friday 10
INMO centenary annual delegate conference 2019. Knightsbrook Hotel, Trim, Co Meath. Contact michaela.ruane@inmo.ie for further details

INMO Membership Fees 2019

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