€5.75 Vol 30 No 1 February 2022

WIN

Journal of the
Irish Nurses and
Midwives Organisation

World of Irish Nursing & Midwifery

Latest INMO CPD education programme
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Occupational health marks 40 years
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Battle continues

Meaningful action needed to protect staff

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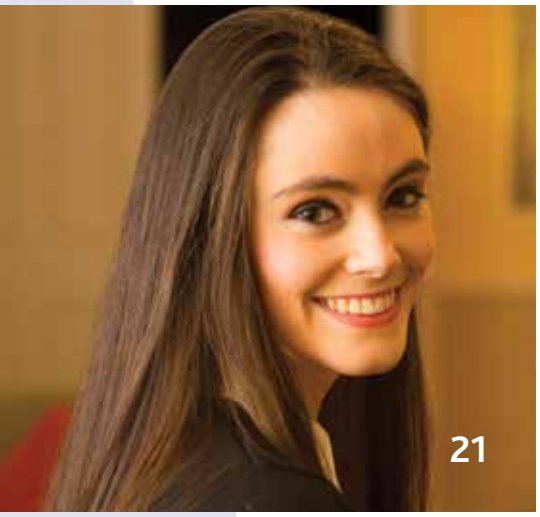

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WIN – World of Irish Nursing & Midwifery is distributed by controlled circulation to **more than 40,000** members of the INMO. It is published monthly (10 issues a year) and is registered at the GPO as a periodical. Annual Subscription: €155 incl. 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.

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Breastfeeding: The best start

Health benefits for infants

Breast milk is the ideal food for newborns and infants. It gives them all the nutrients they need for healthy development. It is safe and contains antibodies that help protect infants from common childhood illnesses such as diarrhoea and pneumonia, the two primary causes of child mortality worldwide. Breast milk is readily available and affordable, which helps to ensure that infants get adequate nutrition.

Long-term benefits for children

Beyond the immediate benefits for children, breastfeeding contributes to a lifetime of good health. Adolescents and adults who were breastfed as babies are less likely to be overweight or obese. They are less likely to develop type 2 diabetes and perform better in intelligence tests.

Benefits for mothers

Breastfeeding also benefits mothers. It reduces risks of breast and ovarian cancer later in life, helps women return to their pre-pregnancy weight faster, and lowers rates of obesity.

Support for mothers is essential

Breastfeeding has to be learned and many women encounter difficulties at the beginning. Nipple pain, and fear that there is not enough milk to sustain the baby are common. Health facilities that support breastfeeding – by making trained breastfeeding counsellors available to new mothers – encourage higher rates of breastfeeding. To provide this support and improve care for mothers and newborns, there are 'baby-friendly' facilities in about 152 countries thanks to the WHO-UNICEF Baby-friendly Hospital initiative.

Work and breastfeeding

Many mothers who return to work abandon breastfeeding partially or completely because they do not have sufficient time, or a place to breastfeed, express and store their milk. Mothers need a safe, clean and private place in or near their workplace to continue breastfeeding. Enabling conditions at work, such as paid maternity leave, part-time work arrangements, on-site crèches, facilities for expressing and storing breast milk, and breastfeeding breaks, can help.

INMO
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The Irish Nurses and Midwives Organisation supports breastfeeding

For more information log onto www.breastfeeding.ie

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

(ISSN: 2009-4264)
Volume 30 Number 1
February 2022

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:
Karen McGowan
Eilish Fitzgerald, Kathryn Courtney

INMO editors:
Siobhan De Paor (siobhanl.depaor@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

We are not there yet

THE positive reaction in communities across Ireland when restrictions were eased has been visible in recent weeks. The societal impact of restricted living will be examined for many years to come; indeed, the government has set out its intention to examine and review this impact and identify lessons learned from the approach taken in Ireland to the pandemic.

We in the INMO will be seeking an independent review and input into the terms of reference of this review, particularly into the position we found ourselves in as front-line healthcare workers when the pandemic hit. We are writing to the government to set out the issues that must be included in any examination of this experience. It would be a mistake to only review the period February 2020 to February 2022.

To examine how Ireland coped, we must look at the health service structures that existed and the policy decisions that were taken in the previous decade that directly affected our ability to provide care in hospital and community services. The decade of restrictions in nurse/midwife recruitment leading up to early 2020 and the negative effects of the recruitment restrictions from 2007-2013, combined with excessive bureaucracy attached to the recruitment process thereafter, undoubtedly put staffing levels on the back foot.

Throughout the pandemic, we were heavily reliant on retired staff, unpaid students, and nurses and midwives working additional hours to ensure surge capacity could be provided and new services such as vaccination centres were staffed.

The moratorium on recruitment and promotion introduced in the health services in December 2007 did more than curtail recruitment, it introduced a mindset in the budget holders of putting cost as the priority even if care provision was affected. That mentality remains and the bureaucracy in the recruitment process and the lack of proactive workforce planning is causing an avoidable delay in the provision of nurses and midwives across the health service. This in turn is exposing those working in areas with unfilled slots on rosters to unnecessary risk in their workplaces.

This recruitment embargo and its legacy have, in our view, caused the single biggest obstacle to the progression of nursing and midwifery and the ability to grow services to meet the growing needs of patients and other stakeholders. The period 2007-2020 also saw the privatisation of 82% of the care of older person long-term care services, where cost of care became the mantra of managers. The cost of these decisions for residents and workers in mainly private long-term care facilities cannot be ignored. The pandemic may be receding but the issues in long-term care remain. This area must be examined in the context of our ability to provide care during a pandemic and the personal cost for staff who were asked to do the impossible in areas that were already under-resourced.

With the lifting of practically all community restrictions, it's difficult not to feel extremely nervous considering the possible effects on health service staff. Covid-19 has not magically disappeared. The current Omicron wave is resulting in fewer admissions to hospitals and fewer ICU admissions, largely due to the high uptake of vaccines and the milder nature of the infection. Lifting restrictions poses a real threat of increasing transmission and outbreaks in healthcare settings. In the last week of 2021 and the first two weeks of 2022, 142 outbreaks were reported in nursing homes and community hospitals, 1,939 cases were associated with these outbreaks and the hospital admission rate and deaths resulting from them identify that this is far from over.

The significant impact of the pandemic on the health services is not over and nurses and midwives continue to work in difficult conditions as they care for patients admitted with Covid-19. The strengthening of support for the exhausted workforce is a must, and a true and independent evaluation of how we have coped must include the policy decisions that left us in the place we found ourselves in February 2020.

Phil Ní Sheaghdha
General Secretary, INMO

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A positive focus
with the president

Karen McGowan, INMO president

Workplace must be safer

AS WE look to the year ahead, having come through a January that was dreaded by us all, we must continue to keep the pressure on in our workplaces to make our environment safer. The curtailment of services is no doubt helpful but, that said, the number of patients on trolleys in several areas does not reflect an improvement in safety. We have seen a record number on trolleys in recent weeks and the number of nurses and midwives not available to work due to Covid-19 was unprecedented, placing increased pressures on rosters and workplace safety. These conditions are horrendous and the HSE must act to improve the situation. Our workforce is being exposed to Covid continuously so it is imperative that the HSE acts to improve the air quality in our hospitals. It is not a 'nice to have' – it is simply a 'must have' and should be mandatory in this climate.

New graduate training in critical care

THIS month I spoke with Sinéad Gill, the critical care facilitator in Tallaght University Hospital. Ms Gill's background is in critical care outreach. The critical care team, which includes five nurses in various roles, has been intuitive and innovative during the pandemic, launching the first new graduate critical care nurse pathway, which outlines the roadmap from student nurse to advanced practice roles in critical care (*see our feature on page 26 for more*).

Pictured (l-r): Sinéad Gill, Shauna Delaney and Bernadette Garvin who are part of the critical care clinical facilitator team at Tallaght University Hospital

This is the first course of its kind in Tallaght University Hospital. Ms Gill said that there was an urgent need to develop these skills and the benefits of having this type of course for new graduates had been previously seen in the UK. The critical care team believed in the course as they had a structured plan and the right supports in place. It was a gamble during a pandemic, but it was necessary with staffing shortages and a construction project onsite that will be complete by the end of the year.

"The passion to learn from the new graduates was very evident and allowed the course to flow so well. The goals, set by nurses, have been achievable and it's so important to see that progression," she said.

The team feel rewarded when they see the graduates grow in confidence throughout the course and become valuable assets to the hospital. Ms Gill's determination was evident as she told *WIN*: "There is such positivity surrounding this programme as a strong recruitment tool. What makes the programme different is that we have a weekly learning outcomes session that is student focused where they can bring up any areas to learn from practice. This leads to students being less overwhelmed and is a safe place to learn from each other. As a clinical facilitator it is so inspiring to see the new graduates gain the skillsets from doing this course. The success of the programme drives the team forward and motivates us for the next intake in October 2022. It has been a very proud moment for us all to see our hard work come to fruition," she added.

The success of this programme shows that the transition of newly graduated nurses into the critical care environment is achievable when coupled with excellent preceptorship and a solid educational programme.

Executive Council update

THE Executive Council met virtually in January. We discussed a number of national issues that are ongoing. We welcomed news that the Independent Body Examining Additional Working Hours has recommended that working time in the civil and public service should be restored to pre-2013 levels from July 1 this year. This was excellent news for nurses and midwives and as officers of the Executive Council we will be watching the handling of this recommendation very closely.

Discussions on the increase in Covid-19 cases and booster vaccinations also took place. In January levels of Covid-19 saw a steady rise as anticipated. We know that these outbreaks are always higher in our healthcare settings and our members have described the stressful environments they have endured during this time. The high number of patients on trolleys, combined with the number of nurses and midwives on Covid-related leave has strained the system beyond its limits. Urgent meetings were held with HSE and the INMO stressed that curtailment of services was required, alongside improvements in air quality in our hospitals.

The annual delegate conference was also discussed and all plans are progressing well. All the branch and section meetings are currently being planned in preparation for May. As the motions are being prepared please remember that anything that is covered by existing organisational policy will not be included. The Executive Council is very thankful to the standing orders committee who work tirelessly in this regard.

The next meeting for the Executive Council is scheduled for February 14 and 15.

If you would like to showcase your nurse-led initiative or role, please get in touch with me via the email address below.

Get in touch

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

Restoring pre-2013 working hours will aid nurse/midwife retention

THE INMO welcomed the recommendation that emerged last month that working time in the public service should be restored to pre-Haddington Road Agreement levels from July 1, 2022.

The Independent Body Examining Additional Working Hours chaired by Kieran Mulvey has sent recommendations on working hours for civil and public servants to the Minister for Public Expenditure as agreed under the Building Momentum Public Service Agreement.

INMO general secretary Phil Ní Sheaghdha said: "The recommendation by the independently chaired hours body is one that will benefit the retention of nurses and midwives. The additional hours have disproportionately impacted our largely female workforce. The additional hours have pushed many nurses and midwives into part-time work due to the additional pressure that was put on caring responsibilities.

"We know that since 2013 the additional unpaid hours have had a considerable negative impact on morale, and the retention of nurses and midwives within the public health service.

"The recommendation to restore pre-2013 working hours is a significant step in addressing this key issue under the Building Momentum Agreement. INMO members voted to accept the agreement and its full implementation now will pave the way for new public service agreement negotiations to begin later this year.

"The INMO, along with other unions that represent public and civil servants, is confident that the return to pre-Haddington Road hours can be achieved without an excessive additional cost to the Exchequer or damage the output of our public sector."

INMO president Karen McGowan added: "The INMO Executive Council has welcomed the recommendations made by the Independent Body Examining Additional Working Hours. Nurses and midwives will be watching the handling of this recommendation by government closely.

"Nurses and midwives have gone above and beyond since 2013 when additional working time was introduced. Their dedication and goodwill have often held our public health system together at very trying times, especially over the past two years. As higher earners in the public service are due to receive pay restoration in July 2022, it is only right that additional hours worked by nurses and midwives are restored to pre-2013 levels in tandem."

Pandemic bonus – "the right thing to do"

THE INMO welcomed the news that nurses and midwives are to receive a €1,000 pandemic bonus announced last month but called for more detail on how it will be applied.

INMO general secretary Phil Ní Sheaghdha said: "The decision by government to grant a €1,000 tax-free payment to nurses, midwives and student nurses is the right thing to do.

"It's a small thank you but it's very welcome. The INMO first lodged a claim for special recognition for healthcare workers in November 2020. Healthcare workers have given their all in the fight against Covid-19. They have adapted rapidly, worked far beyond their normal responsibilities, and thousands have caught the virus in the line of duty.

"The decision to hold a commemorative event in March is also very appropriate to honour the lives lost during the pandemic. In a recent INMO survey, 62% of members indicated that they had cared for patients who died as a result of Covid-19 and while nurses and midwives deal with and care for dying patients normally, the level of death in this short period far exceeded previous levels in circumstances that were far from ideal in many instances.

Call for detailed modelling on public health strategy

REACTING to updated Covid-19 guidance, the INMO called on the government to outline the impact new public health measures would have on the health service.

INMO general secretary Phil Ní Sheaghdha said: "The decision to reduce isolation time for Covid-positive cases and close contacts needs to be examined. Weakening the public health advice has the potential to lead to more people contracting the virus.

"We know that many asymptomatic close contacts have been a feature of the Omicron variant. Allowing potentially infected people to continue to work has a knock-on impact on case transmission. This is a high risk strategy considering the annual pressure on hospitals in the first quarter of the year and considering the current overcrowding and lack of inpatient beds."

The INMO called for detailed modelling on the impact the latest advice would have on the health service. "Nurses and midwives need to be briefed on what exactly is required of them, when patients are admitted for care in respect of isolation protocol in order to work safely," Ms Ní Sheaghdha said.

Derogation policy

It is important that members understand that the HSE derogation policy which allows for the return to work of asymptomatic close contacts following a risk assessment is voluntary. This means that derogation can only occur with the staff member's agreement. Furthermore, derogation can only occur following a negative antigen test.

The INMO has engaged with the HSE to insist that antigen tests are provided by the employer to nurses and midwives. They have agreed to our demand that antigen tests will be provided by the employer either by post or directly from the work location. Anyone requested to derogate should await receipt of a test from their employer.

INMO repeats calls for curtailment of non-emergency services

Meaningful action needed to protect nurses and midwives

THE INMO has made numerous calls for all non-emergency activity to be curtailed in the acute public hospital system, as staff continue to battle the dual problems of hospital overcrowding and Covid-19.

The union has also reiterated its calls for greater measures to be taken to reduce workplace transmission of Covid-19 in our hospitals.

INMO general secretary Phil Ní Sheaghdha said: "The HSE and the political system has a responsibility to an exhausted healthcare workforce to ensure their workplaces are as safe as they can be. There must be no tolerance for hospital overcrowding while a highly transmissible airborne virus is making its way around our hospitals. Improvements to air quality in our hospitals must be a priority.

"Our hospitals cannot operate on goodwill of staff alone, we need an urgent capacity plan from the HSE. Our public hospital system is too small to cope with servicing emergency care, Covid care and elective treatments. It is time for the State to step up and ensure that all capacity that can be gained from the private sector is used.

INMO general secretary Phil Ní Sheaghdha said: "We are dealing with a very different winter in our health service this year, we are seeing huge increases in the number of patients on trolleys and a high number of nurses and midwives on Covid-related leave.

"Day after day we are seeing over double the amount of patients on trolleys compared to the same day in 2021. The directive from the chief executive of the HSE that was issued at the start of January for hospitals to curtail all non-emergency activity must be extended until February in order to allow our members to carry out their work safely.

"Covid-19 is still very much a feature of the day-to-day work of our nurses and midwives. We are still seeing high numbers of Covid-related hospital admissions and nurses in our ICUs are treating very sick patients. While the government is reopening society, Covid-19 is still very much working its way through our hospitals and healthcare settings."

Meaningful action needed to protect nurses and midwives

Early last month, the INMO called on the HSE to take extra measures to protect the nursing and midwifery workforce. It pointed out that there are double the number of patients on trolleys compared to the same time last year but at the same time nursing and midwifery rosters are depleted.

Using figures provided by the HSE early last month, the INMO calculated that 7.29% of nurses/midwives were on Covid-related leave.

"Covid outbreaks are higher in healthcare settings compared to any other setting. The HSE must take meaningful, long-lasting action to protect our nursing and midwifery workforce. That includes curtailing non-emergency activity and making improvements to air quality in our hospitals," said Ms Ní Sheaghdha.

"While we welcome the call from the HSE chief executive for hospitals to curtail all non-emergency care for two weeks last month, we believe that this should be extended until February to give our nurses and midwives some chance of being able to carry out their work safely.

INMO general secretary Phil Ní Sheaghdha: *"Our hospitals cannot operate on goodwill of staff alone, we need an urgent capacity plan from the HSE, backed by government"*

"Air quality in our hospitals continues to be a huge problem while overcrowding continues to be allowed. We believe that as an employer the HSE has an obligation to provide proper air filtration units such as HEPA filters across our hospitals, especially in overcrowded emergency departments and waiting areas.

"It has been especially difficult for nurses and midwives over recent weeks in particular, they are working in extremely difficult circumstances. The HSE as an employer must do everything it can to protect this workforce, who are the most exposed to this virus day in and day out."

Worst overcrowding

The warning signs that trolleys would exceed 500 once again were very obvious, according to Ms Ní Sheaghdha.

On December 13, the number of patients on trolleys hit 534 – the highest number since the pandemic began. The INMO responded by calling for bespoke plans to tackle overcrowding in each hospital.

Calling these figures "a real nightmare before Christmas scenario", Ms Ní Sheaghdha called for "urgent mitigation measures from individual hospitals and the HSE to tackle the number of people on trolleys".

"Overcrowded hospitals reduce the ability to deliver safe care. With this pandemic it is even more important that the HSE takes all necessary steps to avoid the overcrowded wards and emergency departments becoming the source of infection.

"We are once again calling for a fully funded workforce plan and adequate health and safety measures including enhanced ventilation in our hospitals.

"The public service is under too much pressure to be expected to shoulder the entire burden of the pandemic alongside rising numbers of patients presenting at emergency departments. The HSE must seek full utilisation of private hospitals.

"Our members are mentally and physically exhausted. They cannot continue into yet another pandemic winter with trolley numbers out of control while the pandemic continues.

"Decisive action and bespoke plans to tackle overcrowding, particularly in hospitals where we see persistent overcrowding is needed."

Over 70,000 patients without beds

OVER 70,275 patients went without a bed in Irish hospitals in 2021, according to INMO trolley watch figures.

The union has branded the year's figures as an "unacceptable rise in overcrowding while we know this adds to the spread of Covid-19 in our hospitals". This comes as the INMO's figures show an increase of 31% patients on trolleys compared to the first year of the pandemic *(see Table 1)*.

The hospitals with the highest overall figures included:

- University Hospital Limerick, 12,108
- Cork University Hospital, 7,411
- Letterkenny University Hospital, 5,778
- University Hospital Galway, 5,027
- Sligo University Hospital, 4,284.

INMO general secretary Phil Ní Sheaghdha said: "The fact that we have seen the numbers of patients on trolleys rise by 31% during the second year of a pandemic is completely unacceptable. Hospital overcrowding should never be acceptable, especially when we have a highly transmissible virus.

"Radical action is now needed to curb the unacceptable levels of overcrowding in our hospitals. This is not a new phenomenon; the health service cannot continue to make the same decisions year in year out and expect different outcomes."

The INMO pointed out immediate short-term requirements that can be taken:

- Increasing care of sick non-emergency patients in the private sector
- Immediate review of pre-hospital and post discharge care to assist the pressures on acute public hospitals
- The full implementation and funding of the nursing and midwifery staffing review
- Increase supports to provide nursing and midwifery led care in the community.

"We have a nursing and midwifery workforce that is running on empty. They are looking for some kind of indication from their employer that things will be different this year. The commitment nurses and midwives have shown especially with the arrival of Omicron has been exemplary", said Ms Ní Sheaghdha. "While many staff are on Covid-related sick leave, others are cancelling leave and staying longer than they are rostered to ensure patients are looked after. The INMO has raised red flag, after red flag with the HSE and the government. We need to see urgent action by curtailing all non-emergency activity in our public hospitals."

Table 1. INMO trolley and ward watch (Full year analysis 2006 – 2021)

Hospital	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
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	3,321	924	n/a
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	2,937	602	n/a
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	6,031	2,368	2,680
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	4,206	1,042	2,304
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	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	2,381	1,405	1,605
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	4,242	1,720	2,139
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	5,444	2,078	2,474
Children's Health Ireland, 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	102	8	84
Children's Health Ireland, 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	607	406	580
Children's Health Ireland, Temple Street	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	618	224	604
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**	**29,889**	**10,777**	**12,470**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	147	233	627	779	731	1,060	332	126
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	2,137	915	792
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	11,066	6,503	7,411
Letterkenny General Hospital	3,059	1,253	388	378	474	592	539	1,277	2,755	2,814	2,047	4,889	5,174	5,727	1,504	5,778
Louth County Hospital	200	88	152	146	25	n/a	n/a	n/a	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	2,519	2,156	2,776
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	3,173	2,013	2,742
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	2,619	2,768	2,598
Midland Regional Hospital, Portlaoise	469	283	425	297	426	1,926	539	824	1,589	2,162	3,364	3,203	2,815	1,845	502	549
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	3,344	1,254	2,323
Mid Wester Regional Hospital, Ennis	867	961	252	368	431	411	324	333	7	125	330	175	214	195	102	152
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	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	457	52	25
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	1,941	670	614
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	946	655	554
Portiuncula Hospital	403	281	306	605	840	941	821	813	912	1,100	892	1,569	1,302	1,503	888	1,838
Roscommon County Hospital	589	764	725	755	1,036	719	n/a	n/a	n/a	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	4,967	2,530	4,284
South Tipperary General Hospital	727	784	881	500	666	768	2,138	2,762	1,959	2,028	5,399	5,249	5,201	4,075	1,914	3,195
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	6,942	1,649	766
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	7,993	2,334	5,027
University Hospital Kerry	1,144	507	763	337	623	672	606	694	1,005	1,389	1,664	2,215	3,396	3,610	2,350	2,409
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	13,941	9,843	12,108
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	6,313	910	460
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	2,105	704	1,278
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**	**88,478**	**42,548**	**57,805**
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**	**118,367**	**53,325**	**70,275**

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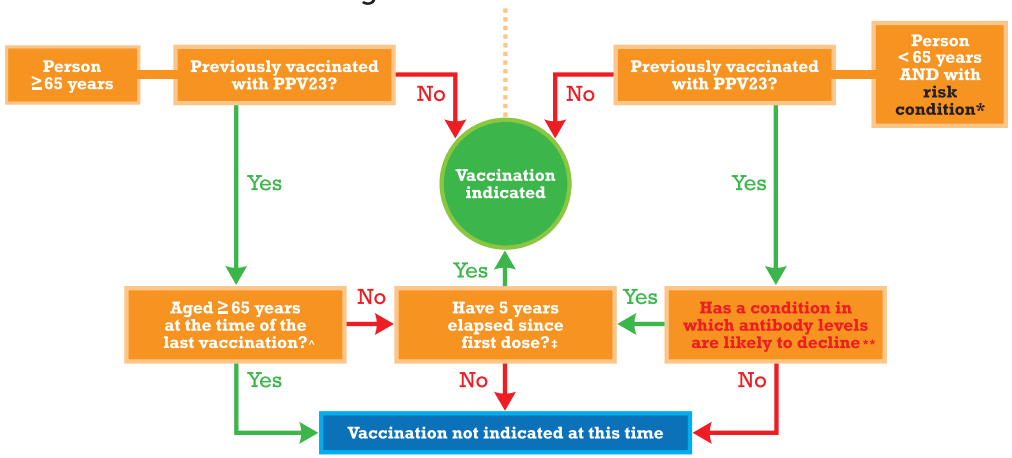
Pneumococcal disease is a very serious disease

Those with the following conditions should be vaccinated with PPV23[1]

Everybody aged 65 years and over Also those aged over 2 years with;

- Diabetes mellitus
- Chronic heart, respiratory or liver disease
- Chronic renal disease, nephrotic syndrome,renal transplant
- Sickle cell disease
- Those with missing or non functioning spleens
- Disorders of the immune system including cancer
- People receiving chemotherapy or other treatments that suppress the immune system
- Persons with HIV infection or AIDS
- Those who have received or are about to receive cochlear transplants

Pneumococcal Polysaccharide Vaccine (PPV23) Algorithm for Vaccination



* Asplenia or splenic dysfunction (splenectomy, sickle cell disease, coeliac syndrome); chronic renal, heart, lung, liver disease, diabetes mellitus, complement deficiency, immunosuppressive conditions; CSF leak, cochlear implant recipients or candidates for implants; children < 5 years with history of invasive disease.

^ Revaccination not indicated for any person who has received a dose of PPV23 at age ≥65 years.

‡ If vaccination has been given during chemotherapy or radiotherapy revaccination 3 months after treatment is indicated.

** Those with no spleen, with splenic dysfunction, immunosuppression including HIV infection, nephrotic syndrome, renal transplant or chronic renal disease.

Algorithm provided by National Immunisation Office[1]

Brought to you by PNEUMOVAX®23 Now in pre filled syringe presentation

(pneumococcal vaccine, polyvalent, MSD)

Supported by MSD

PNEUMOVAX® 23 solution for injection in pre-filled syringe. Pneumococcal Polysaccharide Vaccine.
ABRIDGED PRODUCT INFORMATION Refer to Summary of Product Characteristics before prescribing. **PRESENTATION** PNEUMOVAX 23 is supplied as a single Pre-filled syringe (0.5 mL) with 2 needles. Each dose contains 25 micrograms of each of 23 different polysaccharides of Streptococcus pneumoniae. **INDICATIONS** For active immunisation against pneumococcal disease in children aged from 2 years, adolescents and adults. Refer to SPC section 5.1 for information on protection against specific pneumococcal serotypes. **DOSAGE AND ADMINISTRATION** *The immunisation schedules for PNEUMOVAX 23 should be based on official recommendations. Primary vaccination:* Adults and children 2 years of age or older - one single dose of 0.5 millilitre by intramuscular or subcutaneous injection. Not recommended for use in children below 2 years of age. *Special dosing:* It is recommended that pneumococcal vaccine is given at least two weeks before elective splenectomy or the initiation of chemotherapy or other immunosuppressive treatment. Vaccination during chemotherapy or radiation therapy should be avoided and the vaccine should not be administered any sooner than three months after completion of such therapy. Persons with asymptomatic or symptomatic HIV infection should be vaccinated as soon as possible after diagnosis is confirmed. *Revaccination:* Healthy adults and children should not be revaccinated routinely. Revaccination at intervals of less than three years is not recommended because of an increased risk of adverse reactions. Revaccination may be considered for adults at increased risk of serious pneumococcal infection who were given pneumococcal vaccine more than five years earlier or for those known to have rapid decline in pneumococcal antibody levels. Revaccination after 3 years may be considered for selected populations (e.g. asplenics) who are known to be at high risk of fatal pneumococcal infections and for children from 2 to 10 years old at high risk of pneumococcal infection. **CONTRAINDICATIONS** Hypersensitivity to the active substance(s) or to any of the excipients. **PRECAUTIONS AND WARNINGS** As with any vaccine, adequate treatment provisions including epinephrine (adrenaline) should be available for immediate use should an acute anaphylactic reaction occur. Vaccination should be delayed in the presence of significant febrile illness, other active infection or when a systemic reaction would pose a significant risk, except where delay involves greater risk. The vaccine should never be injected intravascularly; precautions should be taken to make sure the needle does not enter a blood vessel. The vaccine should not be injected intradermally as injection by that route is associated with increased local reactions. If the vaccine is administered to patients who are immunosuppressed due to either an underlying condition or medical treatment (e.g. immunosuppressive therapy), the expected serum antibody response may not be obtained after a first or second dose, so such patients may not be as well protected against pneumococcal disease as immunocompetent individuals. Required prophylactic pneumococcal antibiotic therapy should not be stopped after vaccination. Patients at especially increased risk of serious pneumococcal infection (e.g., asplenics and those who have received immunosuppressive therapy), should be advised regarding the possible need for early antimicrobial treatment in the event of severe, sudden febrile illness. The vaccine may not be effective in preventing infection resulting from basilar skull fracture or from external communication with cerebrospinal fluid. As with any vaccine, vaccination with PNEUMOVAX 23 may not result in complete protection in all recipients. **INTERACTIONS** Pneumococcal vaccine can be administered simultaneously with influenza vaccine as long as different needles and injection sites are used. The concomitant use of PNEUMOVAX 23 and ZOSTAVAX resulted in reduced immunogenicity of ZOSTAVAX in a small clinical trial. However, data collected in a large observational study did not indicate increased risk for developing herpes zoster after concomitant administration of the two vaccines. **PREGNANCY AND LACTATION** The vaccine should not be used during pregnancy unless clearly necessary (the potential benefit must justify any potential risk to the fetus). It is unknown whether this vaccine is excreted in human milk. Caution should be exercised when it is administered to a nursing mother. The vaccine has not been evaluated in fertility studies. **SIDE EFFECTS** *Very common side effects:* Fever and injection site reactions such as pain, soreness, erythema, warmth, swelling and induration. Other reported side effects that may potentially be serious include thrombocytopenia in patients with stabilised idiopathic thrombocytopenic purpura, haemolytic anaemia in patients who have had other haematologic disorders, leukocytosis, anaphylactoid reactions, serum sickness, angioneurotic oedema, Guillain-Barré Syndrome, radiculoneuropathy, febrile convulsions and injection site cellulitis. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **PACKAGE QUANTITIES** Single pack containing one 0.5 mL dose pre-filled syringe with two separate needles. **Legal category:** POM. **Marketing authorisation number:** PA 1286/055/002. **Marketing Authorisation holder:** Merck Sharp & Dohme Ireland (Human Health) Limited, Red Oak North, South County Business Park, Leopardstown, Dublin 18, Ireland. **Date of revision:** November 2019. Further information is available on request from: MSD, Red Oak North, South County Business Park, Leopardstown, Dublin 18 D18 X5K7 or from www.medicines.ie. **Date of preparation:** July 2020. WS064

Adverse events should be reported. Reporting forms and information can be found at www.hpra.ie
Adverse events should also be reported to MSD (Tel: 01-299 8700)

Reference
1. http://www.hse.ie/eng/health/immunisation/pubinfo/adult/pneumo/

MSD Red Oak North, South County Business Park, Leopardstown, Dublin 18, D18X5K7 Ireland

IE-PNX-00025

INMO director of industrial relations Tony Fitzpatrick updates members

Improved PPE guidelines issued to include standard use of FFP2 masks

THE INMO and health sector unions meet with the HSE on a weekly basis on matters relating to Covid-19, including PPE, infection prevention and control guidelines, health and safety, special leave with pay and other relevant matters.

The INMO has been advocating for the use of FFP2 masks as the basic standard in all clinical areas and has been seeking this protection as a minimum for nurses and midwives.

At the union/HSE meeting on December 21, 2021, the HSE stated it was opposed to issuing any revised guidelines and in subsequent correspondence the HSE stated its position that there was no requirement to change the current guidelines and increase the standard use of mask to FFP2 at this time.

The HSE outlined that it was satisfied both with the guidelines as they stood and the availability of FFP2 masks. In addition, it said that there was no evidence to support the introduction of air filtration units into clinical and staff spaces in healthcare settings.

The INMO placed on record its grave concerns with this position adopted by the HSE. Ultimately, the union wanted to ensure maximum protection in place for nurses and midwives, based on available evidence, as they faced into the fifth Covid-19 wave with the more transmissible omicron variant.

The INMO told the HSE: "The evidence to date from across the world is that omicron is more transmissible. This is accepted by the CMO and the HSE and therefore it is required of the HSE that they improve their guidelines to protect healthcare workers and their patients. We seek that you introduce FFP2 masks as standard for all clinical interactions with patients. Furthermore, we seek that the HSE introduces air filtration to every healthcare setting where there could be infected air and where there is not inbuilt, nor is there adequate ventilation/air flow and filtration. This is happening in education, why is it not happening in health, particularly where there are confirmed cases? We note that the HSE outlined its intention to install air filtration units in one hospital, University Hospital Limerick as part of a pilot to assess their benefits. In our view the introduction of air filtration units later in 2022 is not acceptable. Measures need to be taken now, particularly in settings where it is already identified that they suffer from poor ventilation.

"We believe it is incumbent on the HSE to ensure that maximum protection is in place for our members. This requires you to advise staff to wear FFP2 masks as standard and introduce air filtration in all health care settings."

The HSE finally relented and issued guidelines that all healthcare workers directly engaged with patients should be using FFP2 masks as standard. This memorandum was issued to the health service on December 24, 2021 and was contained in updated PPE guidance dated December 29, 2021.

This was a significant achievement for the INMO which consistently made logical arguments of why the precautionary principle should be applied and that nurses and midwives should be afforded the maximum protection possible. The union also said that the revision of the guidelines could only assist in reducing the number of staff that would be absent considering the higher transmissibility of omicron. Based on international evidence, the INMO continues to pursue the need for FFP2 as a basic standard.

Further meetings were due to take place with the HSE on January 18 and 25 where air filtration would be discussed.

PHN training reckonability to go to Labour Court

A BRIEF update on the reckonability of the PHN training year pre-2000 for superannuation purposes was issued to members concerned in late December.

Previous to this, the HSE had advised that it had made a business case to the Department of Health on this matter and that the Department had rejected the proposal.

The INMO sought a reconvening at the Workplace Relations Commission, and a conciliation conference was arranged for November 19, 2021. At conciliation, the HSE outlined that it was not possible to concede to the INMO claim on the reckonability for pension purposes of the PHN training year pre-2000. The HSE said the claim had no merit and also advised that the Department of Health was concerned that conceding the claim would have cross-sectoral implications.

The INMO rejected the HSE position and outlined that a similar claim had been conceded at the WRC involving the Department of Justice. Therefore, it was unreasonable to suggest cross-sectoral implications when it has already been conceded in another sector.

The INMO sought, in line with normal procedure, that the matter would be referred on by the conciliation officer to the Labour Court under section 26(1) of the Industrial Relations Act. The HSE outlined that it needed to consult with the Department of Health and wrote that it was not agreeable to a Labour Court referral and that the matter would be dealt with under sectoral bargaining.

The INMO fundamentally disagrees with this position. When disputes of this nature arise, they can be referred to the dispute resolution procedure established under Building Momentum. This matter was to be discussed in this group last month, however on the eve of the meeting the HSE told the INMO and the WRC that it agreed to attend the Labour Court. The conciliation officer of the WRC is now referring the matter to the Labour Court for arbitration.

on recent national issues under discussion

INMO pursues delays in pension issues

THE INMO and health sector unions now meet with the HSE on a six-weekly basis to address pension matters.

Any member who is experiencing pension issues, particularly delays in receiving lump sum and pension payments, are asked to contact the INMO for assistance.

The union has been given a commitment that matters raised with the head of pensions via the INMO director of industrial relations will be resolved quickly.

The INMO has represented several members who experienced delays receiving pension payments, and the matters were resolved quickly. No member should have to wait longer than a normal pay cycle to receive payment.

Timelines for payment of pensions outside of the east coast area are close to the legal norm for private schemes, ie. within two months. However, the timeline in the eastern region is reducing because overtime has been approved and progress is being made on the filling of vacancies.

In addition, there is a training deficit, and an ongoing training programme is in place to address this. Weekly meetings are now conducted in the east to monitor progress. In addition, the INMO has clarified that nurses and midwives are entitled to seek and receive a pension estimate. This request is often made by an employee as part of pension planning.

In response to questions about delays in passing on national wage increases to pensions, the HSE said that the complexity in the restoration of pensions under FEMPI had involved significant additional work and was very difficult for superannuation departments. However, general pay-rounds are more straight forward and will be applied immediately after they are applied to salary.

In response to the issue of delays in applying pay restoration, the HSE referred to the 20% increase in location and specialist qualification allowances. Under questioning the HSE confirmed that those who had retired prior to March 2019 and who prior to their retirement had such allowances have not had their pensions adjusted to reflect the increase. The HSE said this will take a long time to calculate and work has commenced on it. While the adjustment will be small in the actual pension, it will accumulate over time and INMO members will be owed back-money.

This matter will be discussed in greater detail at the next union/HSE pensions meeting and the INMO will keep members updated.

Serious concerns about safety as UHL overcrowding reaches all-time high

INMO members are repeatedly reporting their concerns about the safety of patients due to excessive overcrowding in University Hospital Limerick and the absence of any improvement since the opening of 100 plus beds this time last year.

The situation hit an all-time high on January 25 when there were 97 patients on trolleys in the hospital and again the following day with a staggering 111 patients on trolleys – the highest numbers ever recorded in any Irish hospital since the INMO began compiling trolley figures in 2006.

The union continuously documents its concerns about safety for patients and staff alike with management, yet the situation in the hospital remains.

The INMO has once again called on the Health Information and Quality Authority (HIQA) to investigate the overcrowding issue at the hospital, repeating a call it has made on several occasions in the past 18 months. To date HIQA has declined to investigate the serious problems at the hospital.

INMO members working in UHL believe that there are measures that can be taken to improve patient flow. The union strongly advises all members working in the hospital to ensure that any potential risks to patients are documented and formally reported to line managers and to contact their local INMO rep or the Limerick office with any concerns.

Mary Fogarty, INMO assistant director of industrial relations said: "The latest trolley numbers in University Hospital Limerick are extremely concerning. Time and time again, UHL is the most overcrowded hospital in Ireland.

"Despite major investment in capacity at the hospital, it is making no dent in the consistent overcrowding problem. Overcrowding adds stress for staff and worsens patient care. It is high-risk in normal times, but even more so during a pandemic. The INMO is once again calling on HIQA to urgently investigate the overcrowding issue in the hospital and make recommendations.

Mary Fogarty, INMO assistant director of IR: *"The staff, patients and wider community in Limerick need to be assured that the longstanding issues at UHL will be resolved"*

"The patients and nurses at UHL deserve better than these conditions. It has been an extremely difficult 22 months since Covid-19 first arrived on our shores but UHL was already overstretched without being dealt with the hand of a pandemic. The staff, patients and wider community in Limerick need to be assured that the longstanding issues at UHL will be resolved."

Absence of consultation on UHL overflow unit

Meanwhile, the INMO has referred to the WRC claim related to the opening of a 10-bed overflow unit late last year without union consultation and agreement at University Hospital Limerick.

This unit is staffed by agency nurses and the redeployment of nurses from other locations which the union has said is unacceptable.

The claim was raised with management at a local forum chaired by the WRC Advisory Service and requests from the INMO for local engagement on the claim were rejected. At time of going to press UHL had not responded to the WRC invitation to attend at a hearing.

Contact details

Members with any queries or concerns about safety or other issues should not hesitate to contact their local INMO rep or the INMO Limerick Office, email: inmolimerick@inmo.ie, Tel: 061 308 999.

Plan needed to tackle Letterkenny safety concerns

RESPONDING to persistent levels of overcrowding at Letterkenny University Hospital, the INMO has called for a bespoke plan to tackle issues of overcrowding and staff safety in the hospital.

INMO IRO Neal Donohue said: "Letterkenny University Hospital is currently experiencing very high levels of patient attendance leading to overcrowded and unsafe conditions in the hospital. This is a hospital-wide problem where the emergency department and wards that are in escalation are overcrowded, providing the ideal environment for Covid-19 to thrive."

Expressing concerns about the ventilation and air filtration in this hospital, which management had not responded to after several months, Mr Donohue said: "Given the excessive overcrowding we are deeply concerned that not enough was being done to mitigate the risks of Covid-19 transmission in the hospital.

"Where extra beds and trolleys are placed on wards, extra staff are not provided to care for those patients. Staff report fears that care being compromised as a result. Letterkenny has consistently been in the top three most overcrowded hospitals almost daily since October. This is a very serious issue of public safety and staff safety. The HSE has an obligation to provide a safe place of work and they are failing in that duty of care. Nurses report on a daily basis that they fear patients are at increased risk due to the HSE's failure to resolve health and safety concerns in the hospital.

"Due to the high levels of patient attendance one nurse in the ED is expected to care for over 20 patients at a time. There is no doubt with such poor staffing ratios patient care will be compromised. Due to the excessive workloads staff often miss breaks and are being asked to defer annual leave. This is resulting in stress and burnout of staff and is adding to the problem with retaining nursing staff.

"The INMO escalated issues of concern to the Saolta Hospital Group. Urgent action must be taken to improve the working conditions in the hospital, to retain staff, and to resolve the overcrowding problem."

Issues with implementation of NiSRP in Southeast referred to WRC

THE INMO has referred the matter of the implementation of NiSRP to the Workplace Relations Commission as a result of serious issues being encountered by INMO members in respect of its implementation, and in particular, the increased workload that has come about as a result.

The National integrated Staff Records & Pay Programme (NiSRP) implements national staff records and payroll systems across the HSE. Its stated aim is to improve access for staff to their own records and pay details, and enhance available workforce information for managers. It is managed by way of an online employee and manager self-service function.

The system has been implemented in some areas of the HSE, with more to follow. However, significant concerns have been raised by the INMO in respect of a number of matters in CHO 5 (South Tipperary, Carlow/Kilkenny, Waterford and Wexford), including access to payslips, difficulties with access to information on annual leave and mileage entitlements. In addition, the oversight and operation of this system has generated a considerable additional workload for members of the nursing management team, is unsustainable, and requires urgent review by all appropriate stakeholders to address the issues arising.

David Miskell, INMO professional and regulatory services officer, said. "This system was introduced at a time when senior nurse managers are endeavouring to ensure the provision of a safe public health nursing service in the midst of the Covid-19 pandemic. It is entirely unreasonable to expect that senior nurse manager's precious time is to be directed towards what are largely clerical and administrative tasks, to the detriment of leading and managing a safe and effective public health nursing service, which has to be the priority. Similarly, staff should not encounter difficulties in accessing information on entitlements or navigating a system that is supposed to improve these issues.

"Ultimately, the decision to introduce any new system must be underpinned by sufficient resources and support, which has been lacking to date in the Southeast. It is regrettable that it is necessary to seek the intervention of the Workplace Relations Commission in such a matter, however, the current situation is wholly unsustainable, and cannot continue."

The INMO will continue to pursue this matter on behalf of its members, with a view to seeking a satisfactory resolution.

Supports secured for staff in four acute hospitals

FOLLOWING several conciliation conferences at the Workplace Relations Commission in the run up to Christmas, the INMO secured a number of measures to support members across four acute sites in the HSE South region – Cork University Hospital, Cork University Maternity Hospital, Mercy University Hospital, and University Hospital Kerry.

The measures concern a number of issues, ranging from recruitment to key frontline posts, staffing supports, meal break supports and overtime measures.

Commenting on the agreement, INMO IRO for the area Liam Conway said: "These measures are to support our members in the most challenging of times whereby staffing has been significantly impacted by the combination of Covid-19 and hospital overcrowding.

"The process will also provide a basis for further engagement and progress for the first quarter of 2022 across the four sites."

Safety concerns addressed at new modular unit in Sligo ED

AS A result of extensive negotiations at Sligo University Hospital, the INMO secured an agreement to ensure safe staffing and safe systems of work for the new modular unit in the emergency department.

Initially management planned to proceed in moving staff to the new unit last summer, without proper consultation with staff. The INMO intervened and sought a consultation process to resolve matters arising for our members in the context of the planned move.

Following local engagement, the union secured larger changing facilities with lockers for members, however, the move to the new unit was postponed due to health and safety concerns and practice concerns where staffing levels and skill mix were not agreed.

Following negotiations at the Workplace Relations Commission, it was agreed that a staffing assessment would be undertaken by Fiona McDaid from the Emergency Department Taskforce to evidence the required staffing levels and skill mix for the reconfigured ED.

This will see Sligo ED have an increase in staffing which will ultimately improve working conditions for members. A local forum was also agreed to facilitate communication for INMO members impacted by the move so that any matters arising can be resolved swiftly.

– Neal Donohue, INMO IRO

On-call in CUH

AFTER extensive engagement with management in 2021, the INMO has ensured that Cork University Hospital is now in line with the Organisation of Working Time Act and the national WRC agreements on theatre on call. Thanks to local INMO reps in theatre, interventional radiology and the Cath lab at CUH, members working in these areas can now be assured of 11 hours compensatory rest to ensure safe practice after being on call.

– Liam Conway, INMO IRO

INMO Professional

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21 February	**The nurses' role in person centred care planning**
28 February	**Restricted practices considerations**
07 March	**Developing behaviour management strategies**
14 March	**Introduction to positive behaviour support**
21 March	**Post-incident reviews (operational and peer debriefing)**
28 March	**Promoting informed consent and positive risk in nursing persons with an intellectual disability**
04 April	**Infection prevention and control in the disability services**

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Extended location allowance secured in Bon Secours

THE INMO has secured an extension of the location allowance in Bon Secours, Dublin and Cork, following an impasse in a claim lodged on this matter last year.

As there was no progress on this matter it was referred to the Workplace Relations Commission. Following a proposal made by the INMO to break the impasse, management has agreed to use its discretion to assess whether the extension of the location allowance now in medical and surgical settings is appropriate on a site-by-site basis, and where the complexity of a case carried out is recognised by nursing management.

In addition the location allowance will apply:

- Where nursing staff in day wards are required by nursing management to rotate to other inpatient areas
- In medical day services, which could include pre-assessment, pre-admission, complex medical day services, outpatient day delivery and intravenous infusion units.

Under this proposal management can decide to extend the location allowance in those sites which meet the above criteria from January 1, 2022.

Building Momentum

The Bon Secours Hospital Group has sought negotiations with trade unions representing staff across the group in relation to the action plan in line with the terms of Building Momentum.

There was an initial meeting with management prior to Christmas and further engagements between the parties are expected to take place in early 2022. Local INMO officials will be contacting members in each area with updates on negotiations.

– Albert Murphy, INMO assistant director of IR

Agreement reached with Sunbeam House on Covid pay and leave

FOLLOWING a drawn-out process at the Workplace Relations Commission, agreement has been reached with Sunbeam House Services on the application of the terms of HSE HR circulars on Covid-19 related matters to staff.

The INMO was steadfast in its pursuit of this claim and, along with other unions, attended seven conciliation conferences, prior to agreement being reached.

Under this agreement, staff who used sick leave and annual leave during periods to isolate due to being Covid positive or a close contact will have such leave reinstated, backdated to March 2020.

Staff who went off the payroll will have pay for such periods reinstated, less social welfare deductions. This agreement encompasses staff who had to cocoon and used up their annual leave, sick leave and/or went off pay for a period.

In addition to the above, management has confirmed that it will apply the terms of all HSE HR circulars on Covid-19 going forward so staff will not have to use up their annual leave, sick leave or go off pay again due to Covid.

Management has advised that it will commence the process of calculating what is owed back to staff immediately and these payments will be made and/or leave reinstated in January/February 2022.

– Lorraine Monaghan, INMO assistant director of IR

Milford enhanced practice claim

THE INMO has made a referral to the conciliation services of the Workplace Relations Commission on behalf of members in Section 39 facility Milford Care Centre, Castletroy.

The INMO had been engaged with management on the implementation of the enhanced nurse practice contract which management was disposed to if funding was secured from the HSE.

This funding was not secured, and management put the matter to their Board with costings to implement the contract.

The Board had advised that they cannot fund the additional costs, but have now requested from the WRC an extension to engage locally with INMO and HSE before attending for Conciliation. A deadline for early March for update has been notified to management.

– Karen Liston, INMO IRE

Mid West Older Person Services

A PROCESS has begun to segregate the roles of multi task attendants (MTAs) and healthcare assistants (HCAs) in older persons services in the Mid West. This involves nine sites, only one of which has put the segregation in place on rosters. A second site, St Camillus Hospital, has a pilot roster ready to trial on one ward. The INMO has been invited to engage with management on this trial roster, and members met to discuss this last month ahead of engagement. It is hoped that segregation will be in place in all sites by year end with agreement on nurse staffing levels.

Enhanced contracts

A SMALL number of enhanced practice contracts issued by HR in CHO3 have not been returned from older persons or community nursing services. Members who may be withholding their contracts are urged to contact inmolimerick@inmo.ie or Tel: 061 308999 to discuss any concerns.

– Karen Liston, INMO IRE

For ongoing updates on all IR issues, see **www.inmo.ie**

Edward Mathews rounds up news from the ICN and ICM

ICN calls for investment in nursing

THE International Council of Nurses (ICN), within which the INMO is the national nursing association for Ireland, has announced the new theme for International Nurses Day 2022: *Nurses: A Voice to Lead – Invest in nursing and respect rights to secure global health,* focusing on the need to protect, support and invest in the nursing profession to strengthen health systems around the world.

Each year, the ICN leads the celebrations on International Nurses Day (IND), held on May 12, the anniversary of Florence Nightingale's birth.

The ICN has also launched a compilation of case studies submitted by nurses across the world to showcase the incredible range of innovative work nurses do every day. These stories, which were highlighted on the ICN website throughout the year, reflect the work of nurses caring for those with Covid-19 throughout the pandemic, as well as the wide variety of nursing that continued throughout the pandemic to care for those suffering from other conditions. From birth to death, non-communicable diseases to infection disease, mental health to chronic conditions, in hospitals, communities and homes, nurses provide accessible, affordable, person-centred, holistic care for all.

Covid-19 has exposed weaknesses caused by underinvestment in health systems around the world. The theme for IND 2022 demonstrates the need to invest in nursing, to build a resilient, highly qualified nursing workforce and to protect nurses' rights in order to transform health systems to meet the needs of individuals and communities now and into the future.

Action in Switzerland

The ICN also recently backed Switzerland's nurses in their recent attempt to address nursing shortages and improve safety and quality of care through a popular vote and calling on more countries to give their people a say on the value and future of nursing. Using a relatively unique feature of the direct democracy system in Switzerland, the Swiss nursing association collected enough signatures for a nationwide vote on the issue. Parliament and the government recommended rejection of the initiative but agreed a counterproposal. Turnout was high with 65.3% of eligible voters casting their vote on the nursing initiative. The vote on changing working conditions for nurses achieved a majority of 61%.

ICN chief executive Howard Catton later spoke about why this vote was unique: "In Switzerland, nurses had heard the applause around the world but they wanted to see real action. And through this vote, which was an overwhelming democratic mandate, the people have spoken."

Again, while the context is relatively unique in terms of Switzerland's democratic process, this means that in four years' time, nursing will appear in the Swiss Constitution, but before then nurses will be working with politicians to bring forward more specific laws in terms of making sure enough nurses are educated, that staffing levels are safe, and that there are good working conditions. What is perhaps most notable about this process is the recognition by public vote of the centrality of investment in nursing in terms of the strength and resilience of health services.

ICM celebrates 100 years of progress in midwifery

THE International Confederation of Midwives (ICM) celebrates its centenary this year. The INMO is the national midwifery association for Ireland within the ICM.

The forerunner of the ICM, the International Midwives Union (IMU) was created in Belgium 100 years ago. Since then, the ICM has transformed into what it is today – a global non-governmental organisation representing more than 140 midwives' associations in more than 120 countries. Together, these associations represent over one million midwives worldwide.

The ICM is proud to stand for midwives and their associations as they stand for the rights, dignity, and health of women and newborns everywhere.

The ICM has reflected on this milestone as an opportunity to acknowledge where it has come from as an organisation, while simultaneously exploring the next 100 years of ICM and what it would mean for global health if midwives received the enabling environment they deserve.

The ICM is committed to fostering and promoting inclusivity and diversity as core organisational values, and in that context the ICM will conduct a 'Listening and Learning' series throughout 2022, creating space to explore and learn in an effort to safeguard the trust women and families have in the profession.

A key component of this work will be hosting open conversations between the midwife community and experts and individuals with lived experience on a range of topics related to equity and inclusion. The goal of these conversations will be to learn from different perspectives and ensure all midwives and the people they care for feel heard and represented.

2022 will be a time for considerable celebration for the ICM, for midwives internationally and for the INMO as an ICM member. The chosen theme for this year's International Day of the Midwife (IDM) on May 5, 2022 is *'100 Years of Progress'.* The ICM looks forward to coming together as a global midwife community to advocate for investment in quality midwifery care around the world, improving sexual, reproductive, maternal, newborn, child and adolescent health in the process.

INMO joins call for United Nations action on Covid vaccine patents

AS 2021 neared its end unions from 28 countries worldwide representing over 2.5 million healthcare workers, including the INMO, filed a formal appeal with the United Nations (UN) over the refusal of the UK, EU, Norway, Switzerland and Singapore to temporarily waive patents for Covid-19 vaccines.

Internationally, more than 115,000 healthcare workers have died from exposure to Covid-19. While roughly 40% of healthcare workers (HCWs) worldwide have been fully vaccinated, in Africa and the western Pacific region less than one in 10 HCWs have been able to avail of a Covid-19 vaccine.

The letter sent to UN special rapporteur on physical and mental health Tlaleng Mofokeng, states that staff represented by the participating unions have witnessed "staggering numbers of deaths and the immense suffering caused by political inaction".

It goes on to say that the refusal of some countries to waive their intellectual property rights to vaccines, while wealthy countries have secured over seven billion vaccines with poorer countries only obtaining around 300 million, amounts to vaccine apartheid. It refers to this inequity as "grossly unjust" and a prominent factor in the rampant transmission of Covid-19 in developing nations, which increases the risk of new variants emerging.

Dr Mofokeng responded saying that the role that healthcare workers have played during the pandemic "provides them with moral authority" over the issue and that she shares their desire to see wealthy nations waive their patents to allow poorer countries greater access to vaccines.

The appeal was coordinated by the healthcare umbrella organisation Global Nurses United (GNU), and Progressive International, a collection of left wing parties, movements and unions.

Unions representing nurses and healthcare staff in the US, Ireland, Australia, Brazil, Canada, Costa Rica, Curacao, the Dominican Republic, Greece, Guatemala, Honduras, Israel, Italy, Kenya, Malawi, New Zealand, Paraguay, the Philippines, Portugal, South Africa, India, Rwanda, South Korea, Spain, Sri Lanka, Taiwan, Uganda and Uruguay all signed the appeal, and stated that refusal to waive patents by the countries mentioned above amounts to an "immediate threat to people's right to health".

Separately South Africa and India have been pressing the World Trade Organization (WTO) to help improve access to vaccines by waiving the multinational Trade-Related Aspects of Intellectual Property Rights (Trips) agreement. This move has been backed by US president Joe Biden.

The INMO has stated that it is imperative that governments must prioritise global health over the profits of multinational companies and is proud to be part of this GNU-led initiative.

– Freda Hughes

Nursing workforce crisis needs a global response

A NEW report has revealed how the Covid-19 pandemic has made the fragile state of the global nursing workforce much worse, putting the World Health Organization's aim of universal health coverage at serious risk. The report suggests that up to 13 million more nurses will be required over the next decade, the equivalent of almost half of the world's current 28 million-strong workforce.

The report, published by the International Centre for Nurse Migration (ICNM) in partnership with the International Council of Nurses (ICN), provides a blueprint for what needs to be done at the national and international level to guide nursing workforce planning globally. It says countries should:

- Commit to prioritising nurses for vaccinations
- Provide safe staffing levels
- Expand their domestic nurse education systems
- Increase the attractiveness of nursing careers
- Adhere to ethical international recruitment standards
- Monitor countries' ability to be self-sufficient to meet their nursing workforce requirements.

ICN chief executive officer Howard Catton, who co-authored the report, said the findings underline the severity of the shortages: "We knew the situation was fragile because of the persistent historical underfunding of nursing around the world, but with the latest information about nurse vacancies, their rates of intention to leave, and staff sickness rates, it must now be recognised as a global crisis.

"We already had a shortage of six million nurses at the start of the pandemic, but with the immense and relentless pressure of responding to Covid and an avalanche of resignations and retirements anticipated, the world will need to recruit and retain up to 13 million nurses over the next decade.

"This is a global health crisis, and it requires a fully funded and actionable 10-year plan to support and strengthen nurses and the health and care workforce to deliver health for all."

Lead author of the report, Prof James Buchan of the University of Technology Sydney and the University of Edinburgh, said: "Covid-19 has had a terrible impact on the nursing workforce in terms of the personal effect it has had on individual nurses, and the problems it has exposed within many healthcare systems. Pre-existing shortages exacerbated the impact of the pandemic and burned-out nurses are leaving because they cannot carry on any longer. Governments have not reacted effectively to the growing worldwide shortage of nurses, and now they must respond to the pandemic, which requires immediate action."

The report says a long-term plan is needed to stem the tide of those leaving nursing because of the additional stresses resulting from Covid-19, and to grow the profession to meet increased future demands of an ageing global population.

Reference
Buchan J, Catton H, Shaffer FA. Sustain and Retain in 2022 and Beyond: the global nursing workforce and the Covid-19 pandemic. International Centre on Nurse Migration, Jan 2022

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Preceptor of the Year 2022

www.inmo.ie

Nominations for the annual 'Preceptor of the Year' Award, sponsored by Cornmarket Group Financial Services, are now open.

Nominations for the 'Preceptor of the Year' must be made on the official nomination form, which can be completed on the INMO website.

The award recognises an INMO member who has inspired and motivated the student to reach their full potential.

The member chosen as 'Preceptor of the Year', together with a partner or colleague, will be invited to receive their award at the annual awards dinner, which will be held during the annual delegate conference in Sligo this year. The student member who nominated the chosen preceptor, along with a colleague, will also be invited to attend.

The deadline for nominations is the 30 March 2022.

For more information visit www.inmo.ie/Preceptor_of_the_Year

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A seat at the table

With so many nurses and midwives working at the INMO, members can be sure of informed and nuanced representation, says the incoming student and new graduate officer. Interview by **Freda Hughes**

ROISIN O'Connell started the new year as the INMO's newly appointed student and new graduate officer. She has already hit the ground running and is anxious to connect with the students and new graduates she represents.

Ms O'Connell qualified as a nurse in 2019, working for six months on a surgical ward in Waterford before Covid-19 hit. She wanted to be closer to home and applied for a job in the emergency department in University Hospital Limerick (UHL), where faced with the realities of overcrowding she threw herself wholeheartedly into the job.

By her own admission, Ms O'Connell became involved with INMO by accident. Initially she wasn't aware of how the union could benefit students but with the 2019 strike looming, she and her colleagues were unsure of whether they should join the picket or attend their placements. They feared they could be penalised if they did not attend placements but they also wanted to support their colleagues and fight for better pay and conditions.

"I was the class rep and I decided to find out what we should do on behalf of my peers. My experience of engaging with the INMO was really positive and I decided I wanted to become part of this great support network. Soon I became the student rep on the Waterford Branch's strike committee and joined the INMO's Youth Forums," she told *WIN*.

Ms O'Connell's role on the strike committee involved drafting the rosters for interns in Waterford, Wexford, Kilkenny and Clonmel. Students were obliged to turn up for placement but it was understood that they would attend the picket rather than work. It was important for them to keep track of their attendance and she put systems in place to help with this. On the picket Ms O'Connell met INMO activists and was inspired by what could be achieved by working together.

She was also approached by RTÉ and gave her first interview when she was still a student nurse. Her colleagues were impressed by her capable, confident approach to activism. In turn she was impressed by the solidarity within the union and this inspired her to increase her engagement. She was asked to speak at the launch of the Nursing Now initiative at the last annual delegate conference (ADC) held in person in 2019. She said meeting the other student reps from around Ireland at that time was inspiring.

The INMO's newly appointed student and new graduate officer Roisin O'Connell (pictured left) had initially tried to avoid nursing. Growing up watching the long hours and hard work that her mother put in as an ICU nurse in UHL she thought it wasn't the career for her. In her teens however she knew she wanted a career that would allow her to travel and to work anywhere in the world and she embarked on a PLC course that allowed her to work on placement in UHL and get a feel for nursing. The following year she was offered a place on the nursing degree programme in Waterford Institute of Technology and the rest is history

(Photo by Louise Brooks Photography)

"I felt I was among my peers. We were all so enthusiastic about our professions and wanted to make changes for the benefit of our colleagues. Next thing I knew, I was asked to speak at the ADC… and honestly a month before that I wouldn't have even known what ADC was. The whole experience was really empowering. So many of us on the wards are burned out so meeting passionate activists really lifted me and gave me the strength I needed," Ms O'Connell explained.

Money is always a big issue for students. College is not cheap and accommodation is out of reach for many. Although she was qualified by the time the pandemic hit Ms O'Connell was incensed when it was revealed that students and interns who worked throughout were not getting paid.

"The narrative around the strike was that we needed to keep our student and newly qualified nurses and midwives but just over a year later they have to fight hard all over again just to get paid for the work they did in the unprecedented danger of a global pandemic."

Ms O'Connell hopes to provide the same support to members that she received from the student officers who helped her become active with the INMO.

"I want to advocate for last year's interns who have not yet received recognition for their efforts during the pandemic. The number one reason nurses and midwives should join the INMO is because of the protection it offers. In our professions we are often dealing with life and death situations. Place this in the context of constant overcrowding and understaffing and you can see that we work in dangerous environments. When you add a global pandemic into the mix it is clear that we need the support of a union that will constantly be there to back us up and provide the information we need to ensure we are working in safe and fair workplaces.

"I also want people to know that if they come to me for advice and don't want to pursue their issue further that's okay too. There is no pressure to pursue every grievance and there are so many positives to be gained from joining a union. The peer support and networks are unrivalled.

"With so many nurses and midwives working within the INMO we can be sure of informed and nuanced input on our behalf in negotiations. We deserve a seat at the policy table and policy will be better informed and fit for purpose when we are given that seat," Ms O'Connell added.

Marking four decades of occupational health

Forty years after Ireland's first occupational health department was set up, **Brigid Quaid** looks back and charts the specialty's evolution

LOCATED in Cork Regional Hospital, now known as Cork University Hospital, the first occupational health department (OHD) in the Irish health service was set up four decades ago on September 21, 1981 by the Southern Health Board.

As the first occupational health nurse (OHN) assigned to this department, in this article I will give a snapshot of the establishment and management of the OHD in its early years. Working closely beside me, on a part-time sessional basis, was the late Dr Emily Twomey, occupational health physician (OHP), with whom I was privileged to have the opportunity to work in developing the occupational health service.

The concept of a cohesive OHD originated within the infection control committee that was first established at St Finbarr's Hospital, Cork prior to the 1979 move to Cork Regional Hospital. The fragmented nature of screening and protection of staff, especially with regard to infectious diseases such as TB, risked the development of medico-legal issues. Furthermore, it was identified by the infection control committee that the OHN could oversee and manage staff who became ill at work.

In contrast to the OHN, the OHP's role included consultations with healthcare workers (HCWs) who were referred by managers in relation to sick leave. Advice was given to the HCW and a report issued. This role was previously undertaken by a medical referee, who was often a GP. It was anticipated that the OHP would have an understanding of the working environments and workplace hazards within the health service.

As there was no Irish health and safety legislation governing hospitals as a place of work at the time, having worked as an occupational health nursing officer in the UK was invaluable to me in establishing the OHD. I was familiar with the 1968 *Tunbridge Report* which documented "the care of health of hospital staff" in the UK.[1] The report was produced by the Central and Scottish Health Service Councils and contained information about setting up an OHD in a healthcare setting.

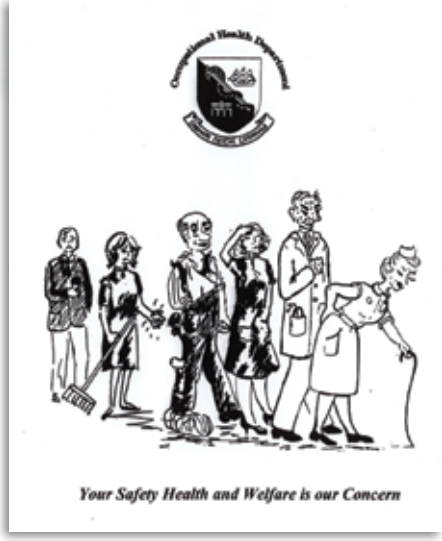

Figure 1: Copy of acetate used for the promotion and role of Occupational Health in the hospital setting

From the outset, my aim was to deliver a professional service with high standards of care for all HCWs. I was also aware of the need to comply with An Bord Altranais (now the NMBI) regulations.

The development of policies, procedures and guidelines were an essential requirement from the outset, giving governance and structure in the delivery of the OHD service. It was imperative to track progress and that was achieved by writing bi-annual reports containing statistics on the activities of the OHD and giving an accurate account of developments. The reports were made available to the matron (now known as director of nursing), administrator and personnel officer.

The OHN role was given the official title of 'sister for occupational health duties'. Duties documented on the job description of 1981 included: "Ensuring health screening of all prospective employees, organising medical examinations according to agreed policy. Ensuring that the confidential record system is maintained. Establishing and maintaining an effective immunisation programme for staff in high risk areas. Primary care of employees as necessary, according to policy. Organising x-ray appointments for staff and collection of specimens. Establishing environmental visits. Participating in health education and hygiene instruction. Providing a counselling service. Keeping up to date with new techniques and legislation in relation to occupational health and safety."

Presentations on the promotion and function of the OHD were made at every opportunity, along with sending notifications that were displayed on notice boards clarifying that the OHD was not a GP service. It was primarily concerned where ill health affected work or where the work affected health. "Your Safety, Health and Welfare is our Concern" was the caption when delivering presentations and promoting the role of the OHD in those early years *(see Figure 1)*.

Unfortunately the early 1980s were recessional times. Financial support was limited and the OHD was not allocated clerical support. Personal computers were making an introduction, albeit only to essential administrative areas.

The accommodation provided for the OHD was located in a building on campus known as 'the doctors' residence'. It was a very small area that included two single bedrooms that became the OHP and OHN clinic rooms, a linen room, toilet and shower. By the end of the first week, I had arranged to have some basic office and medical equipment installed and I started opening up the service.

I acquired an old Pye radio for the waiting room. This was essential as consultation conversations could be heard from

the waiting room and the radio helped to maintain confidentiality. The small waiting room accommodated seating for four people. There were two old-fashioned rotary dial type telephones. We had no access to direct telephone lines to make external calls, therefore switchboard had to be contacted for assistance in connecting calls when the need arose.

The OHD facility was of great benefit to the staff who were involved in the aftermath of the Air India disaster that occurred off the Cork coast on June 23, 1985. Employee assistance programmes were not available at this time.

Occupational health consultations were recorded by two classifications: non-occupational and occupational attendances. In the non-occupational category, the first report, dated October 1981 to April 1982, recorded attendances for headaches, colds, digestive problems, dysmenorrhoea, home injuries, medical conditions, ear and throat conditions, skin disorders, ophthalmic problems, paronychia and abscesses. The occupational category documented attendances for immunisations, pre-employment medical examinations, post-sickness medical examinations, health interviews, dressings, hygiene instruction and referrals relating to occupational injury. Injuries were caused by sharp objects, burns, trap injuries, slips and falls, chemical burns, injuries to the back, foot, ankle, elbow, eye, head injuries and patient assault. Telephone advice for occupational and non-occupational concerns was always part of the day's work.

Pre-employment medicals were performed by the HCW's own GP, with the exception of student nurses, whose medicals were conducted by the OHD. There were two intakes of approximately 30 student nurses twice a year. The procedure included the completion of a medical questionnaire by the candidate recording height, weight, urinalysis and chest x-ray, with tests carried out on eyesight, throat, bloods for haemoglobin, full blood count and erythrocyte sedimentation rate (ESR). The ESR was mouth pipetted and the reading completed in the OHD. A physical examination by the OHP completed the process of the student nurse's medical.

On commencement of training, the student nurses required a Heaf test *(see Figure 2)* and were advised to get a BCG vaccine for TB if indicated. Depending on vaccination history, tetanus vaccine course or booster was offered. Student nurses attended the OHD if they became unwell at work or had other health concerns that they wished to discuss.

Contact tracing was an integral role of OHD in the prevention and control of infectious disease. It involved contacting managers for lists of staff who were exposed to patients or staff who had a confirmed diagnosis of infectious disease such as TB, mumps, measles and chickenpox. Clinical advice, support and follow-up screening ensued. In the early 1980s, awareness was raised of the possible transmission of the hepatitis B virus following an exposure to blood and body fluid or by a needlestick/sharps injury from an infected source. Nurses were encouraged to report exposures to the OHD, where appropriate clinical management follow-up and counselling were offered. The hepatitis B vaccine was not available until 1988.

Environmental visits were part of the role of the OHN and OHP and were carried out on a regular basis in departments such as maintenance, catering, x-ray, theatre and wards where chemotherapy treatments were given to patients. The visits were very useful in identifying hazards and observing certain work procedures. Written reports were given to the managers, documenting outcomes of the visit and making suggestions for improving safety and preventing illness.

There were of course misconceptions about the service, that there was no need for this new type of service. There was confusion too, with many linking the OHD with occupational therapy and public health.

In 1983, the OHD's report documented that expansion and development was hampered by a lack of staff. The workload had greatly increased and there was no clerical support. Consultations were often disrupted by the need to answer the phone or doorbell. Management had great appreciation for the service, especially for the expert advice on health and safety matters. There was a need for a full-time secretary and another OHN, along with a purpose-built OHD. Eventually the OHD was given clerical support for six hours per week, but a full-time secretary was not appointed until 10 years later in 1991, followed by additional OHNs in 2000.

In 1985, staff who had substance abuse issues could be referred by the OHP to avail of a newly opened addiction treatment centre that was located offsite. In 1988, hepatitis B vaccination became available. There was excitement and positivity around the new vaccine and initially it was prioritised for areas of high risk,

Figure 2. TB screening. Heaf testing equipment used in the 1980s

with microbiology staff being the first to be offered vaccination, followed by other high-risk areas such as the ED and operating theatre. The vaccine programme continued until all staff in areas of concern had been offered the vaccine.

In April 1989, the Safety, Health and Welfare at Work Act was signed by President Patrick Hillery. The healthcare setting was included in its recommendations as a place of work. In order to comply with regulations and fulfil criteria contained in the Act, the OHD had a pivotal role. The Act had a major influence on the progression of setting up OHDs in healthcare services throughout the country.

Ongoing publications relating to occupational health followed, including European directives, national guidelines, Health and Safety Authority guidelines and evidence-based research that had an influence on the role and function of the OHD.

Requests were made from newly appointed OHNs and OHPs who wished to visit the department to discuss and observe how the OHD service in Cork operated. It was an opportunity to showcase what we had achieved. I was invited by An Bord Altranais to give presentations on the specifics of the OHN role and its function in the hospital environment.

Reflecting on the early years, the core functions of the OHD have not changed. OHDs continue to provide vaccination and screening programmes, pre-placement health assessments, sickness management referrals, management of blood and body fluid exposures, health surveillance and contact tracing following exposure to infectious disease. Our first slogan – 'Your Safety, Health and Welfare is our Concern' – could still be used today, 40 years later.

Brigid Quaid is a CNM3 in occupational health, HSE South (Cork)

Reference
1. The Tunbridge Report. The Care of the Health of Hospital Staff: Report of the Joint Committee. HMSO. 1968

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A job well done

Public health nurse **Anne Maire O'Gorman** reflects on the successful running of a community vaccination centre during the pandemic

AS THE doors closed for the final time on the community vaccination centre (CVC) at Mallow GAA in North Cork, it was heartwarming to reflect on the small but significant part played by one of the 36 nationwide HSE CVCs in combatting the effects of the unforgiving virus that is Covid-19.

The CVC team formed, stormed, normed and then adjourned with wonderful memories of a venture into the unknown. The transformational leadership of Mary O'Sullivan, our clinical lead, positively impacted the whole team and the sometimes inspirational and always welcome 'thought for today' from me, as deputy clinical lead, provided an extra dimension to what was very repetitive work for the team.

After weeks of onsite preparation, an atmosphere of anticipation and apprehension was apparent at the first morning 'safety huddle' on April 29, 2021. This was overshadowed by the overwhelming willingness and determination of everyone to 'get the job done'. Dressed in scrubs, wearing face masks and with many of us not knowing each other, name badges were very important. Safety was the keyword on the whiteboard and remained the cornerstone and the paramount focus of the whole team for the duration of the CVC.

Open sharing of the many vaccine-related updates by the clinical leads, audit of individuals' vaccination technique, the use of the few incidents as learning tools and a focus on the importance of individual self-care were the catalysts that empowered each person to do their best.

The importance of clinical focus and the need to take allocated breaks was stressed daily. Everyone was encouraged to ask questions and support each other, with the reminder that there is 'no I in TEAM'. Someone was always ready with a word of thanks. The positive and supportive atmosphere that developed, coupled with the wonderfully spacious venue, created a workspace that was truly enjoyable.

The shared laughter and craic was a welcome antidote to the consistently focused aim of the team. The mission was to administer vaccinations safely to all who wanted them, while following all relevant procedures.

Members of the vaccination team pictured outside the HSE community vaccination centre at Mallow GAA in North Cork

The team was respectful and sensitive to the differing needs of the population attending the centre. Many people had come out of isolation or cocooning to attend their appointment and were blatantly scared to be in a large room with lots of people, despite the mandatory wearing of face masks and the availability of hand sanitising stations. People who had needle phobias or extreme anxieties were spared the sometimes long queues via a quick access route. Patience and tolerance were required to vaccinate some attendees for whom the reality of getting an injection was overwhelming. The handful of people who attended the vaccination centre to get their vaccination card but not the vaccine itself belied belief!

Most people were just desperate to get vaccinated. The security team deftly handled all requests and demands and worked closely with the clinical leads to ensure that no eligible person was turned away. At times the commitment of the prep room team to not wasting a single vaccine led to long evenings waiting for people on standby to arrive. The cheeriness and efficiency of the admin team at registration and the friendliness of the Civil Defence and Irish Red Cross volunteers maintaining social distancing in the queue, put the public at their ease.

The welcoming and competent vaccinators were supported by the affable and knowledgeable medic on duty. They listened patiently to anxieties, dealt with the various clinical challenges presented to them and skilfully vaccinated everyone. The mix of irrepressible and steadfast characters in the observation team celebrated with the public, who were so relieved and delighted to be vaccinated that the 15-minute period flew. Behind the hilarity they were ever watchful for signs of adverse reactions and dealt swiftly with the minority who required medical attention. Despite the face masks someone was always ready with a smile because, as one of the thoughts for today reminded us, a smile shows up in your eyes.

By the time Mallow GAA CVC held its last clinic on October 29, 2021 the centre had also facilitated and embraced multiple schools immunisation clinics and peer vaccination flu clinics, while the core CVC team was off-site administering Covid-booster vaccinations in the 15 residential care facilities across North Cork.

As the inevitable closure drew near, the initial nerves of the early days had been replaced by friendships and a camaraderie that was palpable. A meaningful *bualadh bos* at the last safety huddle acknowledged the courage, respect and sincere regard held by all team members for each other. The very gratifying total of 54,425 Covid vaccinations that had been safely administered through over 140 clinics at the centre was celebrated at a well-attended farewell social team event.

The whole experience will live long in the hearts and minds of those who experienced this history in the making.

Anne Marie O'Gorman is an assistant director PHN and was deputy clinical lead at the Mallow GAA CVC

Navigating the critical care nurse pathway

A team from **Tallaght University Hospital** outlines two significant innovations recently implemented at the hospital's ICU nursing service

THE second half of 2021 saw two significant innovations in clinical practice in Tallaght University Hospital's intensive care unit nursing services, with direct entry of new graduate nurses to critical care and the appointment of critical care outreach advanced nurse practitioner (ANP) candidates.

Historically, previous clinical experience has been a prerequisite to starting a career as a critical care nurse in Ireland. Although recruitment of new graduate nurses into critical care is a well-established phenomenon internationally, starting a career as a new graduate nurse in critical care in Ireland is a relatively new concept. This is the first time Tallaght University Hospital has embarked on this journey.

The national critical care career pathway outlines the pathway from student nurse to advanced practice roles in critical care. For the first time, critical care in Tallaght University Hospital now has nurses represented at all levels of the national critical care career pathway.

Education programme

The new graduate nurse in critical care education programme, developed by our critical care clinical facilitators, involves a 12-week supernumerary education programme where newly graduated nurses are supported by preceptors in the clinical learning environment.

The new education programme involves a blended approach to learning, including classroom-based theoretical learning, high-fidelity simulation and clinical skills workshops. A clinical competency document accompanies the programme, with weekly learning outcomes designed to promote focused student-centred learning. The graduate nurse's experience will be evaluated both prior to and following their completion of the 12-week education programme in order to gain

Figure: Critical care nurse career pathway

Pictured at Tallaght University Hospital (l-r): Claire Farralley, Shameer Muhammad, Shauna Vandendries, Gideon Ecube, Nicca Indicar, Alba Cortes and Aileen McCabe

Pictured (l-r): Niamh Skenah, Shauna Vandendries, Fergal Moran and Shauna Delaney

insight into their experience in critical care while also improving the service for students planning to embark on the programme in the future.

Progressing along the pathway

The transition of newly graduated nurses into the critical care environment and the progression of staff into advanced practice roles along the critical care nurse career pathway in Tallaght University Hospital provides exciting, dynamic and innovative opportunities for nursing staff looking to commence a career in critical care.

The high-fidelity simulation sessions have proven successful. They are not set up to be a pass/fail scenario, but are instead a positive learning environment with debriefing at the end of each session. They allow us to provide a safe learning environment where we can teach subjects such as sepsis management, difficult airway management, head-to-toe assessment, incorporating the systematic approach to assessment of a deteriorating patient, identifying the failure of a patient to respond to treatment, to escalate care and discuss possible options for a patient-centred plan of care. These sessions are imperative to allow new graduate nurses to demonstrate and build on their leadership skills through effective communication and task delegation.

It is vital to see newly graduated nurses get the fundamentals of critical care nursing deeply rooted. When we get the fundamental qualities right, we can begin to build on them and therefore have the knowledge, skills and expertise to progress along the critical care nurse career pathway.

Testimonial

Having recently graduated as a mature general nursing student, I was looking to start on my career pathway straight away. I had always had a keen interest in nursing in the critical care setting. When I saw that the ICU was taking on newly graduated nurses I applied straight away. I love the supportive atmosphere working in ICU with great support from the staff nurses, clinical facilitators, management and medical teams. Every day is a learning opportunity.

– Fergal Moran, new graduate nurse

Recruitment and retention

In 2021, we saw a large increase in staff progressing along the critical care pathway. This has only been made possible with the increased number of clinical facilitators in place to encourage, mentor and support staff along the critical care nurse career pathway.

This has resulted positively in the recruitment and retention of highly skilled and well-educated staff in our unit. Recruitment and retention of critical care nurses is recognised internationally as a challenge for all healthcare service providers. The implementation of the new graduate nurse education programme in critical care may have significant implications for future recruitment and retention of nurses in this area.

With the continued fostering and nurturing of critical care nurses through each stage of their professional development, we are future proofing our workforce, thus protecting our patients' needs by delivering high-quality, evidence-based, patient-centred care. We have cultivated a supportive environment that enables and promotes shared visions and goals to be achieved within a progressive and dynamic working group.

Tallaght University Hospital has continued to demonstrate its vested interest in staff by promoting and encouraging continuing professional development through the implementation of educational frameworks. Despite the recent challenges cast upon us by the pandemic, the hospital's critical care team has shown beyond doubt its ability to be proactive, dynamic, progressive and adaptive to all needs and possibilities, as well as a readiness to change. With our new critical care unit due for completion this year, it is an exciting time to be joining our critical care team.

Get involved

The next new graduate nurse programme at Tallaght University Hospital will run in October 2022. Email: criticalcarecf@tuh.ie for details.

Sinead Gill, Bernie Garvin and Shauna Delaney are critical care clinical facilitators at Tallaght University Hospital

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

Help us to update your INMO membership contact details

IMPORTANT: PLEASE PRINT YOUR DETAILS IN ALL FIELDS IN BLOCK CAPITALS
**You will find your INMO number on the postage label of your copy of *WIN*

** INMO number:	NMBI number:
First name:	
Surname:	
Date of birth:	
Home address:	
Work location address:	
Study address:	
Employment grade (eg. CNM1, etc)	
If you are PHN or Community RGN Name of Local Health Office: Name of Community Care area:	
INMO Section:	
INMO Branch:	
Student: (Please tick appropriate) Yes ☐ No ☐	
Telephone Home:	Work:
Mobile Personal:	Work:

Please note that this mobile number will only be used by INMO for important updates and will not be given to any other party at any time. If you have any queries, please call the membership department Tel: 01 6640600

Email Personal:	Work:

The above details are correct as of:

Date: Signature:

Irish Nurses and Midwives Organisation,
The Whitworth Building, North Brunswick Street, Dublin 7, Ireland
Tel: 01 6640600 **Fax:** 016610466 **Email:** inmo@inmo.ie

Membership FAQs

In just a sample of the many things that the INMO can assist members with, membership officers **Mary Cradden** and **Stella Carter** address some of the most frequently asked membership-related questions

QUESTION: *I have been working in a hospital but am moving to a community setting in a different part of the country. I pay my INMO membership fees through my salary. Will this continue?*

ANSWER: You must contact the INMO membership department advising them of this as, in most instances, if you are changing work location, you will be moving to a different payroll department. Most hospitals, no matter where they are in the country, have their own payroll department so any change from one work location to another should be advised to the INMO membership department (email: membersupdate@inmo.ie). We will then send you a new salary deduction form to complete so that there will be no gap in payment of your INMO membership fees.

QUESTION: I will be commencing a two-year career break soon. I pay my membership fees through my salary and I am a member of the INMO/Cornmarket income protection scheme, which is also paid through my salary. Please advise what steps I should take to ensure that both my membership and income protection scheme remain active during this period as I do plan to return to work.

ANSWER: It is important that members contact the membership department and Cornmarket directly, prior to taking a career break. The membership department will talk you through what should happen for the duration of your career break in order to keep your membership active. You will also need to contact Cornmarket directly. They will advise you on their procedures, in order to keep your membership of the income protection scheme active.

QUESTION: *I currently work in a private nursing home and pay my INMO membership fees monthly through my personal bank account. I am moving to a HSE hospital in the coming weeks and want to ensure that I keep my monthly fees up to date and that I am paying the correct rate of membership fee in my new role.*

ANSWER: As you are moving from a private nursing home into a new HSE role, your INMO membership fees will increase to the full rate, i.e. currently from €228pa to €299pa. Please ensure that you contact the membership department and they will send you a standing bankers order amendment form so that you can increase your monthly fee to the correct fee for your new place of work. The current monthly fee will increase from €19pm to €24.92pm. Your bank, as with all financial institutions, will require a minimum of five to 10 working days to process the new payment so it would be important to complete all relevant paperwork prior to taking up your new role.

QUESTION: *I have been on unpaid sick leave for the past four months and have received a reminder for payment from the INMO for the period my membership fees were not paid. I never thought to contact the INMO during my period of unpaid sick leave and I notice that a gap in membership fees has accrued.*

ANSWER: It is important that members contact us prior to taking any period of unpaid leave. Please contact the INMO membership department and they will guide you through the process of what needs to be done from an INMO membership fee perspective during this period of unpaid leave. If you are also a member of the INMO income protection scheme offered by Cornmarket, please also ensure that you contact them directly regarding your period of unpaid leave. As the scheme is linked to INMO membership, it is important that contact is made to ensure your entitlements under the scheme are not impacted.

QUESTION: *Most of my colleagues receive regular updates from the INMO, by email and SMS, but I don't seem to receive any. Could you please investigate on my behalf and ensure that all newsletters and updates are forwarded to me?*

ANSWER: We must not have an active email or SMS on your membership record. Please ensure that you forward all your personal contact details by email to: membersupdate@inmo.ie. It is very important that we have an up-to-date email address for all members as regular notices to members and newsletters are sent by email.

QUESTION: *I will be commencing unpaid maternity leave in the coming weeks. As I pay my INMO membership fees through my salary, I want to ensure that my membership is kept up to date. Could you please advise how I should proceed?*

ANSWER: It is important that members contact us prior to taking any period of unpaid leave, including unpaid maternity leave. Please contact the membership department and they will guide you through the process of what needs to be done during this period of unpaid leave.

State's red tape adds to stress of bereavement

Laura Bambrick calls on the government to put and end to needless bureaucracy around terminating state services for bereaved families

WHEN a relative dies and after they are laid to rest, attention has to turn to getting their affairs in order. This is no small task for a grieving family. For some, this will include starting the probate process, notifying insurance companies and financial institutions, cancelling utilities and subscriptions, closing social media and email accounts. For all, it will require contacting multiple government departments and official agencies to cancel benefits, entitlements and public services.

During this extraordinarily difficult time, a bereaved relative is required to telephone, write or attend each relevant section within each public body to notify them of the death, mostly repeating the same information – name, PPSN, the date of death – over and over.

For example, if the deceased was an older person, within the Department of Social Protection the next of kin must go in-person to a civil registration office to register the death, contact the pensions section, the free travel section and, perhaps, the carers sections. Within the HSE, the medical card section, each hospital department (to cancel appointments and close files) and perhaps the home help section, the respite services section and the day-care services section all have to be notified that the service user has died. Revenue will have to be contacted to settle tax issues, the NDLS to cancel a driving licence and the deceased's passport returned to the passport office for cancellation. To name but a few.

While the sensitivity and professionalism of public servants in their dealings with people after a bereavement is not in question, navigating this bureaucratic maze is complex, time-consuming and risks causing distress. We have all heard of people being blindsided by grief when a jury summons or polling card for a long-dead loved one comes through the letterbox, because the local authority had not been requested to remove the deceased's name from the electoral register.

It is not unreasonable to assume that the paperwork burden imposed on those we leave behind is the unavoidable price for 'big government' that provides us with an extensive range of public services and income supports when alive. However, our process for notifying officialdom of a death is in stark contrast to how it works in the UK, where a free 'tell us once' public service allows a close relative to notify multiple central and local government agencies of the death at the same time. Everything, from a pension to a library card, is cancelled with a single phone call or online form.

During the previous government, a 2017 review of state services around dying, death and bereavement recommended that the Department of Social Protection introduce a joined-up notification service similar to the UK's tell us once service. While the then minister expressed a willingness to explore the option on the floor of the Seanad any concrete action has yet to be taken some four years later.

Already within the Department of Social Protection processes are in place that when a next-of-kin registers a death with the General Register Office this information is shared across all sections that same day to terminate welfare payments, with the Department of Public Expenditure and Reform for information sharing with the public sector pension services, local authorities and relevant public bodies. But this is a fraud prevention measure and is not publicised as a one-stop-shop option available to bereaved families.

Consultation

A public consultation on proposals to address deficiencies in the current death registration process was launched by the Department of Social Protection last summer. The manner and time it takes to register deaths had been found to hamper the ability of the state to provide timely death data from public administrative sources to support the pandemic health measures.

In its submission to the consultation the Irish Congress of Trade Unions recommended the government close the gap in public service delivery for people who have suffered a bereavement by providing a joined-up notification service. In the words of ICTU general secretary Patricia King: "This simple fix would mean so much to the families of the 32,000 people who die in Ireland each year."

Laura Bambrick is the social policy officer at the Irish Congress of Trade Unions

Contact Jean Carroll, Section Development Officer at HQ at Tel: 01 6640 600 or email: jean.carroll@inmo.ie

Looking to the future: Ireland leads the way on children's nursing strategy development

ROSEMARIE Sheehan, project officer for strategy development at Children's Health Ireland (CHI), presented an overview of the *Leading the Way: A National Strategy for the Future of Children's Nursing in Ireland 2021-2031* report at the recent INMO National Children's Nursing Section conference.

The findings of the report, which was published last year, outline the expert knowledge, skills and competencies of the registered children's nurse that will be required to care across a multitude of healthcare settings in Ireland and in many new and innovative roles and ways of working.

Ireland is one of the few countries in the world with an undergraduate and postgraduate programme leading to registration as a children's nurse.

The unique skills, competencies and knowledge that emerged during strategy development are a crucial support for children and their families in Ireland.

There is significant transformation underway in children's healthcare services in Ireland, with the planned opening of the new children's hospital, which will be Ireland's first Healthcare Information and Management Systems Society (HIMSS) level 6 hospital, along with the implementation of the National Model of Care for Paediatric Healthcare Service Provision.

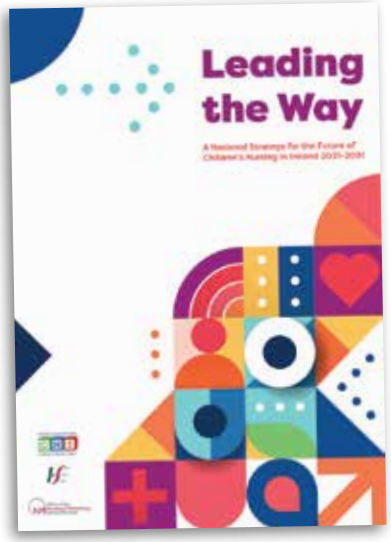
The *Leading the Way* report highlighted the significant role the advancement of children's nursing plays in the transformation of children's healthcare services in Ireland in terms of leadership, digital transformation, advanced roles, meeting the increasingly complex needs of children and their families and integration of care.

Children's nurses in Ireland have developed the Senior Children's Nursing Network led by the chief director of nursing at CHI and the director of paediatric nursing at the SAOLTA University Healthcare Group.

Plans are underway to increase and broaden the membership to drive implementation of the report across the country.

Some recent achievements include: the launch of National Children's Nursing Grand Rounds led by the national group of children's nurse registered advanced nurse practitioners; the development of a hybrid higher diploma in children's nursing; plans for the development of a retention strategy for children's nursing; leadership development initiatives and developing safe staffing in children's healthcare services.

As we begin to implement many of the objectives and actions outlined in the report, children's nurses in Ireland look forward to the continued support and collaboration from colleagues involved in children's healthcare, thus ensuring the delivery of high-quality, child- and family-centred care across the entire health service.



The full report can be accessed on the Office of the Nursing and Midwifery Services Director (ONMSD) section of the HSE website, through the INMO library via Nurse2Nurse or by emailing library@inmo.ie

International section raises funds for homeless people

The INMO International Nurses Section raised funds to support people who are homeless or living in poverty at Christmas. They sponsored a Christmas mass held at the Church of St Mary of the Angels, Dublin 7, donating seven food hampers and a €200 gift card to the Capuchin Day Centre there. Pictured presenting the hampers at the church were (l-r): Toyosi Atoyebi (secretary), Elizabeth Allauigan (chairperson) and Cres Abragan (education officer)

Retired Nurses Section social trip planned for Killarney

THE INMO Retired Nurses and Midwives Section has planned a social trip to Killarney, Co Kerry from Monday, May 2 for four nights (five days).

Accommodation at the Castlerosse Hotel in Killarney is available at a rate of €370 per person sharing, with a single room supplement of €30 per night. The rooming list is due by April 2.

The group will be departing from the Hugh Lane Gallery in Parnell Square North, Dublin 1 at 11.30am on Monday, May 2.

For further information and to book your place, contact Annette McGinley at Tel: 074 9135960 or email: info@jmgtravel.ie See *page 71* for further details.

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INMO EDUCATION PROGRAMMES

In the pull-out this month…

Orientation Programme to Irish Healthcare System and Culture to International Nurses and Midwives

Feb 22

This programme is designed specifically for nurses and midwives who recently arrived or are preparing to come to Ireland. It will give participants valuable information to support them in transitioning to life in Ireland and the Irish healthcare system. For further information, visit **www.inmoprofessional.ie** Please tell your colleagues and friends who are interested in working in Ireland about this free event. Email education@inmo.ie with your name, email address, mobile phone number and your INMO number if you have one. This programme is free to all.

Maximising Your Potential using a Coaching Approach for Nurses and Midwives

Mar 8

This new online course will provide nurses and midwives with techniques for adopting a coaching mindset. Nurses and midwives help other nurses/midwives by mentoring, which is crucial to maintaining competency, encouraging professional expertise and promoting leadership. This course will cover the following: how to build rapport and actively listen; identifying areas of your life that are in and out of balance; learning how to set goals for change and decide on actions; gaining insight into your strengths and resources. The programme will be facilitated by PJ Boyle, European Mentoring and Coaching Council-accredited practitioner and fellow of the Institute of Biomedical Science.

Retirement Planning Webinar

Mar 24

2-3pm. Free for INMO members

Planning for retirement is even more important today than it has ever been. There are many things to consider as you approach retirement. It's good to start by reviewing your finances to ensure your future income will allow you to enjoy the lifestyle you want. INMO Professional, in partnership with Cornmarket Financial Services, have developed this online webinar to help support our members, it will briefly cover the following: superannuation, AVCs, lump sum and investments. Places must be booked in advance to join this webinar. To book, visit **www.inmoprofessional.ie** or email education@inmo.ie with your INMO number, email and the name you are registered with us.

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INMO Professional

Online Education Programmes

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Email: education@inmo.ie

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

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Feb 8 **Competency-based Interview Preparation for Nurses and Midwives**

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

Feb 8 **Infection Control Regulation 27: Guide to Thematic/Focused Inspections in your Facility**

This course is for staff who are interested in infection prevention and control standards. It will identify key areas relevant to the new focused HIQA infection control guidelines/inspections (October 2021). This programme will provide information and outline the actions required by registered providers to ensure that procedures, consistent with the National Standards for infection prevention and control in community services, published by HIQA, are implemented by staff.

Feb 9 **Chronic Obstructive Pulmonary Disease (COPD) – Getting the Basics Right**

This online programme is aimed at nurses working in clinical practice who require basic knowledge and skills to care for people with chronic obstructive pulmonary disease (COPD). It will help participants to understand the clinical evidence underpinning the diagnosis and ongoing care of patients with COPD.

Feb 10 **Become More Assertive**

This short online programme is designed to help nurses and midwives develop their skills to be more assertive to help them to make decisions with conviction and deal with difficult situations.

Feb 14 **Introduction to Effective Library Search Skills**

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

Feb 15 **Complaints Management for Healthcare Staff**

This course is aimed towards senior nurse managers within the acute or residential healthcare settings to provide them with the key skills and communication tools to minimize the negative impact complaints can have in their workplace. Therefore, effective management of complaints is central to improve services and prioritise an open, honest and transparent health service.

Feb 16 **Falls Reduction, Assessment and Review**

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

Feb 16 **Introduction to Wound Management for Nurses and Midwives**

Topics covered in this programme will include wound healing, wound bed preparation, treatment options and dressing selections. Participants will learn about the anatomy and physiology of wound management, the factors influencing wound healing, the differences between acute and chronic wounds, implementation of a holistic assessment wounds and different types of dressing and their application.

Cancellation policy: For cancellations five days before the course due date, a full credit to transfer onto a course at a future date will be offered. For non-attendance, there is no refund or transfer. If a course is cancelled due to insufficient numbers, a full online refund will be issued.

Feb 17 **Understanding and Developing Care Plans for Nurses and Midwives**

This short programme provides nurses and midwives with the most up-to-date information regarding policy and standards. It will enhance their understanding of nursing care plans, reflecting on the past, present and future use of care planning and its importance in the workplace. It will focus on the need for comprehensive assessment, including risk assessment and care planning. Participants will be provided with practical tips on how to prepare for and carry out a comprehensive assessment, enabling them to develop a person-centred care plan.

Feb 21 **Person-centred Care Planning – RNID Services**

The aim of this programme is to outline the nurse's role in the process of person-centred assessment and care planning for service users within a legal and professional framework. This course is part of a series of short online programmes for management and frontline nursing staff that work in health and social care settings. These programmes will provide understanding, knowledge and skills when delivering care to individuals who may present with behaviours that challenge.

Feb 22 **The Importance of Documentation – Getting it Right**

This short programme will assist nurses and midwives in understanding their duty of care and responsibility in the area of best practice in documentation, keeping good records and their ethical and legal responsibility of getting it right. Introduction to legal and professional requirements: NMBI Code and Guidance for Recording Clinical Practice; relevant HIQA regulations and standards; adhering to consent and data protection legislation in record-keeping; purpose of healthcare records; the 'dos' of documentation.

Feb 22 **Orientation programme to Irish Healthcare System and Culture to International Nurses and Midwives**

This programme is designed specifically for nurses and midwives who recently arrived or are coming to Ireland. It will give participants valuable information to support them in transitioning to life in Ireland and the Irish healthcare system. Please tell your colleagues and friends who are interested in working in Ireland about this free event. Email: education@inmo.ie with your name, email address and mobile number, as well as your INMO number, if you have one. For more information, visit **www.inmoprofessional.ie**

Feb 23 **Therapeutic Use of Mindfulness for Nurses and Midwives**

This three-day online course is for nurses and midwives who work in the area of chronic illness, mental health, maternity care, parent education, palliative care, old age care and want to support their patients by teaching them mindful breathing and meditation techniques. Dates: February 23 and March 2 and 9. Time: 10am-3.00pm. Fee: €130 for INMO Members; €390 for non-members.

Feb 23 **Delegation Principles and Practice**

This programme will explore the issues surrounding delegation and decision-making. Participants will learn the difference between clinical and managerial delegation and how delegation differs from assignment of a task. Guidance will be provided on the assessment of a delegate's experience and role and how best to match appropriate clinical supervision to a specific delegated function. The professional, legal and quality of care issues involved when deciding to delegate a function will also be explored.

Feb 24 **Safer Better Care – Eight Themes – Public Health and Community-based Nursing**

This short online programme aims to update nurses/midwives who work in the community setting, on the eight themes of the 2012 HIQA Safer Better Care framework. These themes are: person-centred care and support; effective services; safe services; health and wellbeing; leadership, governance and management; use of resources; responsive workforce and use of information. This programme will examine the ethos within the role of these nurses, customer service, advocacy and procedures and the role of the team.

Feb 24 **Telephone Assessment and Advice Skills**

This short online programme is for nurses and midwives involved in providing telephone assessment and advice, in the emergency department, general practice and other community settings. Such calls assess patients' needs and may provide advice for self care, prompt the caller to seek immediate medical attention or refer the patient to another healthcare professional or agency. This programme will provide strategies and guidance on how best to communicate with each caller and handle each call in a professional and tactful manner.

Feb 25 **Overview of Nursing Assessment and Management of Stroke**

This course will give participants an overview of nursing assessment and management of stroke during the Covid-19 pandemic. At the end of the training participants will be able to: identify and discuss the two types of strokes; identify and ascertain the various treatment options; understand best practice for the nursing care of people who have suffered an acute stroke, including secondary prevention; be aware of aetiology of stroke and rationale for specific diagnostic tests.

When booking online courses please note:
Places must be booked in advance. You will need a reliable computer and internet access. Please ensure a correct email is provided when registering. Certificates for participation will be issued in digital form and sent by email. Do not hesitate to contact us at Tel: 01 6640641/18 or email: education@inmo.ie

Feb 28 **Understanding Epilepsy for Nurses and Midwives**

This short course will provide a good foundation and increase participants' knowledge when caring for patients with epilepsy. Nurses who are not specialists in epilepsy can play a central role in providing optimal care, education, and support to their patients with epilepsy given the proper tools. This course will provide a foundation on which to build increasing knowledge of epilepsy and care of the patient.

Feb 28 **Considerations in Use of Restrictive Practices**

This workshop will focus on clarifying definitions of restrictive practices, criteria and considerations in their use and safeguards against their misuse. The workshop will be relevant to management and frontline staff that work in health and social care settings where there is potential for the use of interventions that may be termed restrictive. This course is part of a series of short online programmes for management and frontline nursing staff that work in health and social care settings.

Mar 1 **Best Practice for Clinical Audit for Nurses and Midwives**

This programme equips nurses and midwives with the necessary skills to plan and implement a clinical audit in their practice and enable them to deliver evidence of improved performance for safer and better care for patients and improved quality service. Participants will be provided with an overview of clinical audit and be informed about each stage in the clinical audit cycle: topic selection, standards development, data collection, data analysis, reporting, implementing changes and re-audit. There will be an emphasis on continuous quality and safety improvement in healthcare.

Mar 2 **Introduction to Leg Ulcer Management**

This short online course will advise participants on leg ulcer management. Topics covered on the day include; pathophysiology, assessment and management of leg ulcers. Upon completion, participants will: have an understanding of the theory and concepts of the different causes of leg ulcerations; have gained a deeper understanding of the pathophysiology of leg ulceration; be aware of different non-invasive assessment for leg ulcerations; understand the importance of compression for venous leg ulcerations.

Mar 3 **Type 1 Diabetes Management for Nurses and Midwives**

This programme will provide nurses and midwives with knowledge and skills regarding type 1 diabetes. The literature would suggest that diabetes, chronic disease management and the self-care that is associated with it brings high incidence rates of depression, anxiety and negative thoughts. The use of different strategies, self-management, treatment options, insulin pump therapy and constant glucose monitoring will be looked at to improve patient self-management. The exploration of these strategies and management of type 1 diabetes is a necessary component to help nurses and midwives to formulate plans to combat issues that clients face.

Mar 7 **Developing Behaviour Management Strategies**

This workshop will focus on approaches that can be used to develop individualised proactive and reactive behaviour management strategies to support individuals that may present with behaviours that challenge. The workshop will be relevant to management and frontline staff that work in health and social care settings where there are individuals who may present with behaviours that challenge. This course is part of a series of short online programmes for management and frontline nursing staff that work in health and social care settings.

Mar 8 **Training Delivery and Evaluation**

This five-day training module will now take place on the following dates: September 20-22 and October 4 and 5, 2022. For more information, email education@inmo.ie

Mar 8 **Maximising Your Potential using a Coaching Approach for Nurses and Midwives**

This course will cover the following: how to build rapport and actively listen; identifying areas of your life that are in and out of balance; learning how to set goals for change and decide on actions; gaining insight into your strengths and resources.

Mar 10 **Risk Management and Incident Reporting**

This programme outlines the principles of best practice in managing risk. It will enable participants to understand terms related to risk management in healthcare, outline the stages of the risk management process based on the international standard and framework for risk management, outline the five steps of risk assessment, understand the purpose of a risk register and complete accurate records of incidents.

Mar 14 **Positive Behaviour Support – An Introduction**

This short course utilises a human right based and person-centred approach as a means of identifying supportive environments for individuals in health and social care settings. The workshop will be relevant to management and frontline staff that work in health and social care settings where there may be individuals who can present with behaviours that challenge. This course is part of a series of short online programmes for management and frontline nursing staff that work in health and social care settings.

Mar 21 **Post-incident Reviews (Operational and Peer Debriefing)**

Post-incident supports are an essential element of workforce wellbeing whilst also helping to ensure quality service delivery. This workshop provides guidance about proactive supports and reactive interventions that can be utilised to support staff wellbeing and organisational learning after incidents. The workshop will be relevant to management and frontline staff that work in health and social care settings where there may be some exposure incidents that may cause a stress reaction. This course is part of a series of short online programmes for management and frontline nursing staff that work in health and social care settings.

Mar 23 **Strategies for Managing Conflict**

The learning outcome for this programme will be to help participants develop the insights and skills necessary to navigate conflict situations and reach satisfactory solutions. In many ways, workplaces are perfect breeding grounds for conflict. As well as our skills, we bring our individual needs, goals, ambitions, personalities, perspectives, backgrounds and vulnerabilities with us to work. It is hardly surprising, then, that conflict can arise from time to time as we interact with others with their own unique take on the world. While a moderate amount of conflict can be healthy, unresolved conflict can lead to many negative outcomes, with consequences for wellbeing and careers.

Mar 23 **Introduction to Treating and Preventing Pressure Ulcers**

This short online course will advise participants on pressure ulcer prevention. Topics covered on the day include; causes of pressure ulcers, risk assessment, and prevention of pressure ulcers. Learning outcomes: discuss the causes of pressure ulcers; identify the factors that place a person at risk of developing pressure ulcers; have an understanding of the key principles of preventing ulcers and be able to take action to prevent pressure ulcers in the clinical environment; have an understanding of pressure ulcer classifications and grading; have an understanding of the key principles of the SSKIN Bundle and how to implement it in the clinical environment.

Mar 24 **Introduction to Positive Behaviour Support**

Positive behaviour support is an internationally recognised evidence-based approach to supporting individuals that can present with behaviours that challenge. This one-day workshop introduces participants to the positive behaviour support model and outlines the benefits and considerations in its utilisation from a practical and applied standpoint. Fee: €60 INMO members; €130 non-members. Time: 9.15am-4.45pm.

Mar 24 **The 'Know How' of Inhaler Technique**

This short, two-hour online programme for nurses and midwives will address issues around inhaler technique. The programme will introduce the participant to current best practice in relation to inhaler technique and assist in the understanding of the role of inhaled medication with the correct use of inhalation devices (fee for members: €20).

Mar 24 **Retirement Planning Webinar**

Positive Behaviour Support is an internationally recognised evidence-based approach to supporting individuals that can present with behaviours that challenge. This one-day workshop introduces participants to the model of Positive Behaviour Support and outlines the benefits and considerations in its utilisation from a practical and applied standpoint. Fee €60 INMO members; €130 non-members. Time: 9.15am-4.45pm.

Mar 28 **Promoting Informed Consent and Positive Risk in Nursing Persons with an Intellectual Disability**

The aim of this programme is to outline principles of practice for supporting clients' autonomy through the promotion of informed consent and positive risk taking in person centred planning. This course is part of a series of short online programmes for management and frontline nursing staff that work in health and social care settings. This course is part of a series of short online programmes for management and frontline nursing staff that work in health and social care settings.

Mar 30 **Introduction to Management and Leadership Skills for Nurses and Midwives**

The aim of this programme is to identify managerial and leadership competencies for frontline managers and to explore how these are applied in practice. The course will include management theory, effective leadership and teamwork, as well as delegation and clinical supervision.

Mar 30 **Introduction to Oncology: Terminology and Patient Pathways**

This course will give participants an increased understanding of the language of oncology in order to improve fluency with patients and colleagues, and increased insight into the oncology journey and stages. There will also be an opportunity to ask questions.

Mar 31 **Medication Management Best Practice – Guidance for Nurses and Midwives**

This programme supports safe, evidence-based practice in the area of medication management thus preventing medication errors and near misses. The programme will cover key topics such as: the key principles of medication management, the medication management cycle, management of controlled drugs and medication safety. Participants will have the opportunity to update their knowledge in line with the NMBI Guidance for Registered Nurses and Midwives Administration (2020) and HIQA requirements for medication management.

Mar 31 **Paediatric Asthma – Understanding the Basics**

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

Apr 4 **Infection Prevention and Control in Disability Services**

This training provides nurses with the knowledge and skills to implement infection prevention and control practices and procedures in the workplace, which is essential for all healthcare workers, especially those who work with vulnerable service users. The session will provide participants with a comprehensive understanding of the process of preventing infections from spreading; this includes proper hand hygiene procedures, the use of personal protective equipment, and decontamination of the environment and waste disposal. This course is part of a series of short online programmes for management and frontline nursing staff that work in health and social care settings.

Apr 5 **Tools for Safe Practice for Nurses and Midwives**

This programme provides safe practice tools to protect the nurse, midwife and patient within the backdrop of staff shortages and skill mix realignment within current healthcare settings. This is an awareness session to ensure participants understand the processes involved regarding patient alerts, clinical incidents and thorough assessment, while remaining focused on the patient. This programme is free to members.

Apr 7 **Diabetes CBT and general wellbeing**

The self-management of diabetes is associated with high incidence rates of depression and anxiety. The use of different strategies, cognitive behaviour therapy (CBT) and clinical trials look at the area of wellbeing and theories and models to help clients and healthcare providers to formulate plans to look at these issues. This programme explores techniques to help clients to manage their diabetes..

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

NEW 2022 DATES
March/April dates have been rescheduled

Training, Delivery and Evaluation

September and October 2022

5 Day PROGRAMME

Day 1	**Tues 20 - Sept**
Day 2	**Wed 21 Sept**
Day 3	**Thurs 22 Sept**
Day 4	**Tues 4 Oct**
Day 5	**Wed 5 Oct**

9.30am to 5.00pm

30 NMBI CEUs

Module 6N3326 - QQI Level 6
Category 1 Approved by NMBI

FOR MORE INFORMATION CONTACT:
Tel: 01 6640642 | Email: education@inmo.ie

Please note: This training is due to take place online, pending further review closer to the time and government's guidelines.

Irish nursing and midwifery research

This month, library staff highlight Irish nursing and midwifery research and published articles

Nursing

- Connolly C, Cotter P. Effectiveness of nurse-led clinics on healthcare delivery: An umbrella review. 2021. Journal of Clinical Nursing
- McDonald A, Frazer K, Warters A. Irish public health nursing services and home support services: governance of older persons' home care. Public Health Nursing 2021
- Giltenane M, Sheridan A, Kroll T, Frazer K. Work environment challenging Irish public health nurses' care quality: First postnatal visit. Public Health Nursing 2021.

Covid-19

- O'Leary N et al. Covid-19 healthcare policies in Ireland: A rapid review of the initial pandemic response. Scandinavian Journal of Public Health 2021;49(7):713–20
- Reynolds CME, Purdy J, Rodriguez L, McAvoy H. Factors associated with changes in consumption among smokers and alcohol drinkers during the Covid-19 'lockdown' period. European Journal of Public Health 2021;31(5):1084–9
- Nestor S, O'Tuathaigh C, O' Brien T. Assessing the impact of Covid-19 on healthcare staff at a combined elderly care and specialist palliative care facility: A cross-sectional study. Palliative Medicine 2021;35(8):1492–501

Caregivers

- Teahan Á, Carney P, Cahill S, O'Shea E. Establishing priorities for psychosocial supports and services among family carers of people with dementia in Ireland. Dementia 2021;20(6):2109–32
- Teahan Á, Walsh S, Doherty E, O'Shea E. Supporting family carers of people with dementia: A discrete choice experiment of public preferences. Social Science & Medicine 2021;287
- Ryan L. Accessing community dementia care services in Ireland: Emotional barriers for caregivers. Health & Social Care in the Community 2021, 29(6):1980–9

Older People

- Keogh F, Carney P, O'Shea E. Innovative methods for involving people with dementia and carers in the policymaking process. Health Expectations. 2021;24(3):800–9.
- Carter L, O'Neill S, Austin PC, Keogh F, Pierce M, O'Shea E. Admission to long-stay residential care and mortality among people with and without dementia living at home but on the boundary of residential care: a competing risks survival analysis. Aging & Mental Health 2021;25(10):1869–76
- Ward M, May P, Normand C, Kenny RA, Nolan A. Mortality risk associated with combinations of loneliness and social isolation. Findings from The Irish Longitudinal Study on Ageing (TILDA). Age & Ageing 2021;50(4):1329–35
- Walsh ME, Nerdrum M, Fahey T, Moriarty F. Factors associated with initiation of bone-health medication among older adults in primary care in Ireland. Age & Ageing 2021; Sep ;50(5):1649–56
- Tuohy D et al. Towards the development of a national patient transfer document between residential and acute care – a pilot study. International Journal of Older People Nursing 2021;16(4):1–12

Library services

The library has a number of services to support your practice and educational requirements, including literature searching, document supply, reference desk assistance and searching consultations. To find out more, call 016640614 or email: library@inmo.ie

Midwifery

- Matvienko-Sikar K et al. Differences in levels of stress, social support, health behaviours, and stress-reduction strategies for women pregnant before and during the Covid-19 pandemic, and based on phases of pandemic restrictions, in Ireland. Women & Birth. 2021;34(5):447–54
- Newnham EC, Moran PS, Begley CM, Carroll M, Daly D. Comparison of labour and birth outcomes between nulliparous women who used epidural analgesia in labour and those who did not: A prospective cohort study. Women & Birth 2021;34(5):e435–41
- Beecher C et al. Development of a survey instrument to evaluate women's experiences of their maternity care. Women & Birth 2021;34(4):e396–405
- Doherty J, Brosnan M, Sheehy L. Changes in care in the fourth trimester in Ireland: 2010–2020. British Journal of Midwifery. 2021;29(12):683–91
- Dempsey B et al. Exploring providers' experience of stigma following the introduction of more liberal abortion care in the Republic of Ireland. Contraception 2021;104(4):414–9

Education

- Tuohy D, Fahy A, Murphy L. Student nurses and midwives' experiences of teaching and learning about "making every contact count" health behaviour change programme: Descriptive qualitative study. Nurse Education in Practice 2021;57
- De Brún A, Rogers L, Drury A, Gilmore B. Evaluation of a formative peer assessment in research methods teaching using an online platform: A mixed methods pre-post study. Nurse Education Today. 2022;108

Online – Introduction to Effective Library Search Skills

Next course date: Monday, February 14

Fee: €30 INMO members; €65 non-members

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

INMO Professional

RCM i-learn

THE ROYAL COLLEGE OF MIDWIVES

Vaccination in pregnancy

The RCM's i-learn repository offers two courses that include the latest information on vaccination against Covid-19 and flu during pregnancy

THE RCM i-learn portal offers two short courses looking at vaccination in pregnant women: the first on vaccination for flu and the second on Covid-19 vaccination.

Flu vaccination in pregnancy

This course aims to provide midwives with information about why pregnant women and their unborn babies are at increased risk from flu. It informs midwives about the safety and effectiveness of flu vaccination, despite the low uptake routinely achieved.

This course also covers some common misconceptions held by pregnant women, and some suggestions on how to encourage uptake.

This module will take approximately 30 minutes to complete.

Learning outcome

Having completed this module you will:

- Have knowledge of the increased susceptibility of pregnant women to flu and its potential severity
- Have knowledge of the protection provided by flu vaccination to the unborn baby
- Ability to distinguish between myths and facts associated with flu vaccination in pregnancy
- Increased confidence communicating with pregnant women about flu vaccination.

Why is flu vaccination important?

There are physiological and immunological changes to women's bodies while they are pregnant. These changes are at their height by the third trimester of pregnancy, when lung capacity and tidal volume are decreased and cardiac output and oxygen use are increased in an attempt to protect the developing foetus.

Pregnant women's immune system functioning and response to infection is weakened, as a result of suppression of T-Helper cells, to protect the developing foetus from attack from the maternal immune system, but which in turn makes the pregnant woman more susceptible to the flu virus.[1]

Role of the midwife

Midwives are the key healthcare professional when providing information to pregnant women. It is therefore imperative that the information midwives provide to women and their families is based on the best available evidence.

Midwives can present the information factually and discuss the evidence with women to enable them to make a fully informed choice about having vaccines.

Midwives may have their own views about the vaccine, but these should not be expressed to women when informing them of the evidence.

Pregnant women have reported that their preferred method of information about flu and the flu vaccination is from midwives, showing the importance of having these discussions.[2]

Covid-19 vaccination in pregnancy

This module will outline the current evidence supporting Covid-19 vaccination in pregnancy and the potential outcomes for pregnant women should they choose not to have the vaccine. This information has changed over the period of the pandemic, based on more information becoming available. It is therefore imperative that midwives understand the current evidence when they are providing women with information on the vaccine. This module will take approximately 10 minutes to complete.

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1. Tamma PD, Ault KA, del Rio C, Steinhoff MC, Halsey NA, Omer SB. Safety of influenza vaccination during pregnancy. American Journal of Obstetrics & Gynecology, 2009; 201(6):547-52.

2. Parsons J. Changing risk and efficacy appraisals for flu vaccination amongst pregnant women. Available online. https://pureportal.coventry.ac.uk/files/27832838/Approved_thesis_JParsons.pdf

RCM i-learn access for INMO midwife members

Free access is available to all midwife members of the INMO. If you are interested in learning more about the modules outlined or in completing a learning module, visit **www.inmoprofessional.ie/RCMAccess** or email the INMO library at library@inmo.ie for further information

Spotlight on Leadership

Benefits of strategic leadership in nursing and midwifery

THE fifth in our series of articles exploring the topic of leadership focuses on strategic leadership. What follows is an overview of the importance of strategic leadership, the skills required to become a strategic leader, and the importance of the instrumental approach in driving the implementation of organisational strategy.

The Nursing Now campaign emphasised the importance of nurses and midwives influencing healthcare policy.[1] Developing strategic leadership capabilities is fundamental to enable nurses and midwife leaders to advocate for nursing and midwifery and improve healthcare.

Transformational leadership continues to dominate much of the leadership research and discussion.[2,3] Other emerging approaches include strategic leadership, which focuses on organisational level leadership rather than individual leaders. At the heart of strategic leadership is the transformation of organisations. Many of the features of transformational leadership, including inspirational motivation and intellectual stimulation, are evident in strategic leadership models.

Healthcare constantly evolves and responds to the external environment and internal organisational pressures. Organisational transformation is a fundamental feature of healthcare and demands a strategic approach to planning, thinking and leadership to ensure that long-term health needs are met.

Strategic leadership can be identified by its broad scope, enduring impact, and implementation of meaningful change.[4] Essentially, it embodies strategic thinking, creating a vision, meeting short and long-term goals alongside ensuring the organisation is strategically placed for the future while meeting current demands. Strategic leadership is about translating an organisation's vision into reality and transforming organisations. It is a fundamental approach for nurse and midwife leaders to influence and lead strategic healthcare policy development and implementation.

Schoemaker, Krupp, & Howland[5] describe the importance of being an adaptive strategic leader, committed and flexible, resilient in the face of setbacks, and capable of reacting strategically to environmental shifts. They identify six essential skills required to achieve this: anticipate, decide, challenge, align, interpret and learn (*see box above*).

According to Hooijberg and Lane,[6] there are three components of strategic leadership; inspirational vision, instrumental leadership and transactional exchange. Inspirational vision requires a leader to create a compelling vision for using values-based and intellectually stimulating leadership.

Transactional exchanges refer to reward systems as the key motivational tools, such as pay, bonuses, promotional opportunities. The component is to engage employees using instrumental leadership techniques. This involves "strategically developing and deploying the organisation's resources to bridge the gap between providing a far-reaching vision and transactional exchanges". This essentially means ensuring that organisational resources are used appropriately and aligned with the overall vision for the organisation.

Three types of resources are outlined; budgetary processes and allocation, human resources deployment and investment and divestment decisions. The deployment of resources to support the implementation of the strategy provide a clear indication that the organisation is serious and willing to put its money and resources 'where its mouth is'.

Nurse and midwife leaders taking up the mantle of strategic leadership can use an instrumental approach to ensure work is completed within the organisation's allocated resources in line with the organisation's vision and objectives.

Six essential skills in strategic leadership

Anticipate: strategic leaders have the ability to anticipate trends, projections and opportunities on the periphery of the organisation
Challenge: strategic leaders challenge the status quo, including their own assumptions and that of others
Interpret: strategic leaders possess the ability to analyse and synthesise all inputs available to them regarding a situation. Using these inputs, they can recognise patterns and seek new insights
Decide: strategic leaders make important decisions in uncertain times, using a process that can balance speed and rigour and having multiple options from the outset
Align: the strategic leader must be able to achieve buy-in from stakeholders with varying views and objectives by finding common ground
Learn: strategic leaders promote active enquiry from both successful and unsuccessful outcomes

Niamh Adams is head of library services and Steve Pitman is head of professional development, both with the INMO

Launched in 2021, the Nursing Now Challenge brings forward the Nightingale Challenge mandate, which focuses on developing leadership opportunities for nurses and midwives globally. Visit ***www.nursingnowireland.ie***

If you are interested in writing or contributing to this series of leadership articles, please get contact Steve Pitman by email to: steve.pitman@inmo.ie.

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2.Dinh JE, Lord RG, Gardner WL, Meuser JD, Liden RC, Hu J. Leadership theory and research in the new millennium: Current theoretical trends and changing perspectives. The Leadership Quarterly. 2014 Feb 1;25(1):36-62.
3. Gardner WL, Lowe KB, Meuser JD, Noghani F, Gullifor DP, Cogliser CC. The leadership trilogy: A review of the third decade of the leadership quarterly. The Leadership Quarterly. 2020 Feb 1;31(1):101379
4. Hughes, RL and Beatty KC. Becoming a Strategic Leader Your Role in Your Organisation's Enduring Success. 2005. Jossey-Bass. California
5. Schoemaker PJ, Krupp S, Howland S. Strategic leadership: The essential skills. Harvard business review. 2013 Jan 1;91(1):131-4.
6. Hooijberg R and Lane N. Strategic Leadership. In Wiley Encyclopedia of Management - Volume 12 Strategic Management (eds Cooper CL, McGee J and Sammut-Bonnici T). Wiley Encyclopedia of Management, 2015, 12

Q and A Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Breastfeeding breaks at work

Q. I am a full time staff nurse working in a HSE hospital. What is the policy regarding breastfeeding breaks? My baby will be eight months when I return to work.

In line with government and HSE policy on infant feeding and supporting more mothers to breastfeed and to breastfeed for longer, nurses/midwives will be entitled to time off without loss of pay for breastfeeding breaks at work for up to one hour per normal working day. This policy was approved by the HSE's executive management team and came into operation from February 2, 2021. Under the policy, nurses/midwives will be entitled to time off without loss of pay for breastfeeding breaks at work for up to one hour per normal working day. Nurses/midwives who are working reduced hours or work longer days can take the breaks on a pro rata basis.

Breastfeeding breaks may be taken in the form of one break of 60 minutes, two breaks of 30 minutes each, or three breaks of 20 minutes each, or in such other manner as agreed by the employee and her manager.

If no breastfeeding facilities exist in the workplace, the employee may reduce her working day by one hour without loss of pay, in accordance with service need, in a manner to be agreed between the employee and her manager. In accordance with the policy, employees should be provided with a designated space where possible for the purposes of breast milk expression. Managers are required to engage with employees in relation to these arrangements, and managers should endeavour to facilitate employees' needs as far as reasonably practicable having regard to service requirements. See HR Circular 006/2021 for more.

National strike and your service record

Q. I recently sought information in respect of my pension as I am due to retire shortly. The superannuation department advised me that the nine days over which I took part in the national nurses' dispute in 1999 are being deducted from my service record. I thought it had been negotiated that we would not lose these dates for pension purposes. Can you please clarify this?

You are correct. The INMO argued that this time should be considered service and the matter was heard by the Labour Court in 2006 and the Court issued a recommendation on November 9, 2006 in respect of this matter. The Court recommended that any period of absence, without pay, due to the industrial action from October 19-27, 1999, would be reckonable for pension purposes.

The Labour Court recommended that the service would be reckonable subject to the payment of the appropriate superannuation contributions in respect of the days being reckoned. Superannuation contributions would be calculated based on pensionable remuneration at the date of retirement.

The only exception to this would be nurses and midwives who already exceeded the maximum reckonable service permitted under the superannuation scheme. The HSE issued a circular following this Labour Court recommendation in 2007. The circular number is 013-2007 and it sets out the terms on which this particular issue is to be dealt with. This period, in accordance with the Labour Court recommendation, can now be considered as time worked and the superannuation that would have been due, had it been worked, is to be calculated at the rate of remuneration that applied for the nurse/midwife at that time.

Quality & Safety

A column by Maureen Flynn

An introduction to human factors for healthcare workers

THIS month we consider 'human factors' – a term that is familiar to most nurses and midwives. However, many healthcare professionals have had limited formal training in this area and our understanding is often based on an aviation model that is focused on improving teamwork and communication. Although these are certainly aspects of human factors, they fail to address the full range of approaches, knowledge and techniques that can be applied to improving the delivery of healthcare.

Human factors

There are many different definitions of human factors. A widely accepted definition is: the environmental, organisational and job factors, alongside human and individual characteristics that influence behaviour at work in a way which can affect health and safety. A simple way to view human factors is to think about three aspects: the job; the individual; and the organisation and how these affect behaviour.

Human factors establishes common ground between humans and their working environments. It draws on many fields such as psychology, anatomy, physiology, social sciences, engineering, design and organisational management. It uses a wide range of theories, measures and approaches in order to improve the safety, quality and efficiency of workplaces. Consideration of human factors is particularly important to nursing and midwifery practice as it is characterised by high levels of human-to-human as well as human-to-technology interactions.

Human factors in healthcare

Human factors thinking arose from the study of aviation mishaps and the design of pilot controls during World War II. There are a small number of references to human factors in healthcare prior to mid-1990s but it was not until James Reason's 1995[1] and 2000 papers[2] on understanding adverse events and human error, alongside the US Institute of Medicine's 2000 report *To Err is Human*,[3] that the healthcare industry became interested in human factors. This interest started in anaesthetics (arguably because this specialty of medicine is most comparable to aviation), but now human factors permeates all specialities of healthcare and nursing and midwifery practice.

Benefits in healthcare

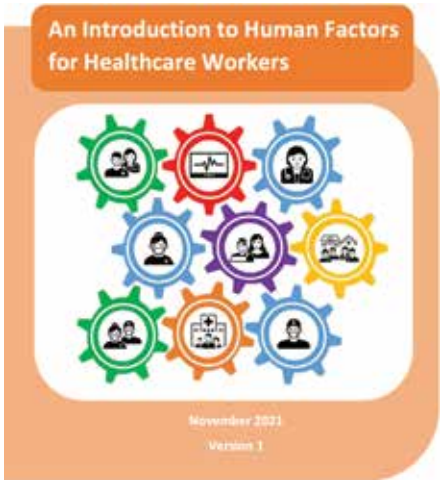
In healthcare, the focus of human factors has been to improve safety for people receiving care and treatment and for the people providing clinical care. However, it also has much to offer to the areas of quality improvement and efficiency.

- Safety improvement: a human factors approach can support our understanding of the contributors to incidents at all levels of the healthcare system, as well as how to proactively improve safety through mitigation, for example, participating in multidisciplinary team safety huddles/pauses or undertaking After Action Reviews (AARs)
- Quality improvement: a human factors approach can support improvements in quality of care, work practices, and workforce satisfaction, for example using iPads for person-centred communications with family members during the pandemic
- Increased efficiency: a human factors approach can support an improved understanding of how work processes and systems can be designed in order to optimise performance, productivity, and cost effectiveness, for example, using video technologies for virtual clinic consultations.

Using the human factors approach

A guide to human factors was published in November 2021. The content of this guide draws upon the human factors research literature. The guide:

- Provides a comprehensive overview of human factors



- Supports healthcare workers to identify the human factors issues in their workplace
- Supports the identification of the human factors contributors to incidents
- Provides examples of human factors interventions that have been used in healthcare settings.

Access the guide

You can download the guide and a summary infographic from the HSE website at: **https://www.lenus.ie/handle/10147/630666**

Get involved

At your team, ward or unit meeting you might like to talk about human factors and identify how you can increase your use of human factors thinking in your daily practice. The guide will help you with this.

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

Acknowledgements: Thank you to National QPS Directorate colleagues and in particular Dr Paul O'Connor, National University of Ireland, Galway and Dr Angela O'Dea, Royal College of Surgeons in Ireland, for preparing the guide and collaborating in writing this column

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3. Kohn KT, Corrigan JM, Donaldson MS. 1999. To Err is Human: Building a Safer Health System. Washington, DC: National Academy Press

12th ICN NP/APN NETWORK CONFERENCE

21–24 August 2022 | Dublin, Ireland

Advanced Practice Nursing Shaping the Future of Healthcare

The INMO is delighted to be collaborating with the IAANMP in hosting the 12th International Council of Nurses, Nurse Practitioner / Advanced Practice Nurses Network Conference in University College Dublin from 21st to 24th August 2022. This year marks 26 years of Advanced Nursing / Midwifery practice in Ireland, and the conference will showcase and celebrate advancements in nursing and midwifery practice from around the world

Who attends?

Who attends? Nurse/ Midwife Practitioners • Advanced Practice Nurses and Midwives • Clinical Nurse and Midwife Specialists • Registered Nurses and Midwives • Those on the pathway to Advanced Practice • Educators • Policy Makers and Managers • Industry Partners • Media

Conference Themes

- Advancing nursing practice to address inequality
- Leading innovation in advanced practice nursing
- Health and Wellbeing
- Global Health and Climate Change
- Building a NP/APN workforce for health
- Evidencing the impact of advanced practice nursing

Call for abstracts now open until 14th March 2022
Visit www.npapndublin2022.com for further details

We Learn. We Innovate. We Advance

Positive behaviour support

Maurice Healy describes the strategies nurses can employ to support their ID service users

"THE time to repair the roof is when the sun is shining." This quote from John F Kennedy is a perfect metaphor for the basic principles of positive behaviour support (PBS). PBS is a person-centred framework for providing long-term support to people who display behaviours that challenge. The aim of this approach is to ensure that positive behaviour is far more productive for an individual and that aspects of their lives that may be causative factors in the behaviour are addressed prior to any other interventions.

PBS is also a statutory requirement under the Health Act (2007) on intellectual disability and older person's services. Over the past 30 years, PBS has become an increasingly popular framework to support the behavioural needs of people with intellectual disability. The work of Horner et al[1] and LaVigna and Willis[2] have been central to its development.

It is important to acknowledge that the PBS model has its critics, particularly in situations where access to a good life can be considered contingent on appropriate behaviour. However, it is important to focus on the variety of supports that must be in place before we ever invoke behavioural change strategies. This article focuses on these supports that nurses can use in their day-to-day interactions with service users.

To simplify the principles of PBS into a framework that is understandable by all, we condense the approach into straightforward concepts. Consider one simple question – what are the five most important things in my life? Jot them down and then consider how many of those things the people using our services are enjoying right now. If you included priorities such as family, health, friends, spirituality, partner, financial security, holidays, pets, food and tea/coffee, then you join a long list of people with similar priorities.

Then consider the following question – in a care setting, which aspects of my life priorities would be absent? How might you feel? How might you respond to others who you feel may be responsible for denying you access to these important aspects of your life? The fact is that sometimes the people we support will respond by using behaviours that we term 'challenging' – often these behaviours are the only voice available to the person to help us understand their needs.

The Meas (Respect) Model outlined in *Figure 1* is a great starting point from which to approach the provision of PBS. Following JFK's construction metaphor, when building a house we don't start with the roof and work downwards; a strong foundation is our first priority, followed by walls and then the roof. In keeping with the analogy, if we try to change a person's behaviour before we address some important fundamentals in their life, we are doing them a disservice and are destined to fail in the goal of improving their quality of life.

The Meas (Respect) Model employs a similar philosophy to Maslow's hierarchy of needs:[3] if the essentials are not in place, we can reasonably expect that the person we are supporting is going to respond with behaviours that may be difficult for carers to understand. This will continue until we figure out what is absent in their life. The Meas (Respect) Model encourages us to consider the following fundamentals.

Health

One of the key foundation stones in the model is our physiology or general health. We would all agree that when our health is affected, our response to outside influences or demands will be affected. Many of the people nurses support may have serious health comorbidities. A person with a toothache, migraine, stomach pain, headache or possibly an undiagnosed health issue doesn't need a behaviour support plan. They need an intervention to assist with the immediate issue, which is very often pain. This may require a medical or pharmacological approach. Taking weeks of observation notes from a behavioural perspective may be counterproductive and could exacerbate the issue.

Investigations can certainly occur in tandem, but addressing any physiological issues is paramount before proceeding with any other strategy.

Environment

When looking at the behavioural presentation of others, we must always examine the impact the environment has on causing/maintaining behaviours that challenge. Overcrowding, loud noise and brightness can all be contributing factors. Are several media competing with each other (eg. TV and radio on at the same time)? Is there a safe space to go and hide and block out the world for a while? Is there a space for silence and contemplation where a person can go to avoid distractions? When we consider the environments in which we provide support, there are many aspects of it that we would change if we could. Ask yourself "would I be happy here?" If not, then identify what needs to change.

Communication

Getting our message across is fundamental to having our needs met. In older persons and intellectual disability services, many people may communicate without words. It is important that we listen with our eyes and our ears to the messages

being communicated to us. If we miss something and a person feels they are not being understood or listened to, it can lead to frustration and stress. Providing supports, such as a good communication passport, can be invaluable in a person's life when they may not be using language to communicate.

Ensure you have support in place such as Lámh, visuals, picture exchange communication systems and TEACCH strategies. It is also important to consider the unconventional communication techniques the person might use. What language is the person most comfortable with? How good is their receptive language? Reducing the number of words used, presenting ourselves in a calm, friendly manner and requesting rather than placing demands can all be effective strategies.

Building relationships

Just because we turn up in our place of work doesn't mean that the person we are there to support will be happy to see us. They might actually have been hoping for someone else to arrive. In all facets of our lives we will meet people with whom we gel instantly, those we take time to get to know and those we hope to never meet again. The same is true in our working life. However we owe each individual we support, our respect, time and expertise without favour.

Building relationships is part of this process and taking time to get to know the person you are supporting is paramount. In any given fortnight, a high number of personnel may be involved with a person we support. How many will have a relationship with that person? How many will be part of that person's life? How many will know that person's story? How many will adapt their approach based on the person's immediate presentation? An absence of these considerations can lead to disrespect, misunderstandings and ultimately to a person having to use a different behaviour just to be heard.

Behavioural management

Behavioural management strategies are interventions that we need to put in place proactively and reactively. Reactive strategies are generally considered a last resort and are only employed when all other interventions have failed. Proactive strategies are strategies we know can be effective immediately in helping to reduce a person's behavioural arousal level. These include staff being able to recognise behavioural cues and identify when a person's behaviour may be escalating.

Giving the person some space can be a useful strategy. Reduce language, lower the tone of your voice and speak clearly. Avoid unnecessary language as this can overwhelm a person who is trying to process. Listen with your eyes and ears and try to understand what the person is saying through their behaviour. Avoid prolonged eye contact as this can be very stimulating and will increase arousal levels.

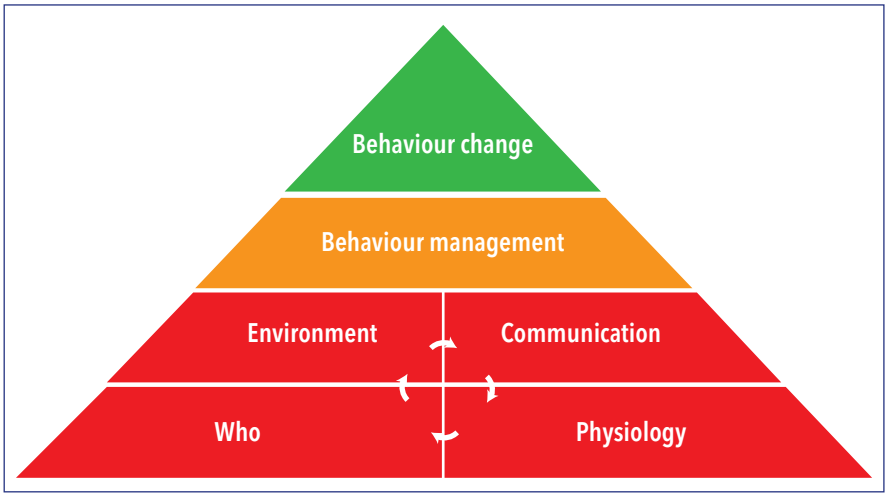
A person's stance can be unintentionally confrontational and standing at an angle when communicating avoids direct face-to-face engagement. Touch can be useful but is best avoided unless staff are aware that it can reduce arousal levels.

Distraction is one of the key strategies in assisting someone in distress and a knowledge of the person and their story will assist here. Behaviour management training is crucial. It is also essential that organisations are mindful of the necessity to choose their training carefully to ensure that the most ethical and safe strategies are being used. A strategic review of the training on offer in Ireland is indicated. We need to ensure that training exceeds standards that we would demand if the staff being trained were supporting our family or friends.

Remember the famous quip from comedian Tommy Cooper: "A man goes to the doctor and says 'Doctor it hurts me when I raise my arm above my shoulder'. The doctor replies 'Well don't do that then'."

Simply put, let's stop doing things that stress, upset, hurt or annoy the people using our services and we can then make positive change in their lives.

Figure 1: Meas (Respect) Model



Maurice Healy is an advanced nurse practitioner specialising in behaviours that challenge at Brothers of Charity Ireland, Galway Services

INMO Professional offers a series of short online programmes for nursing staff who work in health and social care settings. These programmes will provide an understanding of the knowledge and skills required to deliver care to individuals who may present with behaviours that challenge. All programmes will be provided online between February and April 2022, and are Category 1 approved and allocated CEUs. Email education@inmoprofessional.ie for more information

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Mental health and wellbeing support

Last year, Cornmarket partnered with the INMO to create Let's Talk About It, a mental health collective for INMO members. Our aim? To support nurses and midwives by providing access to wellbeing resources, and highlighting some of the support services available;

INMO 24hr Counselling Help Line

A FREE and confidential service for you and any member of your immediate family who lives with you. The service is delivered over the phone and includes onward referral to voluntary and/ or professional services, where appropriate.

24hr Counselling Help Line
1850 670 407 or +353 1 881 8047

50808 Text About It for INMO members

A free, anonymous, 24/7 messaging service providing everything from calming conversation to immediate support. Trained volunteers can help you sort through your feelings by listening to you, asking questions and responding with support until you feel in a calm and safe space.

Text INMO to 50808 to start a conversation, any time - day or night.

text about it
50808

Employee Assistance Programmes (EAP)

Many employers provide EAP programmes that can give confidential help and support for personal and work-related issues that affect your mental health and emotional wellbeing.

- All HSE employees should contact the HSE's EAP by calling +353 81 832 7327.
- Non-HSE employees in the locations outlined below can contact the associated EAP service or occupational health department. Those who are not on this list and not employed by HSE should contact their HR department directly

Non HSE Employee @ Workplace:	Contact Local HR / Occ Health	VHI Corporate Solutions 1800 995 955 eap@vhics.ie wellbeing-4life.com	Abate Counselling 1800 222 833 info@abatecounselling.ie abatecounselling.ie	Workplace options 1800 490 390 eap@workplaceoptions.com workplaceoptions.com
Beaumont Hospital Dublin	01 809 2865 staffcounsellor@beaumont.ie			
Cappagh National Orthopaedic Hospital, Dublin	01 8140406 / hr@nohc.ie			
Coombe Women and Infants University Hospital				✔
Mater Misericordiae University Hospital			✔	
Mercy University Hospital	021-493 5307 or 021-427 1971 (bleep 6626) / occhealth@muh.ie			
National Maternity Hospital Holles Street		✔		
Rotunda Hospital		✔		
Royal Victoria Eye and Ear Hospital	01 634 3677 / 01 634 3671			
South Infirmary Victoria University Hospital	021 4926251 / hr.pa@sivuh.ie			
St. James Hospital*			✔	
St. John's Hospital, Limerick	061 462259 / 061 462163 helen.cashell@stjohnshospital.ie			
St. Luke's Hospital, Dublin	01 245 3513 occupational.health@slh.ie			
St. Michael's Hospital, Dun Laoghaire	01 6639886			
St. Vincent's University Hospital*		✔		
Temple Street Children's Hospital	01 8784398 / ohd@cuh.ie			

*HSE staff of Psychiatric Service should contact HSE EAP

For more support services, visit
Cornmarket.ie/lets-talk-about-it

Let's talk about it

28 days of wellbeing

A collection of bespoke articles, videos, podcasts and more brought together to support nurses and midwives.

Wellbeing	Self-care	Reflection	Coping	Community	Rejuvenate	Sleep
1 Resilience	2 Embracing self-care	3 The wellbeing situation: Covid-19	4 Dealing with stress & anxiety at work	5 Minding our mental health together	6 Space from stress	7 The importance of sleep
8 Breathing exercises	9 The importance of self-care	10 Myths & stigma around seeking support	11 Compassion fatigue and burnout in nurses and midwives	12 Becoming a mental health ally	13 Self-compassion, 'is it ok to just get on with it?'	14 Sleep and calm
15 Space for resilience	16 Starting the conversation on mental health	17 Making lifestyle changes for better health and wellbeing for nurses and midwives	18 Grounding in the moment	19 Supporting the wellbeing of your peers	20 Physical movement & how to reset your body	21 Sleep hygiene for shift work
22 Nutrition elements of a healthy lunch	23 What self-care activity do you have planned?	24 CBT & mindfulness skills for nurses and midwives	25 Recovering from stressful shifts	26 Signs of trauma	27 Muscle relaxation	28 Space for sleep

"I would encourage all our members to use all the mental health supports available to them. We are stronger coming through this pandemic by working together but so many of us are dealing with grief, trauma, and sadness at the toll taken on our patients, our lives, and our communities by this virus".

Karen McGowan, INMO President.

To register, visit
Cornmarket.ie/lets-talk-about-it

PLUS: Claim your free Weekly Wellbeing Planner!*

or use your phone camera to scan this QR code

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Bríd O'Meara
BUILDING A MENTAL WELLBEING CULTURE

*Weekly Wellbeing Planners will be posted to the first 2,000 INMO members who register for 28 days of wellbeing. Let's Talk About It, a mental health collective for INMO members, is brought to you by the INMO and Cornmarket.

17712 LTAI Ad 01-22

WILD-TYPE
ESTIM ATTR-CM

wtATTR-CM: A DISEASE THAT OFTEN GOES UNDETECTED[1]

Introducing the **wtATTR-CM estimATTR**—an online tool that was developed based on an artificial intelligence/machine learning (AI/ML) algorithm to learn how combinations of clinical conditions are associated with this underrecognised disease.[2-4]

Wild-type transthyretin amyloid cardiomyopathy (wtATTR-CM) is an underrecognised, progressive, infiltrative disease that can often be overlooked as a cause of heart failure.[1,3,4] Once diagnosed, untreated patients with wtATTR-CM have a median survival of ~3.5 years.[5-7]

The wtATTR-CM estimATTR is an easy-to-use educational tool that was built leveraging AI/ML and can estimate the probability of wtATTR-CM in hypothetical heart failure scenarios. The tool allows you to test various combinations of clinical conditions in a hypothetical patient, see what combinations are associated with wtATTR-CM, and help distinguish from heart failure due to other causes.[2] This tool is for educational purposes only, and it is not to be used in a clinical setting for the suspicion or diagnosis of wtATTR-CM in individual patients.

www.estimattr.ie

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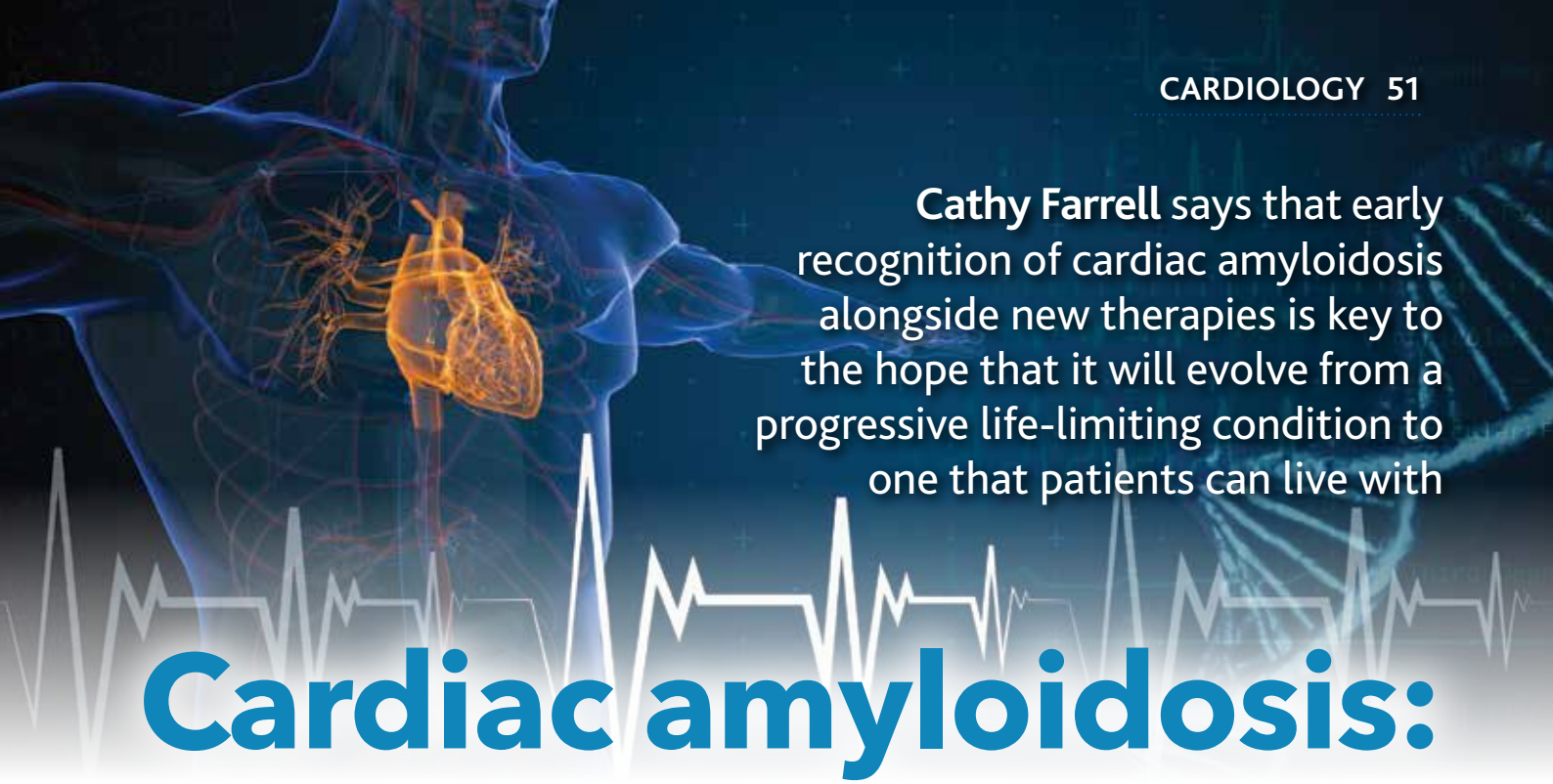
PP-RDP-IRL-0154 October 2021

Pfizer Rare Disease



Cathy Farrell says that early recognition of cardiac amyloidosis alongside new therapies is key to the hope that it will evolve from a progressive life-limiting condition to one that patients can live with

Cardiac amyloidosis: Diagnosis and treatment

AMYLOIDOSIS is a rare condition but awareness of it has increased in recent years due to the development of new treatments which can slow the progression of this disabling and life-limiting disease.

Amyloidosis is caused by abnormal deposition and accumulation of proteins in the tissues of the body. These proteins misfold and are insoluble and cannot be excreted by the body. The proteins infiltrate body organs displacing the organ tissues which leads to organ dysfunction. In the heart, the amyloid deposits displace myocardium and can cause cardiac enlargement with left ventricular hypertrophy (LVH), rhythm disruption and reduced efficiency of the heart pump function.

Amyloidosis is a progressive disorder resulting in premature death often due to heart failure or arrhythmias. It is important to get early diagnosis and correctly identify the type of amyloidosis as while it is associated with a poor prognosis, appropriate treatment is improving patient survival rates.

While this article aims to provide an overview of various types of amyloidosis, it will concentrate on cardiac amyloidosis with a focus on clinical suspicion and investigations required to diagnose and treat transthyretin amyloidosis (ATTR).

Types of amyloidosis

One of the most common type of amyloidosis involving the heart is immunoglobulin light chain (AL) or light chain amyloid. This occurs when plasma cells overproduce immunoglobulin light chain fragments which misfold to produce amyloid fibrils. It is critical to identify or rule out AL amyloidosis if clinically suspected due to clinical urgency as median survival of untreated patients with AL amyloid presenting with heart failure is around six months.[1]

Familial or hereditary amyloidosis occurs due to a mutation in the transthyretin (TTR) gene located in chromosome 18. A family history of amyloidosis should be enquired about if clinically suspected. There are more than 150 variants of hereditary amyloidosis (hATTR) and while it is considered a rare disease, there are pockets of hATTR around the world. In Europe, there are larger numbers in Sweden and Portugal while in Ireland there was a mutation (T60A) recognised in many families in Donegal and it is believed to originate from one man dating back to early 19th century. The majority of cases in Ireland are T60A.

While the European estimate of hATTR is 47 per 100,000 or < 0.0005%, it is estimated that the prevalence of hATTR is around 1% of the population of Donegal. Wild type transthyretin (wt-ATTR) is common in those over 70 years of age and was previously known as senile amyloidosis and often presents as a late onset restrictive cardiomyopathy. It has a better prognosis than other types of amyloidosis with median survival of three and a half years from diagnosis.

The delay in correct diagnosis is a significant problem and it is important that healthcare professionals are aware of the common presentations and red flags in order to expedite diagnosis. Until recently AL amyloidosis was treated as a medical emergency for urgent diagnosis and treatment with chemotherapy but ATTR amyloidosis had limited treatment options and management was supportive of symptoms and affected organ dysfunction.

Clinical clues and red flags

As amyloidosis is a systemic disorder, the presentation can vary. It is associated with significant delay in diagnosis of up to eight years.[2] It has multiple presentations but it commonly presents with neurological or cardiac symptoms.

Cardiac manifestations

Patients may present with typical signs and symptoms of heart failure such as shortness of breath, fatigue and lower limb oedema. They often have preserved ejection fraction and left ventricular hypertrophy on echocardiogram. Other cardiac presentations may include cardiac rhythm or conduction disorders such as atrial fibrillation, bundle branch blocks or complete heart blocks, but also may have chest pain with normal coronary arteries.

Patients with ATTR amyloidosis often have intolerance to traditional heart failure medications such as ACE inhibitors and beta-blockers, showing worsening symptoms of breathlessness or dizziness on these medications. Patients with heart failure of uncertain aetiology or with LVH without history of hypertension should be considered for assessment of amyloidosis.

Non-cardiac manifestations

hATTR amyloid often presents with neurological syndromes such as carpal

tunnel syndrome, peripheral neuropathy, orthostatasis or weakness, as well as gastrointestinal symptoms such as nausea, diarrhoea or constipation. wtATTRA is often accompanied by the same neurological syndromes as well as soft tissue issues such as lumbar stenosis or ruptured distal biceps tendon.

Diagnosis

Amyloidosis is often misdiagnosed for many reasons including the varied clinical presentations which may be neurological, cardiac or a mixture of both. Other reasons include lack of information on the disease, its rarity and use of insufficiently sensitive tests.[3] Most people with cardiac involvement present with signs and symptoms of heart failure. Symptoms occur because of infiltration of amyloid into myocardium which results in reduced contractility of myocardium and diastolic dysfunction. Common symptoms include fatigue and weakness, dyspnoea on exertion, leg oedema, dizziness (postural hypotension), ischaemic stroke, painful polyneuropathy and carpel tunnel syndrome.

Clinical signs found in amyloidosis are those often associated with heart failure such as pulmonary oedema or pleural effusion, raised jugular venous pressure (JVP), cardiac arrhythmias (atrial fibrillation, ventricular arrhythmias or heart blocks). Hypotension may be from low cardiac output or autonomic neuropathy. A change in speech pattern is often seen and can be an early feature of systemic amyloidosis.[1]

Laboratory tests

Initial evaluation will include laboratory testing of troponin and proBNP. Troponin is likely to be elevated at low but persistent levels while proBNP is likely to be elevated. A normal proBNP may exclude need for echocardiogram in those with low suspicion of amyloidosis. If amyloidosis is suspected, initial bloods tests will aim to rule out AL amyloidosis and should include free light chain ratios and serum and urine immunofixation. If present further investigations will be urgently required.

Echocardiogram

Two dimensional trans thoracic echocardiogram (TTE) is usually the next step in evaluation and may reveal the following:

- Preserved ejection fraction is most commonly seen with reduced ejection fraction seen later in the disease. Diastolic dysfunction is the most common finding worsening as disease progresses
- Thickened myocardium – left ventricular hypertrophy (LVH) in the absence of hypertension may suggest an infiltrative disease (not specifically amyloidosis) and is a common feature
- There will be a reduction in global longitudinal strain due to apical sparing, often reported as a 'bullseye' appearance[3]
- The left ventricle may have a speckled or sparkling appearance due to the amyloid deposits. There may be left atrium enlargement (or bi-atrial enlargement later in disease).

Electrocardiogram (ECG)

The following ECG features may be seen:

- Low voltage complexes (QRS amplitude ≤ 0.5 mV in limb leads or ≤ 1.0 mV in all precordial leads) is often present in amyloidosis and is due to displaced myocardium. It is a particular red flag in the presence if LVH on echocardiogram
- Atrial fibrillation or flutter most common arrhythmia but can also see heart blocks, bundle branch blocks
- There may be a pattern of pseudo-infarction in up to 70% of cases with Q waves present or T wave abnormalities
- Longer-term holter monitoring may show lack of heart rate variability reflecting autonomic dysfunction. It may also detect ventricular arrhythmias.

Cardiovascular magnetic resonance

Cardiovascular magnetic resonance (CMR) with late gadolinium enhancement (LGE) identifies myocardial infiltration when, after the administration of contrast, CMR shows a characteristic pattern of global subendocardial LGE. However it is often best seen in later stages of the disease, limiting its use in early stages of disease.

Nuclear imaging

Recent advances in nuclear medicine and molecular imaging have opened new windows to not only diagnosing cardiac amyloidosis, but also to identify the specific subtype, thus potentially allowing for early diagnosis and appropriate medical intervention. DPD scintigraphy can show the uptake of ATTR amyloidosis but is not seen in AL amyloidosis and can be a useful tool to confirm diagnosis and phenotype.

Radiolabeled serum amyloid P (SAP) component scintigraphy is used by scanning after injection of SAP to assess its distribution and extent of organ involvement.

Other testing

Genetic testing is required in ATTR amyloidosis to identify subtype of wild type or hereditary and TTR gene sequencing is recommended in all ATTR cardiomyopathy diagnosis. Pre-genetic counselling is recommended in healthy relatives of patients diagnosed with ATTR.

Endocardial biopsy is the gold standard for diagnosis of cardiac amyloidosis but due to the higher risk associated with this invasive procedure, many now receive diagnosis with CMR or DPD scan followed by genetic testing if appropriate.

Treatment

Until recently, supportive treatment of heart failure symptoms has been the mainstay of amyloidosis with education on fluid monitoring and balance adjusting loop diuretics as required. The traditional treatment of heart failure like betablockers and ACE inhibitors are not recommended as they can exacerbate the condition through further hypotension or bradycardia.

The survival of patients with AL has improved over the years with the advent of more effective chemotherapeutic regimens that kill the underlying plasma cell clone producing the unstable light chains. The treatment of AL amyloidosis is led primarily by the haematology team with collaboration with cardiology to manage fluid volume status as well as monitoring for and treating arrhythmias.

There have been significant developments over the past decade or so in the treatment of ATTR amyloidosis. As the liver produces the majority of TTR, up to now, orthotopic liver transplant was the main options for this disease in selected patients in specialised centres. It does not generally regress peripheral or autonomic neuropathy, but can stabilise disease. It is limited by risks associated by transplant surgery and continued progression of amyloid deposits particularly in the heart.

Recent advances have developed medical therapies which now seem to alter the disease progression. There are two main types of treatments:

TTR stabilisers

Diflunisal is a non-steroidal anti-inflammatory drug (NSAID) but is bound by TTR in the blood and trials are currently underway to assess if this binding will also slow the progression of amyloidosis. As there are considerable side effects of NSAIDs and not extensive evidence of its benefits as yet, it is recommended it is only initiated by specialists in amyloidosis. It is not yet licensed in Ireland.

Tafamidis was developed as a specific drug for ATTR amyloidosis and works by binding itself to the TTR at the thyroxine binding sites which stabilises the tetramer and slowing the dissociation into monomers, slowing the progression rate of amyloidosis. Tafamidis is licensed here but is not yet reimbursed by the HSE.

Gene silencers

Gene silencers are new medications for ATTR-related neuropathy which have recently been shown to prevent production of TTR in the liver by using different genetic targets in the liver.

- Patisiran has been shown to reverse neuropathy in the APOLLO trial and resulted in a median 81% decrease in serum TTR from baseline. It is administered as an intravenous infusion every 21 days
- Inotersen is another gene silencer which is administered weekly as a subcutaneous injection. It was shown in the NEURO-TTR trial to have a median of 77% reduction in serum TTR levels.

Patisiran is licensed for use in patients with hATTR amyloidosis who have stage 1 or 2 polyneuropathy and was approved by the HSE for reimbursement in 2021. Inotersen is indicated for the treatment of stage 1 or 2 polyneuropathy in adult patients with hATTR. It has been authorised for use in the EU by the EMA and is currently under review in Ireland by the National Centre for Pharmacoeconomics.

The development of these new therapies has offered a new lifeline to those currently affected by ATTR amyloidosis with neuropathy and further studies are underway to determine if there is any benefit in those with ATTR without clinical signs of neuropathy. Additionally, the ethical issues and timing regarding treatment of those diagnosed as part of familial screening needs to be addressed.

Medication cautions

Along with awareness of new treatments for amyloidosis it is important that healthcare professionals are aware of drugs that need to be avoided or used with caution. These include the following:

- The calcium channel blockers diltiazem and verapamil which are contraindicated due to their negative inotropic effects and they can precipitate heart failure
- Digoxin, which binds to amyloid fibrils and can predispose patients to digoxin toxicity so if used should only have low dose and blood levels must be carefully monitored
- Amiodarone, which may cause atrioventricular conduction disturbances but is better tolerated than other drugs in atrial fibrillation but should not be used in addition to digoxin.

Conclusion

Cardiac amyloidosis is often misdiagnosed and underdiagnosed, but current advances in treatment of the disease have highlighted the need to be aware of common 'red flags' and clues to allow for earlier treatments to be started.

The new therapies offer hope of stabilising ATTR amyloidosis, perhaps offering hope of living with this as a chronic disease instead of the progressive life-limiting disease it has been.

Early diagnosis will be key in this transition and further studies will need to address the optimal timing of initiating treatments in those found through screening.

Cathy Farrell is an advanced nurse practitioner specialising in heart failure at the Donegal Integrated Service for Heart Failure

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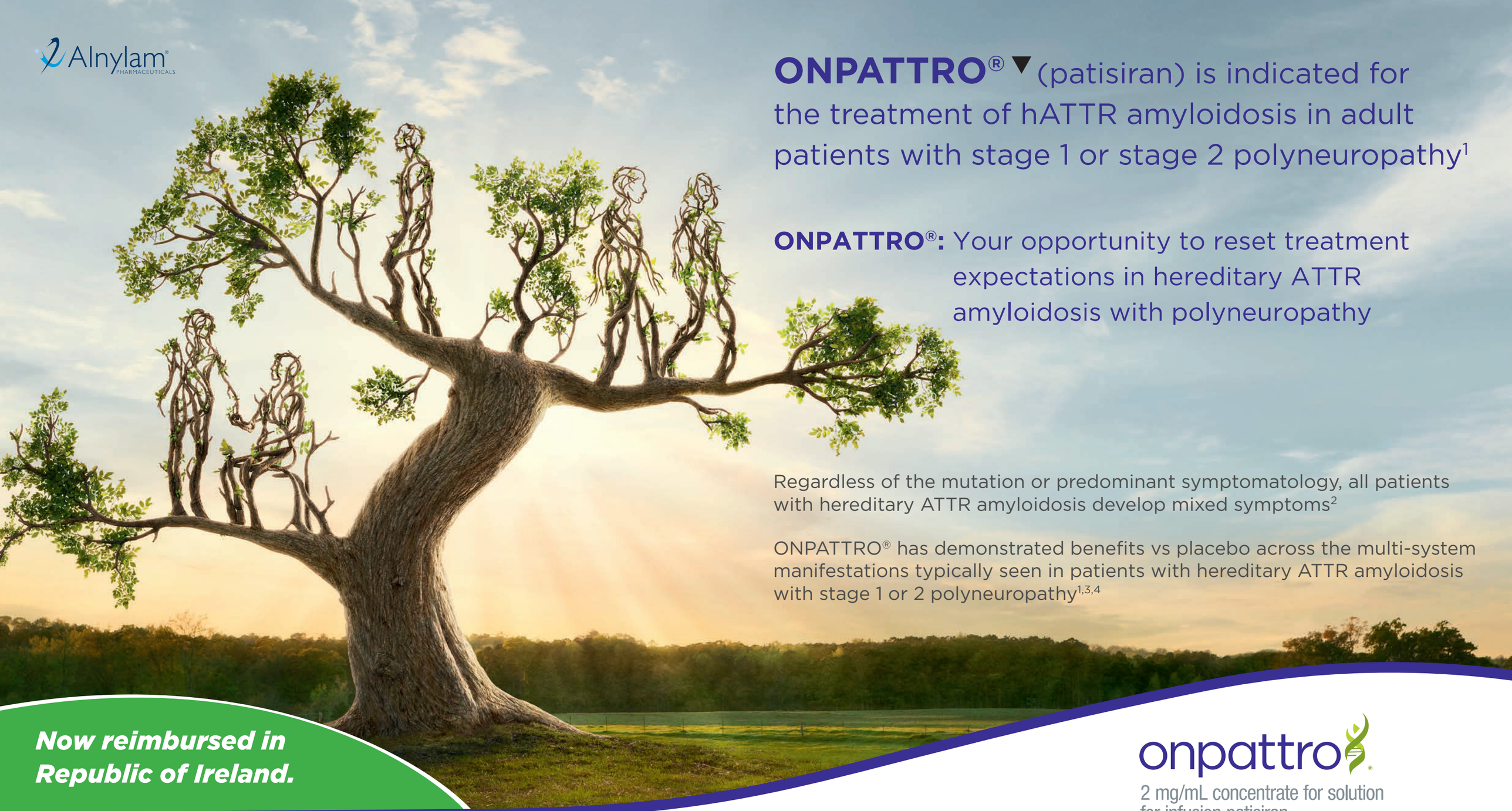

ONPATTRO® ▼ (patisiran) is indicated for the treatment of hATTR amyloidosis in adult patients with stage 1 or stage 2 polyneuropathy[1]

ONPATTRO®: Your opportunity to reset treatment expectations in hereditary ATTR amyloidosis with polyneuropathy

Regardless of the mutation or predominant symptomatology, all patients with hereditary ATTR amyloidosis develop mixed symptoms[2]

ONPATTRO® has demonstrated benefits vs placebo across the multi-system manifestations typically seen in patients with hereditary ATTR amyloidosis with stage 1 or 2 polyneuropathy[1,3,4]

Now reimbursed in Republic of Ireland.

onpattro®

2 mg/mL concentrate for solution for infusion patisiran

Onpattro® (patisiran) Abbreviated Prescribing Information - Republic of Ireland

Please refer to the Summary of Product Characteristics for further information. Name of the Medicinal Product: Onpattro (patisiran) 2 mg/mL concentrate for solution for infusion. **Qualitative and quantitative composition:** Each mL contains patisiran sodium equivalent to 2 mg patisiran. Each vial contains patisiran sodium equivalent to 10 mg patisiran formulated as lipid nanoparticles. **Therapeutic Indication:** Onpattro is indicated for the treatment of hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) in adult patients with stage 1 or stage 2 polyneuropathy. **Posology and method of administration:** The recommended dose of Onpattro is 300 micrograms per kg body weight administered via intravenous (IV) infusion once every 3 weeks. Dosing is based on actual body weight. For patients weighing ≥ 100 kg, the maximum recommended dose is 30 mg. Vitamin A supplementation at approximately 2500 IU vitamin A per day is advised for patients treated with Onpattro. All patients should receive premedication prior to Onpattro administration to reduce the risk of infusion- related reactions (IRRs). Each of the following medicinal products should be given on the day of Onpattro infusion at least 60 minutes prior to the start of infusion: • Intravenous corticosteroid (dexamethasone 10 mg, or equivalent) • Oral paracetamol (500 mg) • Intravenous H1 blocker (diphenhydramine 50 mg, or equivalent) • Intravenous H2 blocker (ranitidine 50 mg, or equivalent). If clinically indicated, the corticosteroid may be tapered in decrements no greater than 2.5 mg to a minimum dose of 5 mg of dexamethasone (intravenous, IV), or equivalent. The patient should receive at least 3 consecutive IV infusions of Onpattro without experiencing IRRs before each reduction in corticosteroid premedication. Therapy should be initiated under the supervision of a physician knowledgeable in the management of amyloidosis. **Consult the summary of product characteristics for further details about the method of administration. Contraindications:** Severe hypersensitivity (e.g., anaphylaxis) to the active substance or any of the excipients. **Special warnings and precautions for use:** IRRs have been observed in patients treated with Onpattro. In patients experiencing an IRR, the majority experienced the first IRR within the first 2 infusions. Across clinical studies, the most common symptoms (reported in ≥ 2% of patients) of IRRs were flushing, back pain, nausea, abdominal pain, dyspnoea, and headache. IRRs may also include but are not limited to hypotension, syncope and pruritus. To reduce the risk of IRRs, patients should receive premedications on the day of Onpattro infusion, at least 60 minutes prior to the start of infusion. If an IRR occurs, slowing or interrupting the infusion and institution of medical management (e.g., corticosteroids or other symptomatic treatment) should be considered, as clinically indicated. If the infusion is interrupted, resumption of the infusion at a slower infusion rate may be considered after symptoms have resolved. The Onpattro infusion should be discontinued in the case of a serious or life-threatening IRR. Some patients who experience IRRs may benefit from a slower infusion rate or additional or higher doses of one or more of the premedications with subsequent infusions to reduce the risk of IRRs. By reducing serum TTR protein, Onpattro treatment leads to a decrease in serum vitamin A (retinol) levels. Serum vitamin A levels below the lower limit of normal should be corrected and any ocular symptoms or signs due to vitamin A deficiency should be evaluated prior to initiation of treatment with Onpattro. Patients receiving Onpattro should take oral supplementation of approximately 2500 IU vitamin A per day to reduce the potential risk of ocular toxicity due to vitamin A deficiency. Referral for ophthalmological assessment is recommended if patients develop ocular symptoms suggestive of vitamin A deficiency, including reduced night vision or night blindness, persistent dry eyes, eye inflammation, corneal inflammation or ulceration, corneal thickening or corneal perforation. Serum vitamin A levels should not be used to guide vitamin A supplementation during treatment with Onpattro. **Fertility, pregnancy and lactation:** There are no data on the effects of Onpattro on human fertility. No impact on male or female fertility was detected in animal studies.There are no data on the use of Onpattro in pregnant women. Animal studies are insufficient with respect to reproductive toxicity. Due to the potential teratogenic risk arising from unbalanced vitamin A levels, Onpattro should not be used during pregnancy, unless the clinical condition of the woman requires treatment. As a precautionary measure, vitamin A and thyroid stimulating hormone (TSH) levels should be obtained early in pregnancy. Close monitoring of the foetus should be carried out in the event of an unplanned pregnancy, especially during the first trimester. Women of childbearing potential have to use effective contraception during treatment with Onpattro. It is unknown whether Onpattro is excreted in human milk. A decision must be made whether to discontinue breast-feeding or to discontinue/abstain from Onpattro, taking into account the benefit of breast feeding for the child and the benefit of therapy for the woman. **Undesirable effects:** The most frequently occurring adverse reactions reported in Onpattro-treated patients were peripheral oedema (29.7%) and infusion-related reactions (18.9%). The only adverse reaction resulting in the discontinuation of Onpattro was an infusion-related reaction (0.7%). The adverse reactions are presented below as MedDRA preferred terms under the MedDRA System Organ Class (SOC) by frequency. Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. The frequency of the adverse reactions is expressed according to the following categories: *Very common (≥ 1/10):* Infusion-related reaction, Peripheral oedema. *Common (≥ 1/100 to < 1/10):* Bronchitis, Sinusitis, Rhinitis, Vertigo, Dyspnoea, Dyspepsia, Erythema, Arthralgia, Muscle spasms. *Uncommon (≥ 1/1,000 to < 1/100):* Extravasation. **Prescribers should consult the Summary of Product Characteristics for further details of the above and for details of other adverse reactions. Marketing Authorisation Number:** EU/1/18/1320/001. **Additional information is available from the Marketing Authorisation Holder:** Alnylam Netherlands B.V. Antonio Vivaldistraat 150 1083 HP Amsterdam, Netherlands. **Legal Classification:** Medicinal product subject to restricted medical prescription. **Pack size and Price:** €8520.84 per vial (10mg/5ml) of Onpattro (patisiran) concentrate for solution for infusion. **Date of last revision:** 09/2021. **Version Final:** TTR02-IRL-00016.

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ATTR, TTR amyloidosis; hATTR, hereditary ATTR amyloidosis; TTR, transthyretin.
Developed and produced by Alnylam Pharmaceuticals

Adverse events should be reported. Reporting forms and information can be found at HPRA Pharmacovigilance, Website: https://www.hpra.ie/homepage/about-us/report-an-issue/human-adverse-reaction-form

Adverse events should also be reported to Alnylam Netherlands B.V. at 1800 924260 (+353 7 667 05596) or medinfo@alnylam.com

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October 2021 | TTR02-IRL-00028

CONFIDENCE *not* COMPROMISE

OTEZLA® can offer solutions to the challenges in this new environment

OTEZLA® has an established efficacy and safety profile for up to 5 years†[1,2]

No warnings regarding risk of serious infection[2]

No contraindications for concurrent use with live vaccination[2]

A short half-life of 9 hours
Means that OTEZLA® is rapidly cleared from the body if administration needs to be stopped[2]

Minimise frequency of clinical appointments
No laboratory pre-screening, and no drug specific blood monitoring required[2]

Immunomodulatory mode of action[2]
Confidence not compromise in immune response, down-regulation of pro-inflammatory cytokines and up-regulation of anti-inflammatory cytokines

Make OTEZLA® the positive choice for your psoriasis and psoriatic arthritis patients

Otezla® (apremilast) 30mg tablets

OTEZLA® (apremilast) 10mg, 20mg and 30mg film coated-tablets Brief Prescribing Information. Refer to the Summary of Product Characteristics (SPC) before prescribing. Further information is available upon request. Presentation: 10mg, 20mg and 30mg film coated-tablets. **Indications:** Psoriatic arthritis: OTEZLA, alone or in combination with Disease Modifying Antirheumatic Drugs (DMARDs), is indicated for the treatment of active psoriatic arthritis (PsA) in adult patients who have had an inadequate response or who have been intolerant to a prior DMARD therapy. Psoriasis: OTEZLA is indicated for the treatment of moderate to severe chronic plaque psoriasis in adult patients who failed to respond to or who have a contraindication to, or are intolerant to other systemic therapy including ciclosporine, methotrexate or psoralen and ultraviolet-A light (PUVA). **Dosage and administration:** Treatment with OTEZLA should be initiated by specialists experienced in the diagnosis and treatment of psoriasis or psoriatic arthritis. The recommended dose of OTEZLA is 30mg twice daily taken orally in the AM and PM, approximately 12 hours apart, with no food restrictions. The film-coated tablets should be swallowed whole. An initial dose titration is required per the following schedule: Day 1: 10mg in the AM; Day 2: 10mg in the AM and 10 mg in the PM; Day 3: 10mg in the AM and 20mg in the PM; Day 4: 20mg in the AM and 20mg in the PM; Day 5: 20mg in the AM and 30mg in the PM; Day 6 and thereafter: 30mg twice daily in the AM and PM. No re-titration is required after initial titration. If patients miss a dose, the next dose should be taken as soon as possible. If it is close to the time for their next dose, the missed dose should not be taken and the next dose should be taken at the regular time. Patients with severe renal impairment: The dose of OTEZLA should be reduced to 30mg once daily in patients with severe renal impairment (creatinine clearance of less than 30mL per minute estimated by the Cockcroft-Gault equation). For initial dose titration in this group, it is recommended that OTEZLA is titrated using only the AM doses and the PM doses be skipped. Paediatric population: The safety and efficacy of OTEZLA in children aged 0 to 17 years have not been established. No data is available. **Contraindications:** Hypersensitivity to the active substance(s) or to any of the excipients. OTEZLA is contraindicated in pregnancy. Pregnancy should be excluded before treatment can be initiated. **Special warnings and precautions:** Diarrhoea, nausea and vomiting: Severe diarrhoea, nausea, and vomiting associated with the use of OTEZLA have been reported. Most events occurred within the first few weeks of treatment. In some cases, patients were hospitalized. Patients 65 years of age or older may be at a higher risk of complications. Discontinuation of treatment may be necessary. Psychiatric disorders: OTEZLA is associated with an increased risk of psychiatric disorders such as insomnia and depression. Instances of suicidal ideation and behaviour, including suicide, have been observed in patients with or without history of depression. The risks and benefits of starting or continuing treatment with OTEZLA should be carefully assessed if patients report previous or existing psychiatric symptoms or if concomitant treatment with other medicinal products likely to cause psychiatric events is intended. Patients and caregivers should be instructed to notify the prescriber of any changes in behaviour or mood and of any suicidal ideation. If patients suffered from new or worsening psychiatric symptoms, or suicidal ideation or suicidal attempt is identified, it is recommended to discontinue treatment with OTEZLA. Severe renal impairment: See dosage and administration section. Underweight patients: OTEZLA may cause weight loss. Patients who are underweight at the start of treatment should have their body weight monitored regularly. In the event of unexplained and clinically significant weight loss, these patients should be evaluated by a medical practitioner and discontinuation of treatment should be considered. Lactose content: Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicinal product. **Interactions:** Co-administration of strong cytochrome P450 3A4 (CYP3A4) enzyme inducer, rifampicin, resulted in a reduction of systemic exposure of OTEZLA, which may result in a loss of efficacy of OTEZLA. Therefore, the use of strong CYP3A4 enzyme inducers (e.g. rifampicin, phenobarbital, carbamazepine, phenytoin and St. John's Wort) with OTEZLA is not recommended. In clinical studies, OTEZLA has been administered concomitantly with topical therapy (including corticosteroids, coal tar shampoo and salicylic acid scalp preparations) and UVB phototherapy. OTEZLA can be co-administered with a potent CYP3A4 inhibitor such as ketoconazole, as well as with methotrexate in psoriatic arthritis patients and with oral contraceptives. **Pregnancy, lactation and fertility:** Women of childbearing potential should use an effective method of contraception to prevent pregnancy during treatment. OTEZLA should not be used during breast-feeding. No fertility data is available in humans. **Undesirable effects:** Psychiatric disorders: In clinical studies and post-marketing experience, uncommon cases of suicidal ideation and behaviour, were reported, while completed suicide was reported post-marketing. The most commonly reported adverse reactions with OTEZLA in these indications are gastrointestinal (GI) disorders including diarrhoea (15.7%) and nausea (13.9%). These GI adverse reactions generally occurred within the first 2 weeks of treatment and usually resolved within 4 weeks. Adverse reactions reported in the psoriatic arthritis and/or psoriasis clinical trial programme and post marketing experience include: very common (≥ 1/10) diarrhoea*, nausea*; common (≥1/100 to <1/10) bronchitis, upper respiratory tract infection, nasopharyngitis*, decreased appetite*, insomnia, depression, migraine*, tension headache*, headache*, cough, vomiting*, dyspepsia, frequent bowel movements, upper abdominal pain*, gastroesophageal reflux disease, back pain*, fatigue; uncommon (≥1/1,000 to <1/100) hypersensitivity, suicidal ideation and behaviour, gastrointestinal haemorrhage, rash, urticaria, weight loss; not known (cannot be estimated from the available data) angioedema. *At least one of these adverse reactions was reported as serious. Please consult the SPC for a full description of undesirable events. **Pharmaceutical Precautions:** Do not store above 30°C. **Legal category:** POM. **Presentation and Marketing Authorisation Numbers:** Initiation pack containing 27 film coated tablets (4 x 10mg, 4 x 20mg, 19 x 30mg) - EU/1/14/981/001; 30mg film coated tablets in a pack size of 56 tablets - EU/1/14/981/002. **Marketing Authorisation Holder:** Amgen Europe B.V. Minervum 7061, 4817 ZK Breda, The Netherlands. Further information is available from Amgen Ireland Limited, 21 Northwood Court, Santry, Dublin D09 TX31. OTEZLA is a trademark owned or licensed by Amgen Inc., its subsidiaries, or affiliates. **Date of preparation:** April 2020 (Ref: IE-OTZ-2000019).

Adverse reactions/events should be reported to the Health Products Regulatory Authority (HPRA) using the available methods via www.hpra.ie. Adverse events should also be reported to Amgen Limited on +44 (0)1223 436441.

† Otezla met the primary endpoint of the pivotal trials in psoriasis: PASI-75 response vs placebo at 16 weeks. **ESTEEM 1:** 33.1% (N=562) vs 5.3% (N=282); **ESTEEM 2:** 28.8% (N=274) vs 5.8% (N=137), P<0.0001. OTEZLA met the primary endpoint of the pivotal trials in Psoriatic Arthritis: ACR 20 response vs placebo at 16 weeks. **PALACE 1:** 38% (N=168) vs 19% (N=168), P≤0.001. **PALACE 2:** 32% (N=162) vs 19% (N=159) P≤0.01; **PALACE 3:** 41% (N=167) vs 18% (N=169) P≤0.001.[2]

References: 1. Kavanaugh *et al.* Arthritis Research & Therapy 2019: 21;118. **2.** OTEZLA (apremilast). Summary of Product Characteristics.

Amgen Ireland Ltd., 21 Northwood Court, Santry, Dublin 9
IE-OTZ-0820-00002 | Date of preparation: September 2020

AMGEN®

Psoriasis: Not just skin deep

Eadaoin Redmond discusses the diagnosis and treatment of psoriasis and the importance of the nurse-patient relationship in its management

PSORIASIS is a chronic autoimmune skin disease affecting 1-4% of the world's population.[1] Psoriasis is not infectious and does not scar the skin. The epidermis contains skin cells which are continuously being replaced, a process that normally takes between three and four weeks. In psoriasis, skin cells divide more quickly so that cells are formed and shed in as little as three to four days.[2]

This process causes raised plaques of inflammation that can look pink or red on fair skin and more pigmented on darker skin. The plaques can have a layer of silvery white scale on top which is made up of immature keratin cells.

Psoriasis has multifactorial aetiology including genetic and non-genetic factors such as smoking, drinking, diet, drugs, infection and mental stress. Once thought to be just a skin disease, we now know that psoriasis also affects nails and joints.

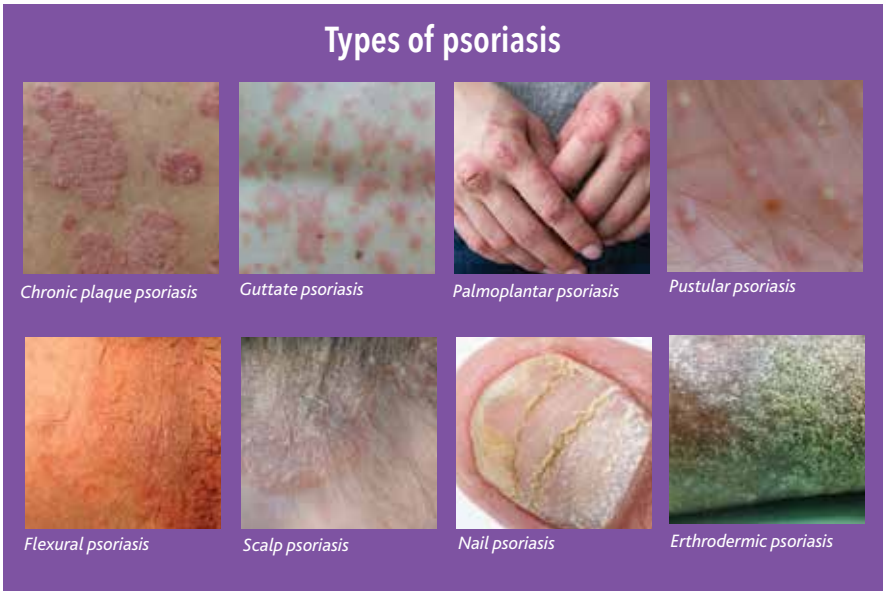
Moderate to severe psoriasis is associated with a higher prevalence of comorbidities such as diabetes, heart disease, obesity, venous thromboembolism, stroke, high cholesterol, hypertension, non-alcoholic fatty liver disease and inflammatory bowel disease.[3]

Apart from the debilitating effect psoriasis can have on a patient's physical health, it also affects the patient's mental health as it interferes with daily routine, work and social relationships. Psoriasis can negatively affect self-confidence and self-esteem and patients are often embarrassed or worried about what others might think. Therefore psoriasis is also associated with an increased risk of anxiety, depression and harmful use of alcohol.

Symptoms

Psoriasis can be itchy, especially in sites such as the scalp and lower legs. Psoriasis on the hands and feet can develop deep cracks or fissures. These are often very painful and affect the patient's ability to walk or use their hands. Psoriasis can cause the nails to thicken and lift, and it can be quite painful when the nail lifts from the finger. Psoriatic arthritis causes pain and inflammation in the joints, which can lead to swelling and stiffness of the joint, affecting the mobility of the patient. Apart from the visual presentation of psoriasis, some patients do not report any other associated symptoms.

Types of psoriasis



Chronic plaque psoriasis is the most common type of psoriasis and can be characterised by large plaques on the knees, elbows, trunk and scalp.

Guttate psoriasis is small teardrop-like plaques scattered all over the body. This type of psoriasis is more common in children or young adults and can be associated with *Streptococcus* which causes throat infections.

Palmoplantar psoriasis occurs on the hands and feet and this type of psoriasis can be quite thick and can crack which causes painful fissures.

Pustular psoriasis is a rare type of psoriasis where little yellow pus-filled spots appear within the plaques of psoriasis. When this happens it is a sign that psoriasis is becoming unstable and will require hospital admission.

Flexural psoriasis affects the folds of the body and genital area. This type of psoriasis is normally smooth and without scale. It can also be prone to candida.

Scalp psoriasis is very common and normally can be identified by silver scaling in the scalp.

Nail psoriasis is characterised by pitting, thickening (onycholysis), yellowing and ridging of the nails. It is associated with inflammatory arthritis.

Erthrodermic psoriasis is a rare presentation, when the plaques of psoriasis start to join up and there is very little normal

skin left visible. This will require hospital treatment.

Aggravating factors

A number of different factors can aggravate and cause a flare of psoriasis;infections such as streptococcal tonsillitis can often flare guttate psoriasis. Psoriasis can also occur in areas of injury or trauma – this is called a Kobner phenomenon. Medications such as betablockers, lithium and antimalarials can trigger a flare, as can the stopping of oral steroids or strong topical corticosteroids.

Stress plays a critical role in the occurrence, development and aggravation of psoriasis. Obesity, smoking and excessive alcohol can all trigger psoriasis but are also associated with poor response to psoriasis treatments, therefore it is important to take a multidisciplinary approach to the treatment of psoriasis.[4]

Assessment and diagnosis

A GP or dermatologist would normally diagnose psoriasis on appearance and rarely a skin biopsy would be required. After diagnosis psoriasis should be assessed using a variety of tools and scores. The Psoriasis Area and Severity Index (PASI) measures the severity and extent of the psoriasis. It measures the erythema, thickness, scaling and the extent of the area on the body affected by psoriasis.

The Dermatology Life Quality Index (DLQI) measures the impact the disease is having on the quality of the patient's life. The Psoriasis Epidemiology Screening Tool (PEST) is a screening tool for patients with psoriatic arthritis. Combining these assessment tools can give an individualised patient specific treatment plan and when used at each clinical visit will also assess the response to treatment. Blood pressure, BMI, blood sugar and lipid profile are used to evaluate for comorbidities for psoriasis.

Treatment

Currently there is no cure for psoriasis but there are many effective treatments to control and manage it.

Topical therapy

Topical therapy is normally used to treat mild psoriasis. It comes in many forms such as creams, gels, ointments, pastes and liquid. Emollients and soap substitutes are used to hydrate the skin and remove scale leaving the skin more comfortable and less itchy. Tar and salicylic acid preparations are used to descale and reduce the thickness of psoriasis, but tar smells and is quite messy, so patients often take a dislike to this option.

Topical corticosteroids reduce inflammation in the skin, they come in many different strengths therefore it is paramount that they are used as directed by the doctor, if used inappropriately they can result in skin thinning and rebounding of psoriasis.

Topical calcineurin inhibitors also work by reducing inflammation and are often used as steroid sparing agents. They can cause stinging initially but this subsides after a few days.

Vitamin D analogues (calcipotriol) reduce the abnormal proliferation that occurs in psoriasis, normalising skin growth. They are well tolerated but can cause stinging or irritant dermatitis. Vitamin D analogues are often combined with topical steroids to provide a more effective treatment.

There are several emollients on the market and it can be quite confusing for patients. The dermatology nurse can help the patient to select an emollient regime to suit the patient and give practical demonstrations of application.

Phototherapy

Phototherapy is the delivery of a specific type of ultraviolet light in a controlled environment to treat skin disease. Patients would normally attend the department twice or three times weekly depending on the treatment selected and a full course of phototherapy usually takes eight to 10 weeks. Some courses may be longer or shorter depending on how the skin is responding to treatment.

Initially patients will be in UV cabinets for seconds but will work up to minutes as the dose is increased with each visit. Phototherapy cabinets are maintained by medical physics to ensure the safe delivery of ultraviolet light. The two types of light used in phototherapy are UVB/TLO1 and PUVA. PUVA requires a light sensitising agent prior to treatment, which can be taken as a tablet or added to water.

Treatment with these UV wavelengths has an anti-inflammatory/ immunosuppressive effect on the skin. Phototherapy is usually more effective than natural sunlight as the harmful and ineffective sunlight rays are filtered out to minimise the risk of burning. The patients skin will be MED (minimal erythema dose) tested prior to treatment to identify the correct dose of light required to treat the psoriasis effectively and safely, and progress will be monitored by the nurse and dermatologist. The amount of UV exposure is recorded and monitored by the dermatology nurse.

Phototherapy is an effective treatment for mild to moderate psoriasis. It is generally well tolerated by the patient but requires a commitment from them to attend regularly. Some patients can have a polymorphous light eruption (prickly heat) but this can be managed with lower doses and topical steroids. Phototherapy would not be suitable for a patient who lives far away from a centre as travel commitment would be overwhelming.

Phototherapy can increase skin aging such as wrinkles and freckles and can increase the risk of skin cancer.

Systemic non-biological medications

Systemic treatment (tablet or injection) is normally indicated for moderate to severe psoriasis when phototherapy has been ineffective, or the patient is not suitable for phototherapy. Bloods will be taken prior to treatment and monitored throughout treatment. The correct systemic agent will be chosen after an assessment from the consultant and discussion with the patient about lifestyle factors, as each of the medications carries its own risk and benefit. Therefore it is appropriate that the medication be specific to each individual patient.

Methotrexate is an immunosuppressant medication. It is normally taken once a week in tablet or injection form. Methotrexate can be used long-term but side effects include nausea and tiredness. It is important to avoid pregnancy as methotrexate can cause foetal harm. Excess alcohol should also be avoided.

Ciclosporin is an immunosuppressant used in a short-term to treat psoriasis. Ciclosporin comes in tablet form and is taken twice daily. Patients usually respond effectively and quickly to ciclosporin, but it is normally only prescribed for eight to 12 weeks due to side-effects of hypertension, renal failure and increased risk of infection and skin cancer.

Apremilast is a type of immunosuppressant agent that works inside inflammatory cells to help reduce the overactive inflammation in psoriasis. It is prescribed for patients unsuitable for or who have failed other systemic and biologic medication. Apremilast comes in tablet form taken twice daily. It is well tolerated, and no monitoring or testing is required for patients receiving this medication. However, it is associated with an increase in depression and weight loss.

Acitretin is a retinoid and works by slowing down cell growth in the skin and is very effective in palmoplantar psoriasis. Acitretin is a tablet taken once a day.

It can cause serious damage to an unborn child and the drug remains in the body for up to three years, therefore it is not normally prescribed to women of childbearing age. People receiving acitretin cannot give blood for three years after stopping in case the donated blood was received by a pregnant woman. Acitretin can cause the skin to be more fragile and peel and can also cause dryness of lips, nose and eyes.

Biological therapies

Biological drugs are designed to mimic normal human molecules. They are targeted to block specific cytokines (TNF-alpha, IL23, IL-17a, IL-12) that cause inflammation in psoriasis. These drugs are delivered by subcutaneous injection except for infliximab which is given by intravenous infusion. They are very effective in the treatment of moderate to severe psoriasis but are quite expensive. The main side effect of biologics is that they are immunosuppressive and raise the risk of infection and may increase the risk of developing cancer. Therefore pre-screening for underlying conditions such as TB, HIV, HBV, HAV and HCV is required, along with regular blood monitoring, vaccination (flu, meningococcal and Covid-19) and regular smear tests.

Upper respiratory tract infections and injection site reactions are common while receiving therapy. Infliximab, adalimumab and etanercept are tumour necrosis inhibitors (anti-TNF). Ustekinumab is an interleukin (IL)-12/23 antagonist. Secukinumab, guselkumab, ixekizumab and risankizumab are IL-17 antagonists. Each biologic has different dosing requirements from twice weekly to once every three months.

Environmental factors and role of the nurse

The psychosocial disability of psoriasis has been equated with that suffered by patients with cancer, arthritis, hypertension, heart disease, diabetes and depression.[5] Patients are often embarrassed by the disease and can avoid social activates such as swimming, gyms and dating for fear of social rejection. Alcohol and smoking are often used as coping mechanisms to deal with stress and social anxiety.

To be effective in helping the patient in managing this disease, a compassionate, knowledgeable approach is required from the nurse. This will help to develop the patient's trust and encourage open conversation about social behaviours and management of psoriasis.

When a therapeutic relationship is established between the nurse and patient, sensitive advice with regard to limiting alcohol, smoking, weight management and stress is received more positively. Practical steps can be taken towards managing harmful behaviours and patients can be linked in with relevant support groups.

Eadaoin Redmond is a CNM2 in dermatology at St Vincent's University Hospital in Dublin

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Breast pump loans:
Report on a quality initiative

The Parentcraft team at Our Lady of Lourdes Hospital, Drogheda takes a look at how hospital pump loans are benefitting breastfeeding

THEME four of the HSE's Breastfeeding Action Plan 2016-2021 states that hospitals should "provide access to suitable breast pumps free of charge to all mothers of preterm and hospitalised infants, and breastfeeding mothers hospitalised after maternity/paediatric discharge (*Health and health reform Section 3.8*)

This is a recognised standard, however, this standard has not yet been achieved at a national level. This is important because breastfeeding is the optimum way to feed a baby.[1] In recognition of the benefits of breastfeeding to mother, baby and society, providing support while initiating and maintaining breastfeeding is paramount to the longevity of optimum breastfeeding.

It is also vital in achieving the key performance indicator of a 10% increase in breastfeeding rates in Ireland over a five-year period as stated in the action plan 2016-2021.[2] It places people's needs defining change at the centre of all change initiatives.[3]

Statistics

Our current breastfeeding initiation rate, on average, is 58% per annum. Our 2021 figures were skewed by the cyber attack on HSE software. A form was created to facilitate manual collection of data which was previously entered into the hospital MIS system. As a result of there being no computerised database system during that time, figures pertaining to breastfeeding were gathered from staff's handwritten discharge information on mothers and babies. The breastfeeding initiation rate of 58% captures women who commenced any breastfeeding in 2021. By discharge, 33% of women were found to be exclusively breastfeeding. The number of women who were mixed feeding on discharge in 2021 was 18% and this was noted to have increased on the 2018 figures by 3%. This highlights that more women are choosing to give breast milk.

Our aim

As the HSE Breastfeeding Action Plan states the intention is to provide suitable breast pumps free of charge to all mothers of preterm and hospitalised infants, and breastfeeding mothers hospitalised after maternity/paediatric discharge. In its absence we put in place a plan here in the hospital to address this.[2]

Our aim is to meet the needs of women breastfeeding for premature and sick

babies by providing support through provision of pumps. This helps mothers to express breast milk to provide optimum nutrition to their baby which results in a shorter hospital stay for the baby. We provide information on rental systems and recommend the use of a hospital grade pump for a premature baby based on the understanding of better outcomes in milk supply and longevity of breastfeeding.

Currently, pump rental is available at a reduced cost from some companies to such women. There is also a charity-based organisation with limited pump supply for premature babies, the Neonatal Health Alliance. We begin our preparation for discharge on our first encounter.

In 2008 we had one hospital grade pump which was lent to women on an ad hoc basis by the department. This continued for a number of years. From our records we can see in 2020 this pump was used by 12 mothers. The demand for the pump was increasing, due to the number of women wishing to express breast milk for their premature baby.

In recognition of the benefits of a pump loan we sourced funding for two further pumps. One pump was funded by a previous quality initiative which saw an estimated saving of €5,000 a year to the hospital. We completed a procurement form and secured two further hospital grade pumps. In light of the breastfeeding action plan, this proposal was supported by management and relevant stakeholders, including the director of midwifery. We also welcomed the recent proposal by the Minister for Health to provide lactation support in the community through the appointment of 26 further lactation consultants.

During the time the pump is on loan, we maintain contact with the mother until such time she secures a pump herself or the baby has transitioned to direct breastfeeding. On average, the mother required the loan of the pump for two weeks. Mothers of very premature babies usually borrow the pump for five to seven days and then usually rent their own pump or we can extend the loan time. During this time they become familiar with its use as well as the transport and storage of milk. In the case of a late premature baby, the loan period can be up to two weeks, at which time the baby has transitioned to direct breastfeeding.

Proposed intervention

The proposed intervention was to achieve the aim stated in Theme Four of the HSE's action plan through a hospital-based pump loan system. The arrival of a preterm or sick baby can be a stressful time for families and the need to avail of a hospital grade breast pump can be an added unexpected stress. Our initiative has helped to provide women with a breast pump during their stay in hospital and when they are discharged home.

"The HSE Breastfeeding Action Plan 2016-2021 is an important step in ensuring that all children in Ireland get the best possible start in life. It is a valuable resource, providing direction for all of us who are working to promote and improve the health of the population, in supporting families who are breastfeeding their babies.

"The Healthy Ireland framework for Improved Health and Well-being 2015-2017 and the HSE Healthy Ireland in the Health Services Implementation Plan seek to improve the health and well-being of the population by increasing the proportion of the population that are healthy at all stages of life and reducing health inequalities. The promotion, support and protection of breastfeeding is a key element of the HSE Healthy Childhood Policy Priority Programme and the Nurture – Infant Health and Wellbeing Programme."[4]

Findings

A detailed log of women availing of the service has been recorded in 2020 and 2021. Twelve women availed of the service in 2020 and in late 2021, at the time of writing this report, 43 women have availed of the pumps, representing an increase of 69%.

All mothers receive double pumping kits on discharge and are encouraged to take home all equipment used during their stay in hospital, in an attempt to avoid waste. All pumps are transported in a protective case.

Our feedback from mothers shows that they are grateful for the service and verbally express relief when the pump is handed to them. We recognise the difficult position parents can find themselves in when separated from their baby and preparing to leave hospital without them. Client satisfaction reflected in longevity of their breastfeeding experience and information they readily shared among their peers. On observation we have facilitated smoother discharge and transition home for families and sustained breastfeeding

Summary

What are the implications of the work?

What are the next steps?

- We provide contact with the mother at least once in her initial days at home to assess comfort and satisfaction with the pump
- All mothers are requested to return the pump to the lactation team in the Parentcraft Department to avoid it being mislaid. The loan system is operated by the Parentcraft team of two lactation consultants. We feel this is the optimum way to identify women who will best avail of the system and provide safe lending of the pump
- There is increased clerical work owing to tracking the breast pump and having it returned in a timely fashion so that it is available to another mother
- In future we will advance this by providing the mother with a short feedback form and through that we hope to quantify and qualify the findings
- For 2022 we need to complete the feedback form for the mothers borrowing our pumps which will be given to them to complete. This form will help us score their satisfaction with the service
- We will provide all stakeholders with relevant information regarding this pump loan service.

Conclusion

Dedication of the team has led to the availability of more pumps for mothers. We have found that the benefits of the pump loan outweigh the workload involved in its maintenance.

In the absence of a service to meet women's needs as identified in the Action Plan 2016-2021 our practice has shown that it is a beneficial practice and achievable. What started out as an ad hoc practice is an organised service now meeting women's needs.

Brenda Pieper Callan and Shineen Mallon are international board certified lactation consultants, Leasa Murphy is a clinical placement co-ordinator and Sarah Stewart is a student midwife at Our Lady of Lourdes Hospital, Drogheda

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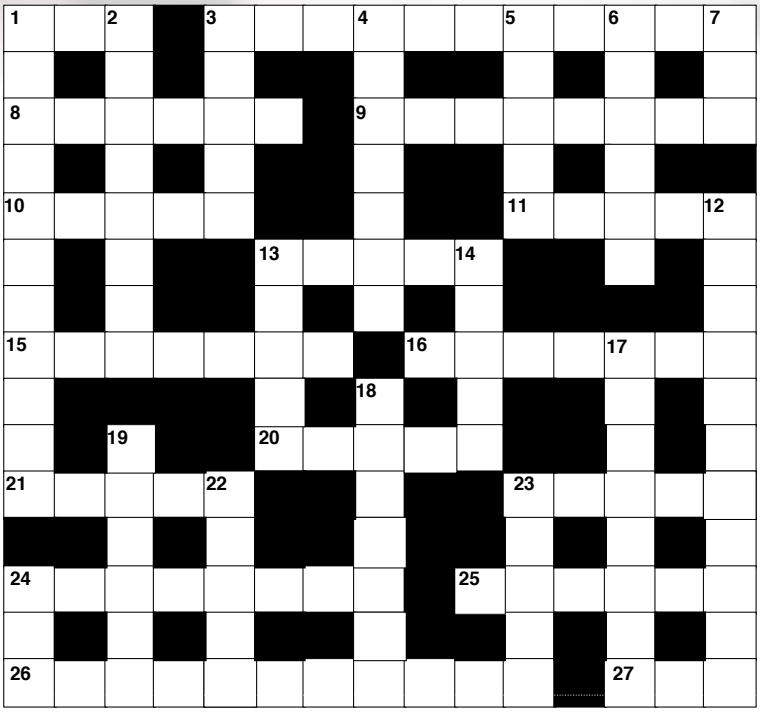
Across

1 Fruit tree native to Mediterranean and Asian regions (3)
3 Oppressed when one has feathers trampled on (11)
8 Area of pasture (6)
9 Many an ancient card game can occasion a temporary lack of warmth (4,4)
10 & 25a Blue gemstone (5,6)
11 Highways (5)
13 Pass out, swoon (5)
15 Vitamin A transported from I'Orient (7)
16 Hairstyle appropriate when some sailors are laid off? (4,3)
20 Odour or perfume (5)
21 Strange enemy country (5)
23 Turned to see the return of decaf (5)
24 One who can speak several languages got Polly upset (8)
25 See 10 across
26 Diverted; led off the subject (11)
27 Large deer (3)



Down

1 They say it breeds contempt (11)
2 Upright mail one receives on scoring in soccer? (8)
3 Portals (5)
4 Casino I upset with Cypriot capital (7)
5 Command (5)
6 & 13d Oral hygiene product (6,5)
7 A short sleep is your best bet (3)
12 One espied Richard at dessert (7,4)
13 See 6 down
14 One of a set of fortunetelling cards (5)
17 Form the opinion that this will finish (8)
18 Get nice mixture that relates to DNA (7)
19 Grinned (6)
22 The time of darkness (5)
23 Criminal offence involving deception (5)
24 Unhealthy matter found in an infected cut (3)

Name:

Address:

You can email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included putting 'crossword competition' in the subject line. Closing date: **Monday, February 21, 2022.** If preferred you can post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Dublin, A96E096

December/January crossword solution

Across: 1 Ali 3 Consultants 8 Remote control 9 Red-nosed 10 Cubed 11 Calls 13 Cages 15 Thermal springs 16 Minibar 20 Trout 21 Elegy 23 Jesus 24 Reindeer 25 Tiffin 26 Middle class 27 Lea

Down: 1 Agriculture 2 Immobile 3 Cited 5 Tonic 6 Nestle 7 Sid 12 Secret Santa 13 Chart 14 Swift 17 Blissful 9 Remind 22 Yodel 23 Jails 24 Rum

The winner of the December/ January crossword is: Olwyn Ballintine, Bantry, Co Cork

LauraLynn nursing team recognised for leadership skills

TWO members of the nursing team at LauraLynn children's hospice were presented with LIFT Ireland Leadership Awards at an online awards ceremony in November.

Director of nursing at LauraLynn, Anne Marie Carroll, picked up the award for honesty and integrity, while Clare Daly, clinical nurse specialist at the hospice, took home the award for empathy and understanding.

LIFT Ireland is a social enterprise that works to build positive leadership skills in communities. It created the awards initiative to recognise strong leadership at all levels of Irish society.

Ms Carroll said: ''Being nominated and then winning the LIFT leadership award for honesty and integrity is such an honour for me. I am very fortunate to work in an organisation with a culture of trust, openness and respect, so living the LIFT values and indeed our own values of compassion, collaboration and excellence really is not a chore. I believe in treating people as equals and, like you, want to be treated equally. If you apply these principles you really can't go wrong."

LauraLynn director of nursing Anne Marie Carroll pictured with her LIFT Leadership Award

Ms Daly said: "I was so thrilled and honoured to be nominated for a LIFT Leadership Award for empathy and understanding and to win it was truly amazing. I have facilitated the LIFT sessions in LauraLynn and it has been a pleasure being involved with such an important initiative. Empathy and understanding are qualities held by so many people in LauraLynn and I feel privileged to work in such an environment."

Founder of LIFT Ireland, Joanne Hession, said: "As an organisation and movement, we have seen exponential growth in the number of people taking part in LIFT and developing the values we build, both in their organisation and their personal lives.

"This has made the task of selecting winners for the awards all the more difficult. Each of the hundreds of nominees are excellent examples of people demonstrating positive leadership at all levels of society. I would like to congratulate each of the 11 winners on their achievement.

"They represent the best of leadership in our society across a variety of ages, occupations and walks of life. The awards are a great reminder that we are all leaders – in our own families, workplaces and communities. We will continue to strive to develop great leaders by increasing awareness of what makes great leadership and facilitating the development of great leaders through the LIFT mission."

Study finds breastfeeding reduces mother's heart disease risk

WOMEN who breastfeed may be less likely to develop heart disease or stroke, new research has found. They may also be less likely to die from cardiovascular disease (CVD).

Breastfeeding is known to confer a number of health benefits on children and is also linked to a number of health benefits in mothers, such as a reduced risk of some types of cancer.

The researchers noted that while previous studies have investigated the link between breastfeeding and CVD risk in mothers, there were issues with these.

"The findings were inconsistent on the strength of the association and specifically the relationship between different durations of breastfeeding and CVD risk. Therefore, it was important to systematically review the available literature and mathematically combine all the evidence on this topic," said the study's senior author, Prof Peter Willeit from the Medical University of Innsbruck, Austria.

The researchers reviewed eight studies conducted between 1986 and 2009 in the US, Australia, China, Japan and Norway, as well as one multinational study. These studies involved almost 1.2 million women who had an average age of 25 at the time of giving birth for the first time. Some 82% of these reported that they had breastfed at some time in their life.

"We collected information, for instance, on how long women had breastfed during their lifetime, the number of births, age at first birth and whether women had a heart attack or a stroke later in life or not," said first author of the study Dr Lena Tschiderer, who is also from the Medical University of Innsbruck.

The study found that compared to women who had never breastfed, women who reported breastfeeding during their lifetime had an 11% decreased risk of developing CVD. Furthermore, women who breastfed for 12 months or longer during their lifetime appeared to be less likely to develop CVD than women who did not breastfeed.

Over an average follow-up period of 10 years, women who breastfed at some time in their lives were 14% less likely to develop coronary heart disease, 12% less likely to suffer strokes and 17% less likely to die from CVD.

The review found no differences in CVD risk among women of different ages or according to the number of pregnancies.

"It's important for women to be aware of the benefits of breastfeeding for their babies' health and also their own personal health. Moreover, these findings from high-quality studies conducted around the world highlight the need to encourage and support breastfeeding, such as breastfeeding-friendly work environments and breastfeeding education and programmes for families before and after giving birth," Prof Willeit said.

These findings are published in the *Journal of the American Heart Association*.

Trinity research finds link between B12 deficiency and depression risk

NEW research from the Irish Longitudinal Study on Ageing (TILDA) shows that low vitamin B12 status is linked with depressive symptoms, but that folate is not associated with depression.

The study, which was published in the *British Journal of Nutrition*, examined the relationship between folate and vitamin B12 status and its associations with greater prevalence of depressive symptoms in a group of community-dwelling older adults.

The study's authors say the findings represent pertinent information for older adults, public health and policymakers to better understand how to identify risk and adopt protective measures to enhance health outcomes for persons aged 50 or over.

In Ireland, one in eight older adults are reported to have low B12 status, while low dietary intake and low blood status have been reported throughout all age groups in the Irish population.

Some of the negative consequences of low B12 status can include megaloblastic anaemia, impaired cognitive function or damage to the protective covering that surrounds the nerve fibres of the brain.

Understanding the link between folate or low B12 status and depression in later life is important as depression is a risk factor for functional decline, admission to residential care and early death, according to the authors.

The study used data from TILDA and examined participants aged 50 years and over who were assessed at wave 1 of the study and who provided measurement of plasma folate and plasma B12 and screening for depression. Researchers observed that those with deficient-low B12 status had a 51% increased likelihood of developing depressive symptoms over four years.

The authors said the findings remained robust even after controlling for relevant adjusting factors such as physical activity, chronic disease burden, vitamin D status, cardiovascular disease and antidepressant use.

Other factors that influence micronutrient status in older adults included obesity, medication use, smoking, wealth, gender and geographic location, with the authors finding that as age increased, the risk of depression decreased.

Dr Eamon Laird, lead author of the study said: "This study is highly relevant given the high prevalence of incident depression in older adults living in Ireland, and especially following evidence to show that one in eight older adults report high levels of low B12 deficiency rates.

"There is a growing momentum to introduce a mandatory food fortification policy of B-vitamins in Europe and the UK, especially since mandatory food fortification with folic acid in the US has showed positive results, with folate deficiency or low status rates of just 1.2% in those aged 60 years and older.

"Our findings should provide further reassurance for policy makers to show that a food fortification policy could offer a potential means to aid the prevention of depressive symptoms in older adults and benefit overall health through the enrichment of food such as breakfast cereals with B12 vitamins and folate," Dr Laird said.

New e-learning package from Diabetes Ireland offers timely support to type 2 patients in self-managing their condition

HEALTHCARE practitioners involved in diabetes care are being encouraged to refer newly diagnosed type 2 diabetes patients to the updated Diabetes Smart e-learning package, which has been produced by Diabetes Ireland.

The idea is to provide resources, guidance and reassurance to assist people in understanding and self-managing their condition in conjunction with their health professional.

With about 180,000 people with type 2 diabetes currently attending primary care, Diabetes Ireland has revised the programme to assist time-pressed healthcare professionals in providing education for patients about their condition.

According to Sinead Powell, regional development officer at Diabetes Ireland, without patient support resources like this, diabetes-related morbidity levels are likely to increase.

"We in Diabetes Ireland frequently hear how a diagnosis of diabetes can be difficult to accept, along with getting used to a whole new way of living. This guide is designed to walk people through new experiences and share thoughts, using real life stories to motivate them to learn, to take positive action and to take control of their condition," Ms Powell said.

"The e-learning package is a tool designed with patients at the centre of the experience. We hope it will add to the range of supports we already have to allow people with diabetes to be able to approach their diagnosis with a sense of purpose to formulate their own treatment goals."

Diabetes Smart is an informal e-learning package aimed at tackling many of the questions that patients may not have had the opportunity to discuss with anyone, as well as all the basics about diabetes.

Diabetes Ireland

It offers practical advice on how to get started with losing weight, tips on getting active including warm-up videos, and key information on understanding medications. It explains issues like how to manage hypos or illness and the requirements for driving. It also offers guidance on how to stay well and avoid diabetes complications.

"I found it to be user friendly, colourful and interactive. The signposting to other resources is great and I really liked the individualised synopsis after the quiz/self-assessment", said Deirdre Hall, clinical nurse specialist, Diabetes East Coast Shared Care.

All of the meetings and conferences listed below will take place online

March

Wednesday 2
CPC Section AGM. 11am via Zoom

Tuesday 29
Maternity Festival in-person and online. Croke Park. Free to attend. See **inmoprofessional.ie** to book

Wednesday 30
Nursing Festival in-person and online. Croke Park. Free to attend. See **inmoprofessional.ie** to book

April

Tuesday 5
Retired Section tour of Kilmainham Gaol. 11.40am. Contact social committee member Ger Sweeney at Tel: 0872794701

Wednesday 6
ODN Section meeting. 7pm. Zoom

Thursday 7
Retired Section meeting. 11am. Zoom

Thursday 7
ED Section meeting. 11am. Zoom

May

Monday 2
Retired Section trip to Killarney. Four-night trip. See *page 71*

July

Monday 2
Retired Section day trip to Galway. Lunch at 1pm at Park House Restaurant. Contact Teresa Connolly on 087 640 2962

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

Condolences

❖ It is with much sadness that the nursing team at the Mater Hospital learned of the death of Lisa Browne, ANP cardiology, after a courageous battle with illness in St Vincent's Hospital. Lisa was in the first group of accredited advanced nurse practitioners in the Mater and worked tirelessly in pursuit of cardiovascular excellence. We extend our deepest sympathy to her husband, children, parents and extended family. May she rest in peace.

Notice

❖ INMO golf outing, May 27, 2022 Adare Manor Golf Club, Co Limerick. Booking opens on April 19. Contact Ritamaher52@gmail.com

INMO Professional Library Opening Hours

February
The library is closed to visitors. Please contact us by phone or email if you require assistance

For further information on the library, please contact
Tel: 01 6640 625/614
Fax: 01 01 661 0466
Email: library@inmo.ie

INMO Membership Fees 2022

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

Breastfeeding: The best start

Breastmilk is the ideal food for newborns and infants. It gives infants all the nutrients they need for healthy development. It is safe and contains antibodies that help protect infants from common childhood illnesses such as diarrhoea and pneumonia, the two primary causes of child mortality worldwide. Breastmilk is readily available and affordable, which helps to ensure that infants get adequate nutrition.

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

The Irish Nurses and Midwives Organisation supports breastfeeding
For more information log onto **www.breastfeeding.ie**

WIN Recruitment & Training

Mailed directly to Irish nurses and midwives every month

Acceptance of individual advertisements does not imply endorsement by the publishers or the Irish Nurses and Midwives Organisation

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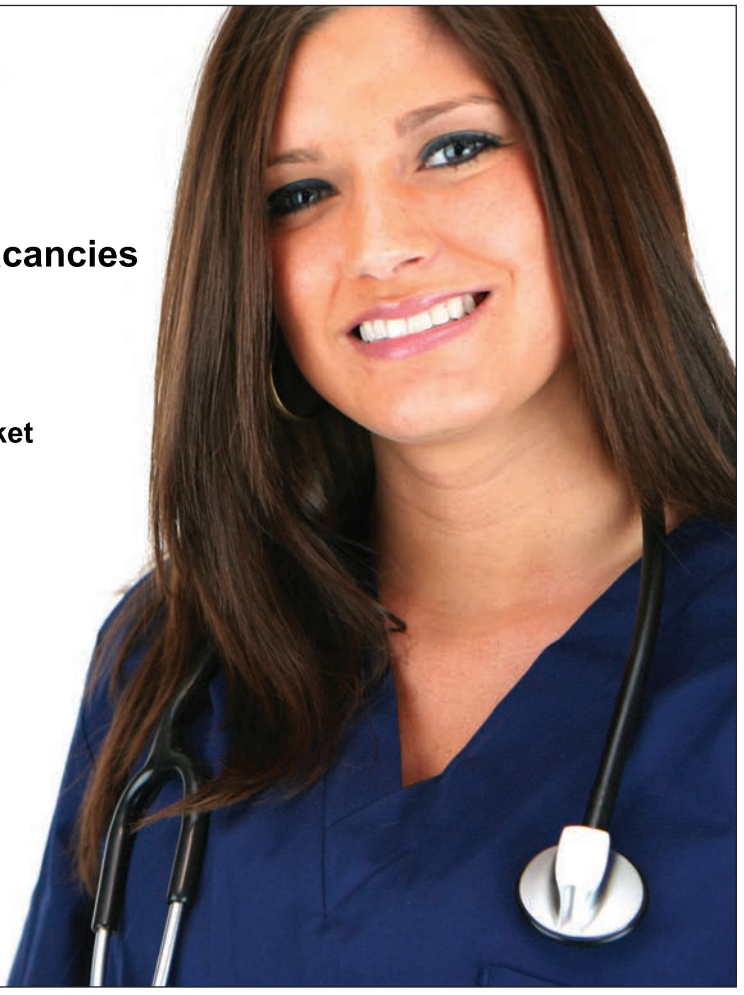

Female Registered Nurses x 3 vacancies

Six month contract:
* Earn EUR 5000 tax-free per month
* Luxury villa provided free of charge
* Mobilization, annual and repatriation ticket
* 30 calendar day of paid annual leaves
* 11 days Holidays
* Medical insurance provided for free.
* End of Services Award

Private case. Join three Irish nurses who have been there six months and have extended their contract. Immediate interview with start dates ASAP (March). Located in Saudi Arabia or travelling.

CV to jobs@profco.com
Call / WhatsApp + 353 85 862 2413
https://www.profco.com/index.php?job_id=14019

Irish Cancer Society Nurses

The Irish Cancer Society are seeking registered nurses who can provide a minimum of two nights per week and have some palliative experience. Training will be provided.

- Job description on **www.cancer.ie**
- Email CV to **recruitment@irishcancer.ie**
- Informal enquiries to 01-231 0524 or **mferns@irishcancer.ie**

Irish Cancer Society

Do you have managerial or supervisory experience in Home Support or Disability Services?

Are you looking for an interesting and rewarding role (full time or part time)?

ALHomecare, the live-in care specialists, would love to hear from you.

Phone Tom Quinlan, Manager of ALHomecare on **087 744 0729** or email **manager@alhomecare.ie**

MAYO UNIVERSITY HOSPITAL

Graduate Nurse Recruitment

Introducing new career pathways for 2022 graduates

- **Critical Care Nursing** and
- **Medical Nursing**

MAKE THE MOVE TO MAYO!

Saolta
Grúpa Oll-Scoile Cúram Sláinte
University Health Care Group

Mayo University Hospital, Castlebar is situated in the heart of the Wild Atlantic Way in the West of Ireland and while the remote scenery and lack of traffic jams is a bonus we are far from remote! With an international airport on our doorstep, Galway City a one hour drive and train service to Dublin, Mayo is a region that has lots to offer.

Mayo University Hospital provides a range of acute services with Emergency Department, ICU, CCU, General Surgery, Orthopaedics, Medicine, Cancer, Renal, Maternity, Obstetrics and Gynaecology, Paediatrics and a busy Outpatient Service.

We are now recruiting our future registered nurses (RN) who are keen to work in new and developing models of care. We are welcoming applications from final year **General Nursing students who are expected to graduate in September/October 2022**. We have opportunities in all clinical areas including two new pathways.

NEW PATHWAYS

Our pathway RNs commit to two years of six month rotation in a very supportive environment combined with postgraduate study:

Critical Care Pathway – Theatre, ICU (Critical Care) and Emergency Department combined with a Postgraduate Diploma

Medical Pathway – Acute Stroke, CCU and Respiratory Medicine combined with a Postgraduate Diploma

APPLY TODAY

More details:

https://saolta.ie/MUH-2022

Closing date: Monday March 28, 2022 at Midday
Interviews will be held on April 21 & 22

Director of Nursing and Patient Services with the Irish Motor Neurone Disease Association

This role will provide the strategic and operational delivery of all nursing care and patient support services across the IMNDA. You will lead and manage our outreach nursing service, oversee the day-to-day management of patient services and our relationships with statutory and non-statutory partners. You will ensure effective monitoring of the quality of our services and those services provided by our partner agencies. You will be responsible for the services team in delivering the highest level of support and care through the provision of specialist equipment, home care grants, support with counselling and therapies. Reporting to the CEO and with the support of a clinical advisory panel, you will be at the forefront of engagement with external clinical and healthcare professionals.

What are we looking for?
We are looking for an exceptional candidate with a background in healthcare management, who can demonstrate strong experience of operations management and managing clinical and non-clinical teams and the ability to manage the complex needs of IMNDA clients and families. We need someone who can take on the broad scope of the role but is flexible in approach to deal with short, medium and longer term aspirations in ensuring that all our clients are provided with the highest level of service, regardless of where they live.

Your key skills will also include:
- Demonstrable ability to develop business cases and proposals for service development
- Excellent leadership skills, emotional intelligence and the ability to coach and develop individuals and teams
- Demonstrable ability to manage organisational change programmes
- Performance and quality management skills
- Interpersonal and negotiation skills with the ability to persuade, influence and challenge with tact and diplomacy
- Proactive approach to work and problem solving and the ability to deal with issues as they occur

Closing date for applications is **February 25th 2022**. Shortlisting will take place the week of February 28th, 2022 with interviews scheduled for the week of March 7th. Applicants should submit a detailed CV and cover letter outlining their suitability for the role to: Lillian McGovern, Chief Executive Officer, IMNDA Unit 3, Ground Floor, Marshalsea Court 22/23, Merchant's Quay Dublin 8. For a detailed job description contact **info@imnda.ie** or **01 670 5942**

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Bon Secours Hospital Galway is a 120-bed acute care medical and surgical facility which has expanded significantly over the past number of years. We are part of the Bon Secours Health System, Ireland's largest independent private healthcare provider with a network of modern, JCI-accredited acute hospitals located in Cork, Dublin, Galway, Tralee and Limerick, together with a care village in Cork.

JCI ACCREDITED

Staff Nurse - Cardiac Catheterisation Laboratory

Part-time and Full-time positions available – permanent

Applications are invited from suitably qualified individuals to support our Cardiac Catheterisation Laboratory and related activity growth. We now wish to fill the above position.

Requirements for the position include the following:

- RGN
- 2 years post-registration experience
- Previous cath lab or acute care experience desirable
- Appropriate clinical skills with evidence of continuing professional development
- Excellent interpersonal, leadership, accountability and communication skills
- Flexible approach to work patterns

Staff Nurses – all areas required – both part-time and full-time positions available

Informal enquiries can be made to Niamh Hughes, Assistant Director Of Nursing by phone: **091 381923** or by email: **nihughes@bonsecours.ie** Forward a letter of application along with a CV to: Ms Michelle Kenny, Head of Human Resources, Bon Secours Hospital Galway, Renmore Rd, Renmore, Galway. Email: **galwayhr@bonsecours.ie**

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Tuaisceart Chathair & Tuaisceart Chontae Baile Átha Cliath

Community Healthcare Organisation
Dublin North City & County

Nursing positions available

Who are we?
CHO Dublin North City and County (CHO DNCC) is responsible for providing care and services to a population of around 621,405 people. Community Health Services are the broad range of health services delivered outside of the acute hospital setting. They are delivered through the HSE and its funded agencies to people in local communities, as close as possible to their homes.

Our services
Primary care; older persons; disabilities; mental health and wellbeing; quality, safety and service improvement

Our current vacancies
We have excellent opportunities for nurses: Staff Nurse, Clinical Nurse Specialists, Clinical Nurse Managers and ADON. If you are interested in providing quality care and developing a career in nursing, we offer a wide range of opportunities with many benefits.

We welcome applications from all qualified individuals who meet the eligibility criteria for these roles. Further information is available in the Job Specification for each position. Search 'Rezoomo CHO DNCC Jobs' or visit **Rezoomo CHO DNCC Jobs** for all our current vacancies.

Practice Nurse Required, 12-20 hours per week

This is a unique opportunity to gain first-hand experience in functional medicine, a treatment approach based on systems biology, focusing on identifying and addressing the root cause of disease. This approach is increasingly being offered in centres of excellence in the US and aims to restore vibrant wellness and quality of life, especially in those whose quality of life has been hijacked by long-term illness, and to reduce dependency on long-term medications. Job satisfaction is high. The role includes phlebotomy and administration of intravenous treatments. Comprehensive training and ongoing mentoring and will be provided.

Send your CV to **vacancies@drummartinclinic.ie** with 'Nurse' in subject line, with a letter outlining your skills and why this position appeals to you. Informal enquiries to Nurse Kathryn McDermott-Teehan, phone: **01 296 5993**

PRACTICE NURSE VACANCY

Deansgrange Medical Practice, Blackrock, Co Dublin (deansgrangegp.ie)

Practice nurse required to join our friendly 3-partner training practice with full admin support. Ideally full time (30-40 hrs. per week) but p/t hours will be considered. Previous practice nurse experience an advantage but not essential. Full training will be given. Core duties include: phlebotomy, childhood immunisations, smear taking, ABPM, ECGs, chronic disease management etc. Email cover letter with CV to **berna@gpms.ie** by **February 25**.

Read a good book recently? Write a review for *WIN*

Every month we publish a book review written by one of the *WIN* team or by an INMO member. It doesn't have to be nursing/midwifery related, but if you have read something that you found helpful to your practice, please consider writing a review for an upcoming issue of *WIN*.

Submit your review to nursing@medmedia.ie

Word count: 400

Irish Nurses Rest Association

A committee of management representing the Guild of Catholic Nurses of Ireland, the INMO, the Association of Irish Nurse Managers and Director of Public Health Nursing exists to administer the funds of the Irish Nurses Rest Association. It's open for applications from nurses in need of convalescence or a holiday for a limited period who are unable to defray expenses they may incur or for the provision of grants to defray other expenses incurred in purchase of a wheelchair/other medical aids.

Please send applications to:
Ms Margaret Philbin, Rotunda Hospital, Dublin 1.
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