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WIN

Journal of the Irish Nurses and Midwives Organisation

World of Irish Nursing & Midwifery

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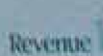

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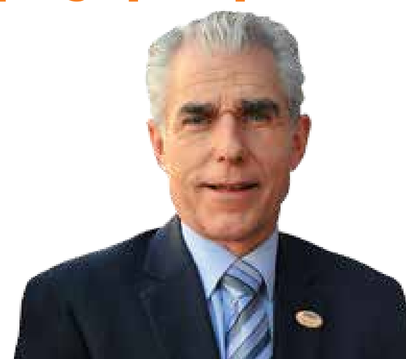
Council recommends the acceptance of pay proposals



AS YOU read this issue of *WIN* the Organisation will have commenced its nationwide information meetings, leading to workplace ballots, in relation to the proposed Lansdowne Road Agreement, which represents the first step in restoring pay to public servants in recent years.

The Executive Council, after detailed consideration of the proposals and all related matters, has decided to recommend acceptance to members, in the nationwide workplace ballots which are commencing at this time.

In deciding to recommend acceptance the Council is aware that the proposals are minimal and the government should have been much more positive in this first phase of restoration. However it was also mindful of the correct weighting towards the lower paid, the guarantee in relation to freezing NMBI fees, up to and including 2018, and the need to measure actual hours worked when attending for duty as a first step in our demand for a 37-hour week which, together with other issues, form part of the overall proposals.

In addition, the Council is aware that the decision will be taken on a collective basis, through the cumulative vote of all public sector unions. This will leave very narrow room for alternatives for any union that rejects these proposals. That union would then find itself isolated.

The centrepiece of this issue contains a pull-out and keep information sheet, which I would ask all members to read closely before casting their ballot. In addition, I implore every member, if at all possible, to attend one of the information meetings so that any questions can be tabled and answered with clarity.

In the consultation process, which the Organisation undertook prior to these latest discussions commencing, it was quite clear from members' feedback that staffing levels and the resultant excessive workloads were the primary source of concern at this time. That is not to say that the need to restore pay and working hours were not viewed as critical. When asked, members said the area of greatest need at this time was to improve staffing levels, thus reducing workloads supporting safe practice. In this context it should be noted that these proposals do not cover staffing levels. Therefore, any recommendations that emerge, from the Taskforce on Nurse Staffing (which will report shortly), are completely separate from the current exercise.

In recent times, the Executive Council has shown great wisdom and leadership in providing advice/guidance to our members. Some examples of this include:
- The decision to lead the successful campaign against the flawed Croke Park 2 proposals in March/April 2013, which were ultimately rejected by the majority of public sector unions
- The successful campaign that saw the reversal of the increase in annual retention fee levied by the NMBI
- The commencement of our Safe Staffing campaign which led to the establishment of the Taskforce on Nurse Staffing.

It is against this background that the Executive Council is recommending acceptance of these proposals at this time.

This is the first phase of restoring the pay and conditions, of all public servants including nurses and midwives. If they are accepted it has also been agreed that further discussions will take place, in May 2017, with a view to the next phase of restoration.

The Executive Council recognises that members will want to consider these proposals carefully. However, and the Executive Council is quite clear on this, when the proposals are taken in their totality, inclusive of the side agreements applicable to nursing and midwifery and the likely outcome of the ICTU ballot, acceptance is the best strategy.

Please attend the information meeting nearest to you and, most importantly, cast your ballot in your workplace in the coming days.

Liam Doran
General Secretary, INMO

Each ED needs tailored plan of action

ED taskforce implementation group meets to oversee progress

THE group established to oversee the implementation of the recommendations of the emergency department taskforce, which were published in April, met for the first time on Monday, June 15 and, at the time of going to press, was due to meet again on Monday, June 29.

The implementation group was established against the backdrop of a 31% increase in trolley numbers in May 2015, compared to May 2014. These were also the worst figures for May of any year since the INMO started counting more than 10 years ago.

At the first meeting a number of issues emerged including:

- The reasons for the continued levels of overcrowding were not the same for every hospital, and any response must reflect this
- The number of delayed discharges has reduced to just over 600 from a peak of 800, but remains very problematic in a number of hospitals
- In other hospitals the number of delayed discharges is quite small while the trolley figures remain high. It is agreed that, in these situations, additional acute bed capacity must be brought on stream as quickly as possible
- The inability of the HSE to recruit nursing staff was exacerbating the crisis as it left patients without proper care and staff facing intolerable workloads.

Against this background, the implementation group agreed that an action plan, based on the ED taskforce recommendations, would be drawn up for each of the hospitals currently facing the greatest level of overcrowding. The implementation of these action plans was due to be considered at the implementation group meeting on June 29 and, thereafter, rolled out through the HSE.

INMO general secretary Liam Doran said: "There is no doubt that the trolley crisis, despite the added investment from government, continues to grow and further, major investment is required. The year-on-year figures should be alarming to every stakeholder, and suggest the coming winter will see an even worse situation than emerged last winter, unless significant remedial action is taken.

"There is an increased awareness that additional beds and staffing are the only solution. Therefore, what is required now is for the government to release the funds necessary to allow this extra capacity to be introduced, at the earliest opportunity and, crucially, before we move into the autumn period. This growing crisis cannot, and will not, be solved without additional beds and staff".

Highest trolley figures for time of year – yet again

TROLLEY figures for May 2014 are up a staggering 83% on May 2006 – the year the then Minister for Health declared the crisis a national emergency.

This was revealed by the INMO's monthly analysis of its trolley/ward watch figures, which showed a 31% increase for May 2015 compared to May 2014 figures. A total of 7,713 patients waited on a trolley for an inpatient bed during May this year.

Hospitals with the highest number on trolleys in May are listed in *Table 1*.

Table 1: INMO trolley and ward watch May 2015: Hospitals with highest number on trolleys

Hospital	May 2015
Beaumont Hospital, Dublin	782
Our Lady of Lourdes Hospital, Drogheda	718
University Hospital, Limerick	538
University Hospital, Galway	524
Mater Hospital	497
Cork University Hospital	454
Midland Regional Hospital, Mullingar	435
St Vincent's University Hospital, Dublin	427

"In recent weeks, the crisis plunged to a new low when two women over 100 years of age had to spend more than 24 hours on a trolley awaiting a hospital bed. Every day is the same inside emergency departments where elderly people on trolleys are lined up, head to toe, along small narrow corridors with insufficient nurses to care for them. INMO members are, at this stage, embarrassed to have to face patients and their families who have to suffer this indignity in our healthcare system," said INMO general secretary Liam Doran.

In considering the latest figures, the INMO Executive Council called for urgent sustained action, including major investment, to address the crisis as follows:

- Urgent action on discharge practices to include weekend discharges
- Urgent initiatives to recruit the required additional nursing staff
- Additional resources to provide for the expansion of the role of the nurse, both in acute and continuing care/community environment, to improve the response time and, vitally, avoid unnecessary re-admissions to hospital from longstay facilities
- More acute bed capacity and stepdown facilities to be brought on stream.

"We have seen a new dimension to the crisis in our emergency departments in recent weeks," said Mr Doran.

"While some investment has been made recently, it is only the tip of the iceberg. The government, as a whole, needs to take responsibility for this ongoing crisis as we continue to see a deterioration in the figures month on month. The stated target of having a reduction in the level of daily overcrowding in EDs by October 1 is merely a pipe dream without investment in acute beds, stepdown beds, enhanced community services and recruitment initiatives for nursing and other staff."

Executive Council recommends 'Yes' vote on pay proposals

AFTER lengthy analysis and review, the INMO Executive Council took the decision to recommend acceptance of the proposals to begin restoring the pay of nurses, midwives and all public servants.

The decision to recommend acceptance was taken although the Executive Council felt that the proposals were minimalist and could have been much more positive.

The Executive Council did, however, note the weighting towards the lower paid which was welcomed and is supported.

The Executive Council also noted the initiatives and processes agreed as part of the proposals, including the freeze on the annual fees levied by the Nursing and Midwifery Board of Ireland (NMBI) at €100 for the lifetime of this agreement.

It also noted the requirement to measure all hours actually worked by nurses and midwives, seeing this as a very necessary first step in the INMO campaign to have the working week reduced to 37 hours in line with all health professionals.

Within the proposals is a commitment from employers to support training and continuing professional development (CPD). The Executive Council considers this as critical in the context of CPD obligations that will emerge for nurses and midwives in the next two to three years.

INMO information meetings and workplace ballots

The INMO has now commenced a detailed, comprehensive nationwide process of engagement with members, involving information meetings and workplace ballots. This process commenced in the week beginning Monday, June 29, 2015.

INMO members who are working in the public service and who are affected by the terms, including fourth year student nurses on 36-week clinical work placement, will be balloted. Private sector and retired members will not be balloted as the proposals do not cover issues relating to them.

Details of regional meetings where balloting will be conducted are given on page 4 of the special Questions & Answers pull-out section with this issue.

The outcome of the workplace ballots will be known on Thursday, July 30, 2015.

• *See Q&A pull-out section at centre pages for full details*

INMO calls for more all-Ireland collaboration on health

THE INMO called for increased collaboration between health services North and South when making a presentation in late May to the Joint Committee on the Implementation of the Good Friday Agreement. This was part of a discussion on the identification of opportunities to upgrade the health services on an all-Ireland basis.

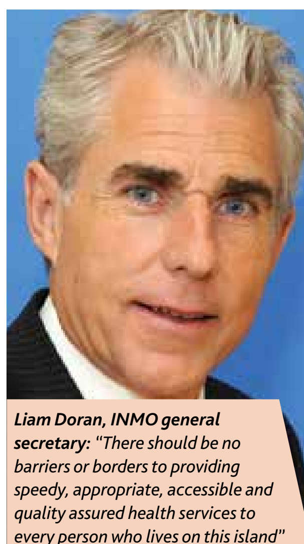
The INMO's presentation acknowledged that significant research has been done in this area, all of which confirms that citizens on both sides of the border would benefit from improved collaboration leading to maximising capacity, minimising duplication and ensuring resources are used to optimal effect.

In making the presentation the INMO identified further areas where patients/service users would benefit from improved collaboration, as follows:

- Provision of emergency department services (cross border)
- Maternity services
- The new children's hospital in Dublin and ensuring it can provide specialist services to all of the children of this island
- Intra-professional initiatives/placements
- Savings arising from reduced cost of drugs.

A copy of the full and detailed presentation is available on the INMO website (**www.inmo.ie**).

INMO general secretary Liam Doran, in making the presentation, said: "It is our firm view that there should be no barriers or borders to providing speedy, appropriate, accessible and quality assured health services to every person who lives on this island. Cross border service developments can lead to minimising duplication, delays and waiting lists, and maximising the outcome for patients whatever their requirements or address.



Liam Doran, INMO general secretary: *"There should be no barriers or borders to providing speedy, appropriate, accessible and quality assured health services to every person who lives on this island"*

"The Good Friday Agreement, while under severe strain at this time, has, undoubtedly, improved the lives of everyone who lives on the island of Ireland. It is now imperative, in building upon the work done in recent years, that we optimise our health services on an all-Ireland basis, and any obstacles or obstructions to achieving this key goal must be overcome."

Mr Doran outlined how the INMO already has strong links with its colleagues in the Royal College of Nursing and the Royal College of Midwifery, in Northern Ireland, and how the three organisations are committed to greater cross border collaboration.

"The INMO is calling upon politicians, North and South, to prioritise this area of closer partnership in the interests of all," Mr Doran said.

Relocation of services from Portlaoise must be halted until resources in place

THE INMO has sought immediate discussions with the HSE to discuss the implications arising from the decision to relocate certain services from the Midland Regional Hospital, Portlaoise.

The INMO notes the recommendations in the recent report from the Health Information and Quality Authority (HIQA) and fully supports the delivery of services in a manner which ensures they are of the highest quality and excellence.

However, in the context of transferring services from Portlaoise to other hospitals, the reality of the overcrowding, which currently exists in these receiving hospitals (St James's, Tallaght and Tullamore) must be acknowledged and addressed.

The INMO believes that it is self-evident that additional bed capacity, combined with additional staff, must be in place in these receiving hospitals, before any services can be relocated from Portlaoise in a quality assured manner.

INMO general secretary Liam Doran said: "The decision to commence relocating certain services, ie. complex surgery, away from Portlaoise to other hospitals, is the simple part of this service reconfiguration. Before any services can be relocated, to any receiving hospital, the ability of that hospital, in terms of bed capacity and staffing, to receive additional services must be examined."

The INMO has sought an immediate meeting with the CEO of the Dublin Midlands Hospitals Group, Dr Susan O'Reilly, to discuss when the additional bed capacity, together with staff, will be in place to allow these services be relocated.

"In examining this issue the INMO will be requiring the HSE to examine the trolley/ward watch figures for the first five months of this year, for all the receiving hospitals, which demonstrate these hospitals already face daily overcrowding, increased demand over bed capacity and severe staff shortages," Mr Doran said *(see Table)*.

"All of us want to ensure that the patient receives treatment in the optimum location designed to ensure the best possible outcome for any intervention or treatment. However, simply to curtail a service in Portlaoise, and to relocate it into already overcrowded hospitals, is not a cogent, coherent or acceptable solution.

"Extra bed capacity, together with the additional staff required, must be in place before any service reconfiguration can take place".

Table 1. INMO trolley/ward watch report for Jan-May 2015 for main hospitals in the Dublin Midlands Hospitals Group

Hospital	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015
St James's Hospital	236	234	335	385	258
Tallaght Hospital	394	433	409	309	325
Eastern	630	667	744	694	583
Midland Regional Hospital, Mullingar	374	473	562	468	435
Midland Regional Hospital, Portlaoise	210	214	217	166	167
Midland Regional Hospital, Tullamore	219	303	204	172	116
Country	803	990	983	806	718
Total	1,433	1,657	1,727	1,500	1,301

Crucial time as staffing taskforce finalises its report

THE Taskforce on Staffing and Skill Mix for Nursing, which is looking at medical/surgical wards, was finalising its report at the time of going to press, with a view to publishing its recommendations as soon as possible.

The key issues that are at the centre of attention in all discussions include:

- What process would be used to determine the required nurse/patient resource – the INMO preference is still that nursing hours per patient day can be converted to ratios, as they are in New South Wales, Australia
- The need to guarantee that the clinical nurse manager 2 is 100% supervisory in all medical/surgical wards
- The minimum skill mix (nurse/HCA), after safe nurse staffing levels have been established, which should be applied in medical/surgical areas
- The need to empower senior nurse managers to ensure that whatever nursing workforce is required is always maintained, regardless of economic circumstance, in the interest of safe patient care

It is thought likely that the final recommendations of the taskforce will be, in the first instance, subject to a pilot to assess their implementation to ensure that they can be applied seamlessly across all medical/surgical wards.

Speaking as we went to press INMO general secretary Liam Doran said: "There is no doubt, based upon all of our contact with members, that staffing levels, and the need to make them safe to allow safe practice, is an absolute priority for members across the country. That is why the report of this taskforce, as it relates to medical/surgical wards, is so vital and why it is so critical that we get all final recommendations correct.

"The INMO, as part of its safe staffing campaign, will persistently demand a set of recommendations which will ensure all wards are safely staffed, on a continuous basis, and that staffing level is based, using scientific data, upon patient need and not economic or budget factors".

Midwifery staffing working group to issue final report in September

Recruitment drive to commence ahead of final recommendations

AN INMO delegation met with the HSE and a Birthrate Plus representative in mid-June to discuss matters arising from how the working group on midwifery staffing is progressing.

The INMO was represented by members of the Midwives Section, Mary Higgins, Margaret Carroll and Naomi O'Donovan (Executive Council member), and Liam Doran, general secretary, at the meeting with Dr Michael Shannon, HSE director of nursing and midwifery, and Sheila Sugrue, HSE midwifery officer. Marie Washbrook, programme director of Birthrate Plus, also attended the meeting.

This meeting was convened due to the INMO's growing concerns that the working group was moving away from using the Birthrate Plus measurement tool. A number of matters were clarified at the meeting, including that:

- The midwifery staffing working group is applying the Birthrate Plus tool subject to some adjustment to reflect the existing practices within the Irish healthcare system
- The group is currently validating, through a process of dialogue with all maternity units/hospitals, the figures previously circulated to ensure they fully reflect existing staffing numbers
- The group is to meet again on July 28 to review this validation exercise and move to finalise all key recommendations
- The group intends to publish its final report and recommendations in September.

The INMO also raised the need to commence an international recruitment campaign for midwives, ahead of any final report from the group. This is necessary in order to have the necessary additional midwives to meet the criteria that will be set by any final recommendations.

Dr Shannon agreed that recruitment should commence, which he undertook to raise with the National Recruitment Service immediately.

INMO general secretary Liam Doran said: "This meeting was very useful and certainly allayed the growing concerns of our midwife representatives, that the working group was moving away from the internationally accepted Birthrate Plus measurement tool.

"We will certainly continue to engage with the working group. We encourage all maternity units and hospitals to finalise its current staffing profile with the working group, so that a full assessment, of current resources can be completed and ratios recommended for the future.

"In addition, we welcome the commitment given by Dr Shannon to support the commencement, immediately, of a recruitment campaign for midwives. This is essential as they will, most certainly, be required to begin restoring our midwifery staffing levels to that which is required by current service demand."

The INMO, which is represented on the midwifery staffing working group by director of professional development, Elizabeth Adams, will continue to work with the group in the lead up to the final report and its full implementation.

INMO bids a fond farewell to Patsy Doyle

AT THIS time it is appropriate that we send our very best wishes to our long-term colleague, Patsy Doyle, industrial relations officer in the INMO Cork Office, who has decided to take a career break from the INMO in order to take up a post as an adjudicator under the new workplace relations legislation.

Patsy joined the Organisation in January 2000. She first worked out of INMO HQ in Dublin, covering the Mater Public and Private Hospitals, Bon Secours Hospital and St Michael's House and the North East region. In more recent years, she has covered the southern area from the Cork office.

"Throughout her time with the INMO, Patsy has been a fearless representative for our members, who has, without fear or favour, striven to secure the best possible outcome for each and every member she has been involved with. Indeed, it can be said, there are many members who are better off today, not just financially but otherwise, because of the work of Patsy Doyle as our industrial relations officer," said INMO general secretary, Liam Doran.

Patsy has decided to take a break from the Organisation and take up a new position as an adjudicator (similar to the previous Rights Commissioner role), primarily covering the Cork/Kerry area.

"We have no doubt that she will bring her professionalism, intelligence and wisdom to bear in every case she examines and in every recommendation she makes. As Patsy bids farewell, it is appropriate that I acknowledge her excellence, commitment and achievements.

Patsy Doyle is stepping down as INMO IRO to take up a position as an adjudicator under the new workplace relations legislation

"Patsy is one of a kind, and the Organisation has been enhanced by her efforts and determination. Patsy we wish you well and look forward to many favourable recommendations in your new role. As Patsy has often said the INMO is always right!", said Mr Doran.

Mary Rose Carroll has taken up the industrial relations officer post in the INMO Cork Office. She can be contacted at Tel: 021 4703000; Email: maryrose.carroll@inmo.ie A full interview with Ms Carroll will appear in the next issue of *WIN*.

PHNs and CRGNs collaborate on strategy for community nursing

Strategy for Community Nursing workshop:
Top: PHN and CRGN members collaborate on the consultation document, Quality Integration and Collaboration: A Strategy for Community Nursing
Above (l-r): Virginia Pye, national lead for public health nursing in the office of the Nursing and Midwifery Services Directorate; Susan Kent, deputy chief nurse at the Department of Health; and Phil Ní Sheaghdha, INMO director of industrial relations

FOLLOWING the publication of the consultation document on a strategy for community nursing by the Office of the Nursing and Midwifery Services, Clinical Strategy and Programmes Division, the INMO held a workshop for public health nurses and community RGNs to collaborate on the proposals.

The objective of the workshop, held on Saturday, May 23, at the Gresham Hotel in Dublin was to develop a collective INMO response to the strategy document, which is entitled *Quality Integration and Collaboration: A Strategy for Community Nursing*.

The workshop was also aimed at developing and agreeing a response on issues relating to the governance of home help.

It was envisaged that the outcome of the day would be that all attendees would have an informed view and their opinion counted as part of the collective group of PHNs and CRGNs represented by the INMO. To ensure PHN and CRGN members were well informed in advance of the workshop, the strategy document was made available to them for review and, local and regional meetings were held by IROs ahead of the workshop. This facilitated members to formulate feedback and develop their responses ahead of the workshop.

As this community strategy developed by the directors of public health nursing potentially affects the terms and conditions of PHNs and CRGNs, a large turnout was anticipated. More than 100 members attended the Saturday morning workshop. Several IROs were on hand to answer queries and provide assistance to members. Membership officer, Mary Cradden was also on hand to answer membership queries, to enable members to update their contact details and for non-members to join the Organisation at this critical time.

The workshop began with an introduction from Phil Ní Sheaghdha, INMO director of industrial relations. Next Susan Kent, deputy chief nurse at the Department of Health presented on the Department's future vision of community nursing and midwifery. She outlined the role and function of the Office of the Chief Nurse, the style of management envisaged for the community nurse/midwife and the local, national and international dimension of the nursing and midwifery management.

Following this, Virginia Pye, national lead for public health nursing in the office of the Nursing and Midwifery Services Directorate, presented the consultation document *Quality Integration and Collaboration: A Strategy for Community Nursing*. A very informative questions and answers session followed this presentation.

A workshop then commenced, facilitated by Eithne Ní Dhomhnaill, nursing consultant. These talks were robust and debate and engagement was widespread.

"The community strategy developed by the directors of public health nursing potentially effects the terms and conditions of PHNs and RGNs in the community. It is very important that members are fully appraised of the proposed changes in order to have an informed view and their opinions counted," said Phil Ní Sheaghdha, INMO director of industrial relations.

Grave concern at ID cuts

INMO members at St John of God North East Services, St Mary's, Drumcar, Co Louth have voted by 99% in favour of industrial action due to budget cuts and a reduction in staffing levels.

The INMO has written to HSE director general, Tony O'Brien seeking an investigation as to why the HSE Service Improvement Team has sought a reduction in staffing and skill mix at the same time as the Health Information and Quality Authority (HIQA) has stated that insufficient staffing levels are having a negative effect on residents within the service that provides residential and daycare for people with disabilities.

The INMO is gravely concerned at the recent HIQA report, said INMO IRO, Tony Fitzpatrick. He outlined how budgets have been cut consistently over the past five years and staffing levels reduced to unsustainable levels. Despite a negative HIQA report, management at St John of God Services wrote the INMO recently indicating its wish to:

- Further reduce staffing and skill mix within the service
- Introduce a cost containment plan as it had overspent by €2 million to end May 2015
- Have non-registered staff administer medication instead of a registered nurse in intellectual disability (RNID).

"The problems highlighted within these centres are widespread especially with regard to inadequate staffing. However, nurses and other frontline staff go to work every day and, to the best of their ability, provide good quality care and service to their clients. They come in on days off, work late, work through shifts without lunch or breaks, while always striving to deliver maximum comfort to those in their care. They do this in the face of dwindling resources and extra demands, but they do their job with compassion and professionalism which is at the core of disability nursing," said Mr Fitzpatrick.

The INMO has attempted to engage with management to address concerns in order to develop workable solutions to ensure the provision of quality care to service users.

"The INMO is gravely concerned at what appears to be an attempt by St John of God Services to reduce the provision of services to people with intellectual disability. Our members will stand up for the rights of the clients within the services to receive the best possible care," Mr Fitzpatrick said.

"We have highlighted our concerns around the Service's attitude to the role of the RNID. We believe any dilution of the role results in a diminution of services to clients."

Fond farewell to loyal Letterkenny rep

THE Letterkenny Branch recently bid a fond farewell to Therese Gallacher, a loyal and true member and rep after many years of dedicated service to the INMO.

Before returning to her great love of midwifery, Therese worked in Surgical 2 of Letterkenny General Hospital for a brief period. She was awarded the Gobnait O'Connell award having been nominated by her colleagues in recognition of the dedicated voluntary service given to the INMO down through the years.

During her time with the INMO Letterkenny Branch, Therese held the position of chairperson, secretary, PRO, treasurer and unit rep. Therese was held in the highest esteem by all her work colleagues. Therese was an extremely active INMO representative, championing the rights and entitlements of nurses and midwives in LGH.

Farewell to a stalwart: *INMO stalwart, Therese Gallacher (right) receives a bouquet and a fond farewell from Maura Hickey, IRO, on behalf of the INMO, both nationally and locally*

At a gathering in the Maternity Unit in LGH, Maura Hickey, INMO IRO recalled completing rep training with Therese in Knock, Co Mayo and how struck she was with the passion that Therese had for her great loves – midwifery and the INMO.

"I remember the 1999 strike and Therese issuing orders to the troops from her hospital bed – such passion and dedication," Maura said.

Maura extended the wishes of the INMO, both nationally and locally, to Therese and her husband Brian for many years of good health in her retirement.

Regional update

- The HSE has commenced the implementation of HSE HR circular 05/2015, which reverses the new entrant pay scale for those with previous public sector service in the European Union. The INMO Cork office carried out a review of membership in the area since January 2011 and submitted the names of anticipated beneficiaries for payment to the HSE. The HSE has confirmed that these applicants are being processed and a 10% pay increase will be applied with retrospection by reversing the new entrant payscale in favour of the 2010 scale. The INMO urges all members with past EU service to discuss the applicability of circular 05/2015 to their own particular circumstances.

  – Patsy Doyle, INMO IRO

- Attempts by management at Croom Orthopaedic Hospital, Co Limerick to implement an ad hoc rotation system of staff was the subject of LRC talks recently. Management were attempting to redeploy nursing staff on an ad hoc basis to University Hospital Limerick in the event of closed beds at Croom. This was initiated under the Public Services Agreement/Redeployment Protocol. However, this protocol does not cover ad hoc redeployment. Management has stated that it is referring the matter to the Health Service Oversight Body.

  – Mary Fogarty, INMO IRO

- A successful basic nurse representative training session was held in Letterkenny recently, with reps from a cross section of areas attending, including the acute, care of the elderly, education and community sectors. The session was delivered by Dave Hughes, INMO deputy general secretary; Albert Murphy, organiser and IRO; and Catherine Hopkins, information officer.

  – Maura Hickey, INMO IRO

Regional update

- Talks have been ongoing with the HSE on staffing levels at Regina House CNU, Kilrush. Previously the HSE had given full approval for agency cover to ensure a 50/50 nurse/support staff ratio, however securing agency staff has become difficult. The INMO has proposed to management the appointment of two permanent staff nurses and two on fixed term contracts given that there is an existing panel of 68 nurses. Difficulties in attracting agency staff to this West Clare unit have resulted in staff working extra hours or cancelling annual leave meaning that there are currently 40 weeks annual leave outstanding.
- INMO members at Milford Care Centre in Limerick have requested that the INMO seeks that management makes pension deductions from their current salary instead of pensionable salary figures.

– Mary Fogarty, INMO IRO

UHG ED awaits progress on implementing LRC report

AN EXTENSIVE report on matters at University Hospital Galway's emergency department was issued by the Labour Relations Commission last month, following agreement reached after intensive talks.

The LRC agreement covers additional posts, nursing staff rostering, health care assistants and clerical administration.

The agreement also includes the formation of an implementation committee chaired by Brian McGinn from the LRC conciliation service. The INMO considers Mr McGinn's chairmanship to be essential to drive the implementation of each element of the agreement.

A review of the ED, due to commence in June, is being carried out by Garrett Martin, deputy director of the Royal College of Nursing, Belfast, who was the INMO's nominee for this role. Mr Martin's review is aimed at making recommendations to improve patient flow within the ED.

While all this has been welcomed by the INMO, IRO Clare Treacy said: "Since the LRC agreement issued, matters in the department have deteriorated, with massive overcrowding, and significant resignations, thus nullifying the recruitment efforts. Overall, members are expressing disappointment with the lack of progress on implementing the agreement."

Talks avert action at Portiuncula ED

AS WE went to press, talks were continuing to address the crisis situation in the emergency department of Portiuncula Hospital, Ballinasloe.

INMO members in the ED had voted 100% in favour of industrial action, driven by consistent overcrowding, poor staffing levels, delayed care, delayed triage and reduced bed capacity. However, action was deferred by members after talks at the Labour Relations Commission in early June made sufficient progress.

"The parties met for three hours on June 2 and sufficient movement was made by the employer to allow the INMO to defer the industrial action to facilitate further discussions," said INMO IRO Clare Treacy.

Proposals under consideration included increased nursing staffing levels, increased administration support and portering. The INMO was awaiting a proposal regarding security, as currently there are no dedicated security personnel in the ED.

Protest at downgrading of ID post at Belmont Park

INMO members at the Brothers of Charity Services South East, Belmont Park, Waterford held a lunchtime protest last month to highlight their dissatisfaction at management's decision to downgrade one of the two night duty senior nurse positions within the service.

No to downgrading of nursing posts: *INMO members protesting outside the Brothers of Charity Services South East, Belmont Park, Waterford last month*

The service provides residential and daycare services for approximately 45 persons with intellectual disability and the downgrading of the post will have a serious impact on the autonomy of the role in the provision of care to the service users.

This is the latest example of management practices that have diluted the quality of services in the area of intellectual disability, which is reflected in a number of negative reports on ID services by HIQA. This post is in charge at night and, consistent with HIQA's approach, should be empowered and graded to ensure all services required by clients are readily available and accessible.

"The management strategy is all the more bizarre when it is realised that this proposal would see the role being filled by two people of different grades and, therefore, with different levels of autonomy and authority. This is both illogical and unequal and will only result in a disjointed service," said INMO IRO, Mary Power.

"Local discussions with management have been unsuccessful and INMO members decided to hold the lunchtime protest to highlight their dissatisfaction at this action of management, and in support of the maintenance of the necessary level of authority, at management level, on night duty".

An INMO delegation joined the Mandate Trade Union demonstration march on June 6 2015 to Dunnes Stores Head Office in Dublin, in support of the calls for the end of exploitative contracts of employment and for trade union representation rights. The march was supported by a number of unions, including the ICTU, with more than 3,000 people attending

Beaumont action deferred due to new LRC deal

INDUSTRIAL action was deferred by INMO members in Beaumont Hospital emergency department last month following agreement reached at the Labour Relations Commission.

The action was planned due to delays in recruiting agreed additional nursing staff and to other failures to apply measures to address the unsafe conditions in the ED. The latest LRC agreement includes:

- Management has recruited nurses and agreed commencement dates to fill existing vacancies in ED. It also agreed to interim measures to ensure all shifts in the ED were fully covered until new recruits are in place
- A workforce review will commence, with an independent chair, to establish appropriate staffing levels for the ED. This group will aim to issue recommendations within four weeks
- Management agreed to intensify efforts to recruit nurses throughout the hospital. A joint staff management group has been established to examine the best use of media outlets to get the message out, both nationally and internationally, that Beaumont Hospital is recruiting
- Management also submitted a plan to the hospital board to implement measures across the hospital to ease ED overcrowding, ie. to support earlier discharge of patients to facilitate progression of admitted patients from the ED. Work is also continuing on accessing additional community beds to reduce levels of delayed discharges.

INMO IRO Lorraine Monaghan said: "Significant progress has been made to address the unsafe situation in the ED. We are pleased to see that management is finally producing the necessary results. There is now a recruitment plan in place which should see existing nursing vacancies filled shortly. Measures will also be implemented aimed at improving patient flow in the hospital and, in turn, reducing overcrowding in the ED. The situation will now be closely monitored and the parties will meet again under the auspices of the LRC to review implementation of this agreement."

Mater Private agrees recruitment deal

FOLLOWING intense discussions between the INMO and management of the Mater Private Hospital to address overcrowding issues, the following changes have been agreed:

- The hospital has agreed to fill a further 16.3 full time equivalent nursing posts. Following recruitment efforts by the hospital 10 positions have been offered and start dates have been agreed
- The hospital is also committed to hiring 'eight nurse graduate class', and is organising a six-person back to nursing programme
- A joint working group has been established to examine improvements to patient/staffing issues
- In addition to the posts that have been agreed, the hospital has agreed to deploy an additional floating/twilight nurse from 8am to 8pm and also 8pm to midnight Monday to Friday to help fill roster gaps that emerge.

– Albert Murphy, INMO IRO and Organiser

Training and organising update

Fitness to practise

- INMO Fitness to practise information sessions are proving highly popular with members. These short sessions are aimed at informing members of the important changes that are taking place with NMBI hearings now being held in public. Last month sessions were scheduled to take place in six locations throughout Ireland. For more details on a session near you, please contact your local IRO.

Branch training

- The INMO is developing branch officer training sessions, which will be available later this year and into next year. This will be a short course of approximately 2.5 hours duration, which can be offered to members either during working hours or out-of-hours depending on demand from members. Full details will be circulated to members in due course.

Rep training

- Feedback has been overwhelmingly positive for the revised training programme for reps, which concentrates on basic representation skills. These sessions include grievance handling, meeting management, sources of information, the role of the INMO and organising in members' areas. A draft programme for basic rep training and branch training sessions has been drawn up and will be advertised as soon as the dates are confirmed.

Youth summer school

- As we went to press, final arrangements were being put in place for the inaugural INMO Youth Summer School being held in HQ on July 3-4. Places are limited to approximately 20. This was advertised in the Student Section E-Zine and in *WIN*.

– Albert Murphy, INMO organiser and IRO

Global unity: *Addressing the Canadian Federation of Nurses Unions last month, Dave Hughes, INMO deputy general secretary, highlighted the crippling impact that the moratorium on staffing had on the quality of care in Ireland.*

Health cutbacks and nurse/midwife understaffing – a global phenomenon

Dave Hughes, INMO deputy general secretary, addressed a gathering of more than 1,000 nurses in Canada last month, where he said, his own view that health cutbacks are not purely related to austerity programmes was reaffirmed

IN HIS address to the biennial convention of the Canadian Federation of Nurses Unions (CFNU) in Nova Scotia last month, Dave Hughes told Canadian nurses about the efforts the INMO made to resist pay cuts, which had temporarily succeeded only to see a divided trade union movement have lesser, but significant cuts subsequently imposed by government.

He highlighted the crippling impact that the staffing moratorium over the previous five years had on the quality of care in Ireland and of the renewed strength that has emerged among the nurses and midwives of Ireland. He described how they have found their feet and marched to protect patients in emergency departments, maternity units, care of the elderly and ID sectors.

Conference delegates gasped when they heard of the attempts of the Irish regulator NMBI to increase its fee by 50% and stood up in admiration for Irish nurses and midwives for their campaign which had resisted that increase and saw it being withdrawn.

As part of his presentation to the conference, Mr Hughes presented the INMO video *'You are the Voice'*, which was shown at this year's ADC.

In addition, Mr Hughes participated in an international panel on the state of health services and nursing and midwifery across the globe, along with Kenneth Zinn of the National Nurses United/Global Nurses United, US; Marios Pantzalis, president of the Greek Nurses Union PASONOP; and Solange Aparecida Caetano from the National Federation of Nurses of Brazil.

The experience of nurses and midwives across the globe is that healthcare politically has been targeted with the twin approach of cutbacks in public service funding and an increasing level of privatisation with governments attempting to shift the cost of personal healthcare back to the individual.

Whether nurses and midwives are in Greece and Ireland, which have been subjected to the severest of austerity programmes in Europe, or they are in Brazil, the US or Canada, the story is the same: health service budgets being cut and the nursing and midwifery workforce taking the brunt of those cuts through understaffing and falling levels of safety in healthcare.

Kenneth Zinn of the Global Nurses United said: "There is an emerging alliance of committed dedicated nursing unions across the globe who are prepared to stand up for patients and themselves and take militant action in doing so where necessary". He said the ultimate necessity for such an approach was nowhere more evident than in Liberia where nurses were forced to strike just to get protection from an illness which was being transmitted from their patients to them, and taking the lives of both nurses and doctors throughout that country. Such was the extent of the cross infection that Ebola had become known in some affected countries as the 'nurse-killer disease'. It was only through strike action that these nurses were either paid appropriately for the dangerous work they were doing or provided with the essential protective clothing to safely care for their patients.

In Brazil long working hours and gross understaffing had brought nurses of that country to action in defence of their pay and conditions and the protection of their patients. Mr Zinn said: "The common characteristic across the globe is that nurses take actions not only in their own interests but, particularly, in the interests of those whom they care for. They are unique in this regard among trade unions and there is an increasing awareness that the issues faced by nurses in every country are the same, albeit that they are to different degrees, across the globe."

Even in Canada – a nation recognised globally for its humanity and civil rights –Linda Silas, president of the CFNU, graphically outlined the impact of the Harper federal government's approach to health on the delivery of healthcare across the provinces of Canada. The reduction in federal funding for provincial healthcare through devolving responsibility for funding healthcare to cash-strapped provincial governments has seen cuts of $36 billion to the provinces, a reduction of 26,000 federal government jobs with a further 9,000 set to be cut by 2017 and proposals to eliminate sick leave pay for workers.

Employment is dropping in Canada and many jobs now created are temporary or part time. Ms Silas quoted Alex Himelfarb, one of Canada's retired top bureaucrats, as calling the current cutback policies a "trickle down of meanness" – cutting at the bottom increasing poverty and inequality while concentrating wealth with 20% of Canadians controlling almost two thirds of the country's extensive wealth.

Ms Silas said: "Canadian nurses must become political and that the CFNU would lead them in challenging all parties on their health agenda. Nurses will be clear on what they expect from the next batch of MPs." She said the nurses of Canada need to be clear on four platforms to put to potential political candidates:

- Firstly, that federal funding for healthcare should not fall below 25% of the provincial cost of delivering that care. (It has already fallen to 18% and plunged many of the provinces into a health service crisis)
- Secondly, nurses will demand a national Pharmacare programme. (One third of seniors in Canada take repeat prescriptions that are proven to put them at risk, 69% of medication-related hospitalisations are due to prescription drug non-adherence, costing the health service $7.9bn a year. Drug costs now make up 13.5% of the total cost of healthcare). A report by Dr Marc-Andre Ganon suggests up to 40% savings can be made from the introduction of a Pharmacare programme
- Thirdly, Canada needs a senior agenda – 15% of the population is now over the age of 65 and that is expected to increase to 25% of the population by 2036. 98% of seniors who are receiving homecare for complex conditions could not stay in their home without help from others and 250,000 Canadians live in long-term care. 14% of the acute bed stock is occupied by people awaiting long-term care and in 2012 nearly half a million Canadians had unmet homecare needs while eight million people (28% of the population) serve as care-givers.
- Fourthly, nurses are demanding a national healthcare human resources plan with the pressure on nursing and midwifery staff now costing more than overtime in the health service, the combination of sick leave and overtime payments costing over $1.7b a year, never mind the unmeasured cost of such sickness to the individual nurses and midwives because of the pressure of work.

Linda Silas, president of the CFNU, and Dave Hughes, INMO deputy general secretary, along with other representatives from international nurses unions join a protest in solidarity with water workers in Halifax, Canada who are on strike to preserve their defined benefit pension scheme

Ms Silas concluded by telling the 1,000 assembled nurses: "No-one understands that a group of healthcare professionals as large as nurses with close to 350,000 members and representing close to 70% of healthcare budgets are still fighting to be heard.

"Yes, they tell me nurses need to tell their story. Well I think we need a better story – nursing is not just about caring or about patient advocacy or about saving lives. Our story is healthcare's story. We are not only the heart and soul of healthcare, nurses are the backbone of our system. We are the brains behind the solutions. So when you are not involving nurses and midwives in your decision-making process, well that is just stupid and it is no wonder politicians are making stupid move after stupid move."

Ms Silas pledged to walk 500 miles in pursuit of protecting health budgets and safe staffing.

This is a familiar story and a familiar call to action.

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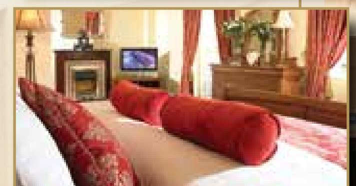

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To enter send this form to: Bridge House Giveaway, MedMedia Ltd, 17 Adelaide St, Dun Laoghaire, Co Dublin.
Closing Date: August 20, 2015. Winner will be announced in next issue.

Name: .... Phone no: ....

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....

INMO – The complete package

The INMO offers a one-stop shop for nurses and midwives across a range of services. New members are the key to our future success

THE number one answer given by those asked why they are not in a union is *'I wasn't asked!'* Building the union is in every member's interest and recruitment is the business of every member. A key element of our work is organising in the workplace so the greater our number, the more effective we can be as workplace representation is strengthened.

In the workplace

Four out of five nurses and midwives already see and experience the benefits of being an INMO member. The INMO has 14 industrial relations officers (IROs) who provide professional representation and workplace representation on grievances and disciplinary issues. All of our IROs are fully qualified, trained and skilled to represent members in all employment law third-party procedures.

Campaigning

The INMO has an exceptional record of organising and campaigning on local and national nursing and midwifery concerns.

We are renowned nationally and internationally as the voice of nursing and midwifery in Ireland. We are the organisation that the media rely on for the facts about nursing, midwifery and patient conditions. We have a daily presence in the media through trolley/ward watch. We have led the way in protecting pay and conditions when others introduced the doctrine of core pay.

The INMO campaigns for:

- Nurses and midwives
- Patients
- Public health services
- Equality
- Safe practice
- Members' health and wellbeing.

Continuous professional development

The INMO also provides continuous professional development through our Professional Development Centre (PDC). Tools for safe practice courses are delivered in the workplace by INMO representatives and we also provide a comprehensive specialist library and research service that is exclusive to nurses and midwives.

Regulation

The INMO lobbies and promotes safe care and regulation to support nurses and midwives. We support and defend our members where complaints or allegations are made. We also provide professional legal representation in all procedures before NMBI and often times the INMO are the only support to a nurse or midwife facing fitness to practise hearings.

It is important for all members and staff to open the eyes of non-members and ask them to join the union because together we are stronger!

Membership update

Mary Cradden and Michaela Gonzales, of the INMO's Membership Department, have had an overwhelming response from members contacting them with employment and personal detail updates for membership. It is important that the INMO has up-to-date contact details and place of employment on record for all members, especially for the purposes of member notices and updates from the INMO, not forgetting the ballots.

If you would like a supply of 'Update your Membership' Forms, to be forwarded to your work location, please contact the INMO Membership Office. You may also require a supply of INMO Membership Application Forms – again please contact the Membership Office and we will forward a supply to your work location.

As always, we greatly value your membership as, together, we are stronger in these challenging times.

Keep your membership up to date. Contact the office at Tel: 01 6640600.

Spotlight on

Telephone Triage Nurses Section

The Telephone Triage Nurses Section is a nationwide Section with 200 members, predominantly working in the out-of-hours setting. Telephone triage is a systematic process by which the nurse reviews the patient's symptoms for urgency and offers advice to the caller, based on the severity of the problem described. We provide patients with the nursing/medical care necessary to treat conditions that require urgent help or treatment that cannot safely wait until the patient's own doctor's surgery is open. The variety of illness/injury dealt with ensures that a vast array of knowledge is vital, hence education is key to the work of the Section. We meet three times a year and vary the location to facilitate travelling nurses. Our meetings always include an educational component. Our 11th national conference takes place on September 30 in the Castletroy Park Hotel in Limerick. Feedback from previous conferences and requests from triage nurses will shape the content for the day. We hope the conference will be of interest to all nurses in the primary care setting and all are welcome.

Section Officers

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mcmahonjcs@eircom.net

Vice chairperson

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Education officer

Hazel James
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Affiliation Form for INMO Section Membership

Name:____________________

INMO membership No:____________________

Home Address:____________________

____

____

Tel (work):____________________

Tel (home/mobile):____________________

Email:____________________

Place of employment:____________________

Job title:____________________

Second section option (to obtain information only):

____

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

Tick ONE relevant Section you wish to affiliate with

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

Limerick to host TT Section conference

Telephone Triage service provides patients with urgent medical care

THE INMO Telephone Triage Section has been up and running for over ten years. Last September saw the section celebrate its 10th national conference. Plans are well underway for this year's event, which will be taking place on 30 September in the Castletroy Park Hotel, Limerick.

The Telephone Triage Nurses Section wishes to highlight that their conferences are of interest to all nurses and midwives working in the primary health care setting.

Telephone triage is a systematic process by which the nurse reviews the patient's symptoms for urgency and offers advice to the caller, based on the severity of the problem described.

The triage nurse is an experienced nurse with a broad knowledge base in one or more medical fields including general, midwifery, paediatrics, psychiatric, geriatrics etc. The triage nurse can offer nurse advice, advice about home care or may direct the caller to the most appropriate healthcare setting.

The aim of the triage system is to gather all relevant information from the caller relating to the patients symptoms, medical history, current medications, etc and utilising that data to assist the patient. The nurse makes an informed decision regarding the management of the patient's symptoms and offers expert guidance.

The pathway suggested by the nurse may result in:

- Nurse advice – free advice is offered by the triage nurse and is based on the information received from the caller. The advice offered by the triage nurse is evidence-based and if the caller is satisfied with the advice the consultation ends there with the option to ring back at any stage. Some 30% of the calls would finish with nurse advice at this point.
- However following a full consultation with the telephone triage nurse and where the requirement for further medical assessment has been established the patient may be referred to the GP on duty and/or other services including ED, CIT, ambulance, maternity, and psychiatric.

The aim of the out of hours service is to provide patients with the medical care necessary to treat conditions that require urgent help or treatment that cannot safely wait until the patient's GP surgery is open.

Armagh set for 21st midwifery conference

ALL PLANS are in place for this the 21st Annual All Ireland Midwifery Conference, taking place in Armagh on Thursday, October 15, 2015.

The programme, which is finalised and in circulation, should make for a very interesting day.

The theme of this year's conference is 'The Journey from Harm to Norm' and will feature a variety of high profile speakers including Prof Richard Greene, director of National Perinatal Epidemiology and professor of clinical obstetrics at University College Cork, Prof Declan Devane of NUI Galway and Saolta University Healthcare Group, along with Susan Kent, deputy chief nursing officer at the Department of Health.

The poster competition forms an integral part of the conference and applicants are invited to submit a proposal to participate.

The full criteria are available on the INMO website **www.inmo.ie** but, in brief please note the following:

- Posters addressing the conference theme may be submitted by individual midwives, groups of midwives, midwifery students or service users.
- Presenters must be currently working in the midwifery, maternity services and women's services/healthcare.
- The title and overview of poster presentation – 50 to 100 words – should be submitted by email to Helen O'Connell: helen.oconnell@inmo.ie by Friday, September 25, 2015.

This is not a competition, but an opportunity to share information and to enable you to present your work or ideas. It must be related to midwifery.

For full details please see page 54.

We look forward to receiving your application.

Retired Section takes trip to Ashford

Retired Nurses and Midwives Section on the road again: *The Retired Section's outing to Mount Usher GardenS, Ashford, Co Wicklow on May 18 was organised by Teresa Mahon. The Section members were privileged to have a special visit to see a great display of Seamus Heaney's works in Ashford's Community and Heritage Centre where they were also given a talk by Sheila Clarke, who was very informative. The trip was capped off with a visit to Mount Usher Gardens, followed by a lovely lunch enjoyed by all*

Professional Development Centre

The INMO's Professional Development Centre offers and extensive range of courses and workshops for nurses and midwives to support their professional development

See pages 35-46 for full course details

Bulletin Board

With INMO director of industrial relations Phil Ní Sheaghdha

Query from member

I am a PHN student from the class of 2014-15. As this training year is drawing to a close, I am quite anxious about what placements will be offered after November 1 of this year (I understand that I am to remain in my sponsorship LHO until November 1, 2015). I have heard conflicting information regarding when these placements will be offered and where these placements will be. Can you update me on possible placement locations?

Reply

Thank you for your query. The INMO has met management of the HSE nationally twice in respect of the situation arising for 2015 graduates, who have signed contracts that confirm they will be offered permanent posts as PHNs on qualification in the areas where such work is available. The INMO is currently seeking information on where these placements are likely to arise but the HSE does not have this information as yet. The HSE is committed under contract, to afford permanent employment to each student graduating as a PHN this year. Therefore, the placement of these students is a matter that has to be dealt with, prior to August. The INMO has requested that the HSE brings forward a proposal and we have sought that as little disruption as possible is involved in the placement of these qualifying students. The next meeting on this matter was due to take place on the July 1, 2015. The INMO will do the best it can to get a fair and equitable agreement in respect of placement. However, the fact that contracts have been signed individually in respect of this issue is a reality that we cannot ignore. We have notified all student who are members of the INMO about the issues by circular update. If you do not have this, please contact the INMO official with responsibility for your area to ensure your details are known to us so that you can receive future updates. Thank you for your query.

Query from member

I have been advised that an allegation of abuse has been made against me by a patient. I have been asked to respond to this complaint and I am very concerned as I don't believe this complaint refers to me. My employer appears to have come to the conclusion that the complaint is against me although I am not named. Please advise what my rights are in this instance.

Reply

In the public service, and in most organisations funded by the health service, the policy for investigating a complaint is, in respect of allegations of abuse entitled 'Trust in Care.' Abuse is defined in this policy as "any form of behaviour that violates the dignity of patients/clients. Abuse may consist of a single act or repeated acts. It may be physical, sexual or physiological/emotional. It may constitute neglect and poor professional practice." On receiving a complaint, an employer is obliged under this policy to conduct preliminary screening. The preliminary screening must be carried out to establish the facts pertaining to the complaint. This includes establishing whom the compliant is against. There have been many cases where we have successfully established that the complaint is not against the person management determined it to be, for example,

- The person was not on duty
- The person was on their break during the time that was identified
- There were many employees, both nursing and non-nursing, who could have been the party complained against and it is not clear and not established whom the complaint is against.

In the first instance, we would need to notify your employer that you are not responding to the allegations as you do not accept them and it has not been established that the complaint is against you. If management advise that they have evidence and are basing the belief that the complaint is against you on established facts, you are entitled to see this evidence, challenge it if required and be represented at this forum.

I would advise you to seek advice, assistance and representation from an INMO official in respect of this. If necessary the INMO will then make contact with your employer on your behalf as a matter of urgency to ensure the facts are established correctly. I hope this answers your query but please do not hesitate to contact us in the event that you require our assistance.

Quality & Safety

A column by Maureen Flynn

Open disclosure matters

THIS month we take a look at open disclosure and its relevance to the role and responsibilities of nurses and midwives working across all of our healthcare services. The Australian Commission on Safety and Quality in Health Care defines open disclosure as:

> *An open consistent approach to communicating with patients and their families following adverse events in health care. This includes expressing regret for what has happened, keeping the patient informed, providing feedback on investigations and the steps taken to prevent a recurrence of the adverse event.*

Background

The HSE and State Claims Agency launched a national policy, national guidelines, staff support booklet, patient information leaflet and staff briefing guide on open disclosure in November 2013. The imperative for open disclosure and the impact on patients and their families when open disclosure does not occur has been a topic highlighted in many recent high profile media cases nationally and internationally relating to the management of adverse events in healthcare. A key recommendation of the Francis report (2013) arising from the Mid Staffordshire NHS Foundation Trust Inquiry was to establish a culture of openness in all health services, including nursing and midwifery, through a duty of candour.

> *The report defines candour as the volunteering of relevant information to persons who have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint has been made.*

Role of nurses and midwives

Nurses and midwives working in Irish healthcare services are subject to four forms of requirements in relation to engaging in open disclosure with patients following adverse events in healthcare: (i) organisational; (ii) regulatory; (iii) professional; and (iv) ethical.

Organisational: Since November 2013, open disclosure is HSE policy. This policy requires that:

- *Incidents are identified, managed, disclosed and reported and that learning is derived from them. The person must be informed in a timely manner of the facts relating to the incident and an apology provided, where appropriate. This includes open disclosure when harm is suspected. The policy also promotes that 'no harm' events should generally be disclosed. Near miss events should be assessed on a case by case basis and where there is a risk of or potential for future harm from the event then this should be discussed with the person*
- *When a clinician makes a decision, based on his/her clinical judgement, not to disclose to the person that an adverse event has occurred, the rationale for this decision must be clearly documented in the person's healthcare record and this decision may need to be reviewed by the clinician at a later date, depending on the circumstances involved*
- *The salient points discussed with people during open disclosure meetings, including the details of any apology provided, should be documented in the person's healthcare recorded in accordance with the National Guidelines on Open Disclosure (2013).*

Regulatory: Open disclosure is a requirement of HIQA National Standards for Safer Better Healthcare (2012). Standard 3.5 under Theme 3 of these standards, ie. *Safe Care and Support* states:

> *Service providers fully and openly inform service users as soon as possible after an adverse event affecting them has occurred, or becomes known, and continue to provide information and support as needed.*

Professional and ethical: The NMBI-revised *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives* (2014) states in Principle 3: *Quality of Practice* that:

> *Safe quality practice is promoted by nurses and midwives actively participating in incident reporting, adverse event reviews and open disclosure.*

Why is open disclosure important?

Recent cases have highlighted the 'second harm', which patients and their families describe when they talk about the psychological impact caused by the failure of healthcare professionals to communicate with them honestly and openly following adverse events in healthcare and also the failure of healthcare organisations to keep them updated and included in relation to reviews and proposed quality improvement plans. Open disclosure is the humane response following adverse events. It is what we would expect for ourselves or for a loved one.

Support for staff

It is important that staff involved in adverse events are supported by colleagues, line managers and senior management and that staff support services are available and accessible. Staff are often traumatised and may experience varying symptoms associated with post traumatic stress. For further advice see the HSE staff support booklet *Supporting staff following an adverse event: The ASSIST ME Model* available from **www.hse.ie/opendisclosure**

Opportunity to get involved

The HSE and State Claims Agency are currently rolling out an open disclosure 'train the trainer' programme nationally. If you are interested in becoming a trainer for your organisation or an open disclosure champion please discuss this with your line manager. Further information on the train the trainer programme is available from orlab.oreilly@hse.ie For further information on open disclosure visit www.hse.ie/opendisclosure or contact angela.tysall@hse.ie

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Acknowledgement
Special thanks to Angela Tysall, national lead for the HSE in open disclosure (authors of the policy and guidance documents) for so willingly sharing information and assistance by preparing this column.

References available on request

Quality Improvement Division

The Quality Improvement Division (QID) was established in January 2015. The vision for QID is: working in partnership to create safe quality care. Our mission is to provide leadership by working with patients, families and all who work in the health system to innovate and improve the quality and safety of care. The division has four strategic priorities: (i) supporting person-centred care; (ii) supporting staff to improve quality; (iii) innovation, communications and connectivity; and (iv) information and evaluation for quality improvement

On the reform agenda

Speaking to *WIN*, Health Minister Leo Varadkar outlined his pragmatic approach to dealing with some of the well-documented flaws in the Irish health service. Interview by **Niall Hunter**

LEO VARADKAR has had a longer than average 'honeymoon period' as Health Minister. Now nearly a year in office, his direct but amiable communication style has so far helped him avoid many of the 'Angolan' landmines that dogged his predecessors.

That's not so say that he has so far solved any of our major health service problems – far from it, access to and pressures on the system appear to be worse than ever and safety levels are frequently being queried.

The Minister argues however, that the seeds of improvement are being sown. It helps of course, that Leo Varadkar has more funding at his disposal than his immediate predecessors and that he may not be in Hawkins House long enough to see whether or not his initiatives work.

We spoke to him in his Leinster House office as he was keeping abreast of plans to introduce the controversial free GP care for under sixes scheme, the first significant initiative of his term of office.

ED crisis

Asked if the recent recommendations of the emergency department taskforce will be resourced, the Minister said much of the most expensive components of this had already been resourced.

"The most expensive thing was making the Fair Deal scheme demand-led; €44 million has been provided for that and the Fair Deal wait is now down to four weeks from 18 weeks and that is making an impact. The second most expensive thing was opening more community hospital/district hospital beds, opening Mount Carmel in Dublin, all those things.

"The next set of actions are not enormously expensive, but they are the trickiest because they involve changes in working practices, changes in culture. If you could sign a cheque for € 1 million and make those things happen I would but they don't work like that," he said.

Changes recommended in the taskforce report include: developing integrated care pathways; regular patient reviews by senior decision-makers; ensuring senior decision-making in EDs at peak hours; ensuring that on-call admitting consultants are fulfilling their ED activity commitments; and expanding the role of nurses in both clinical and discharge areas.

However, there have been recommendations in previous action plans quite similar to many of those in the taskforce report. Does he believe this plan is going to work, or will we be looking at yet another ED crisis next winter?

"There will always be surges in EDs. Anyone who tells you otherwise isn't telling you the truth. Every country in the world experiences ED surges from time to time. When we had huge numbers on trolleys here in January it was exactly the same in Northern Ireland and in England.

"This is not something you can ever say will just go away. What we can do is to make sure that it isn't a year-round phenomenon, which it is in Ireland in some hospitals, and that we are better prepared for surges when they do occur.

"A lot of what is in the taskforce report is not very different to what was in the 2006 one, which wasn't particularly implemented at the time. What I am doing is trying to make sure it gets implemented. We are setting up a small implementation group, which will meet every six months to drive it forward, and that wasn't done in the past. The crisis would happen in the winter, the report would be published, and was kind of forgotten about over the summer. That's not going to happen this time.

But that's not saying that we're not going to have a surge in January – it's very likely we will," he said.

The Minister said he agreed with the policy of placing trolley patients in wards as a temporary solution to ED overcrowding when deemed necessary.

"I agree with this policy; it's a question of putting patients first when it comes to making policy decisions. I ask myself what's better for the patient. Is it to have 25 trolleys in the ED, or to have one extra bed on every ward? To me it's a no-brainer and the research supports this view."

Acknowledging that the INMO is opposed to this policy, he said: "Where I do agree with the nurses is where they say when you do that, it becomes the norm, and you end up having extra beds on wards for weeks and months on end. They're right about that, and that shouldn't happen, but that is what is happening and that would be where I have a problem. Where extra beds are put on wards it should be dealing with a surge. It becomes institutionalised, and that's where I would agree with the nurses."

Waiting lists

On the issue of another perennial crisis, that of treatment waiting lists, Minister Varadkar says plans to deal with this will be through activity-based funding.

"What we do at the moment is public hospitals provide a certain amount of service and then when waiting lists arise very often they are outsourced to the private sector. If we had proper activity-based funding, we could match the demand to the funding. From day one if we know that next year we need X number of hips done we put them out to tender and they can go to the public hospitals or the private hospitals."

The HSE is publishing an action plan on activity based funding, previously known as 'money follows the patient'; a term Minister Varadkar doesn't like. He points out that activity-based funding is already in existence on a 'shadow basis' in the system, in areas like day-case procedures.

"It will be trickier to extend it to other areas. While it does work, other countries took nearly 10 years to implement it. It's very easy to put a price on a gallbladder; but it's not so easy to put a price on treating an old lady with multiple medical problems who comes into the hospital with pneumonia – that's where it gets tricky.

"There is a tender out at the moment for the private sector to assist with very long waiters – people waiting more than 18 months at the moment or people who will be waiting 15 months by the end of the year. What we're also doing is where there is capacity in the public sector we are using that more.

> If we use our beds as efficiently as we should, we won't need any more

"An example would be Cappagh Hospital – it was doing very little work last year. We have now re-opened quite a number of theatres there so it can do more procedures. The constraint in Cappagh is that they have trouble getting theatre nurses. Meanwhile, in some of the private hospitals they have theatre nurses but not enough work, so the common sense thing to do is to let the private hospitals do some of the work, and that's what we are doing," said the Minister.

More beds

Asked if one of the basic solutions was not simply to get more acute beds into the system, Minister Varadkar says in general he doesn't agree with this.

"We certainly need more social care beds for long-term care. We need to develop primary care and community intervention teams so that fewer people end up in hospital in the first place and people get out of hospital quicker. We need more ambulatory care, so that people come in for a day rather than a stay. Often people stay in hospital for days just to get investigations done, so I think if we use our beds as efficiently as we should we won't need any more."

He does, however, think there may be a small number of hospitals that may need additional beds. "These would be those which are central hospitals to hospitals that have been reconfigured. Obvious examples would be Limerick University Hospital, which is now picking up a lot of patients who would have previously gone to Nenagh and Ennis; the Lourdes in Drogheda, which is picking up patients who would have previously gone to Dundalk; St Vincent's, which is picking up patients who previously went to St Columcille's; and then whatever happens in the midlands – I would imagine Tallaght will need additional beds to pick up patients from there. The latter is being progressed – one of the closed wards is now being opened."

Reform

On plans to reform the HSE, Minister Varadkar says there has been so much change and structural upheaval within the health service in recent years and he would like 'things to settle down a bit'.

"There are too many people who are relatively new in their jobs. There are too many people who are interim or acting. I'd like to have a bit of stability in the health service for a little while."

He said, however, the plan still was to dismantle the HSE, with the hospital groups and community healthcare organisations a major part of the new health service structure that will be put in place.

"What you will have replacing the HSE in due course is a health commission – a health purchaser. But there will still need to be some sort of national oversight." The Minister admits we will probably never get to the point where health service management is 'popular, loved and liked'.

NHS vs HSE

Asked if there was not more of a sense of pride and public ownership in the NHS, despite its problems, compared to our system, the Minister said the NHS was perceived differently.

"People in Britain see the NHS as the service they get, and then there are also these 'nasty managers'. People in Ireland see the service they get, and they are not always that critical of it, but they see the HSE as the management. A friend of mine who had cancer described it well. He said the doctors and nurses cured his cancer, but if anything had been misdiagnosed it would have been (the fault of) the HSE, when in truth it would have been the exact same people.

"The HSE is, in many ways, a mudguard that gets the blame for anything that goes wrong in the health service."

The Minister was asked about the labyrinthine and often confusing levels of bureaucracy within the HSE, for example the recently formed community healthcare organisations (nine in number) do not appear to be aligned with the hospital groups (six in number) although presumably they are supposed to be part of the same integrated system of care.

"They are not geographically the same and that is a difficulty. What we attempted to do with the hospital groups is to match up large hospitals with smaller ones for obvious reasons, so you can have a hub and spoke model, and hospitals with an academic partner, a university, and that just doesn't work on a neat geographic basis.

So there will be overlap areas and we need to pay particular attention to these so that people don't fall between two stools."

Following the inclusion of new chronic care programmes in primary care for asthma and diabetes in the recent agreement on the under sixes contract with GPs, the Minister indicated that further chronic care cycles are due to be rolled out next year in heart failure and COPD.

"I think you pick the common things first. You can have other things in there as well such as the management of some mental illnesses.

"My endgame is greater access to better healthcare for primary care. I'm not hugely hung up on the sequencing," said the Minister. He believes more chronic illness cycles of care could be implemented next year subject to agreement.

Primary care

On the poor direct access from primary care for patients to hospital diagnostic tests, the Minister stressed that a pilot project was being organised in the west of the country, providing €700,000 worth of abdominal ultrasounds for patients, with access promised within five to 10 days.

Asked why, since the benefits of such schemes were self-evident, initiatives to improve access to diagnostics shouldn't be rolled-out nationwide, the Minister said this was subject to available finance.

"What I do think seems to work well is using the private sector, because the public hospitals are so swamped with their own work it's easier to provide a dedicated resource on a tender, particularly for things like ultrasound," he said. He added that while access to plain film x-ray 'isn't bad', current access to ultrasound is patchy and access to CT is 'terrible'.

"Every group in health, every specialty, whether it is nurses or consultants or physios or pharmacists etc, they all have really good proposals coming forward, and unfortunately because of the bad blood that has existed in recent years and the slow progress in coming to the agreement on the under sixes and implementing it, that actually delays things.

"Quite frankly I would like to have seen things happen faster, and if the under sixes had come in two years ago more could have been done, but unfortunately when progress is being held up in one area it prevents progress in other areas," he added.

Asked if he agreed it was ethically unfair to provide free GP care to the children of better off families at the expense of children and others on low to moderate incomes, the Minister highlighted the logistical and ethical difficulties involved in deciding on eligibility for services based on means and levels of sickness.

"When it comes to means tests, you always have people who are just a little bit over the threshold, and when you raise the threshold then you have a different group of people who are just above it.

"We had an expert group that tried to come up with a sickness test for medical cards and not only could they not decide who should get a medical card and who should not, they said to do so would be unethical and unfeasible. There is no perfect way to do this but I would really question why people who are such big fans of means tests and sickness tests believe they are somehow morally right.

"I am absolutely convinced that the only system that is ever going to be fair is one that provides universal coverage, but we can only do that in steps," he said.

> "If you compare mortality and morbidity statistics with those of Britain, for example, we perform better"

Free GP care

Minister Varadkar said he cannot put a timeline on when free GP care for the whole population will be rolled out, should the current government be re-elected.

"Firstly, that has to be done by negotiation, secondly, we need to see how the under sixes pans out; whether it really does significantly increase attendances and, as I've said, I'm not particularly hung up on how we do the next phases. I'm open to suggestions, for example, whether we prioritise chronic diseases first. But what I definitely want to do is to cover all children in the next term of the government, if we do get one. I don't think it's right that children are means-tested on the basis of their parents' income. We don't do that for education, we don't do it for child benefit, it's only in health."

Universal health insurance

On universal health insurance (UHI), Mr Varadkar says he realistically cannot predict at this stage the timeline for its roll-out, or what model will be used. "There are a lot of factors in play that affect timelines."

Asked was he against the UHI model proposed by his predecessor, of private health insurance companies running such a scheme, Minister Varadkar said he was not in principle opposed to this. "I just want to see the numbers, to see how much it would cost people in terms of premiums, and I want to see evidence that it will bring about efficiencies. I also want to see how much would actually end up going to the profits of insurers, and in transactional costs, rather than into services," he said.

Can an argument not be made to have a State-run and funded system?

"There's certainly an argument for it, but having studied different funding models in different countries, no one system is the same. Anyone who thinks there are two or three or four models to choose from…there aren't. There are about 60 different models. We need to decide for ourselves which is the one that's best for us," he said.

Mr Varadkar says he believes, in general, that our health services are safe, despite recent controversies.

"If you compare mortality and morbidity statistics with those of Britain, for example, we actually perform better. We have lower or similar perinatal mortality and maternal mortality rates we are quite similar on c-sections, lower surgical complications, lower rates of in-hospital mortality from heart attacks and strokes. So if you look at the OECD stats we are as safe as anywhere else, but it's a foolish person who would ever say that every single person in the health service is safe and that every single unit within the health service is safe. That's an impossible thing to say, which is why we need to be much more vigilant in auditing our health services and licensing them, which we will do in the health information legislation."

Public health

Minister Varadkar said he is planning major changes to the current childhood vaccination programme. "Among the issues being considered are whether we need to continue to give the BCG to all children." The Department of Health is, he said, also examining the introduction of new vaccination schemes to protect against rotavirus and meningitis B, and is also considering the introduction of the HPV vaccine for boys, and men who have sex with men.

He said cost would be a key factor in terms of expanding the range of vaccination schemes available, but he hoped to be able to make some decision on this in October or November.

Fitness to practise focus

In a series of articles, **Edward Mathews** explains the NMBI fitness to practise system. This instalment looks at the end of the hearing process

THIS month we examine how the Fitness to Practise Committee (FTPC) approaches matters towards the end of a hearing, and in particular what occurs after they have heard the evidence against you, and the defence, and have deliberated on the matters of concern.

Pursuant to Section 67 of the Nurses & Midwives Act 2011 (the Act) the FTPC, when completing an inquiry into a complaint, submit a report to the overall Board of the NMBI. This report specifies the nature of the complaint against the nurse and midwife, gives a summary of the evidence that was presented to the Committee, and presents its relevant findings.

Findings

In terms of findings, each allegation contains a set of facts that are proven or not, and thereafter the FTPC determine whether the proven facts amount to professional misconduct, or another relevant matter. Consider that a nurse is alleged to have stolen a piece of property, the first thing that the Committee will be required to report on is whether or not, based on the evidence they receive, they are satisfied that the nurse did in fact steal the piece of property in question.

If they find that the nurse did steal the property in question, they then must consider, whether or not they are satisfied that such a theft amounts to a serious falling short of the standards of conduct to be expected of a nurse or midwife, and thus constitutes professional misconduct, and then they report a finding on this matter.

There may be a number of circumstances where the facts of a particular allegation may be proven, but it may not be found to amount to professional misconduct, in light of an explanation given.

Another set of circumstances which arises with relative frequency, is that the nurse is alleged to have suffered from a relevant medical disability, and in those circumstances, the Committee simply reports whether or not they accept that such a disability has been proven.

Additionally, the Committee may report on other matters, and often does, including a recommendation as to what sanction should be imposed by the overall Board of the NMBI, and a rationale for that sanction. It is not a requirement that the FTPC recommend the sanction, as ultimately it is the overall Board of the NMBI who decide what sanction the Board will either impose, or recommend to the High Court, however, and this is positive in my view, the Committee often does recommend the sanction, and provides a detailed rationale for that sanction.

I think it is appropriate that the Committee do recommend a sanction in most cases, as they have had the benefit of hearing the evidence both for and against the nurse or midwife in question, and one might say that they are in some respects in the best position to recommend on the appropriateness of a particular sanction in the given circumstances.

Report

The FTPC sends its report to the overall Board of the NMBI. If no allegation has been found proven against the registrant, then the complaint is dismissed. In other circumstances the Board must consider a finding against a nurse or midwife, and must decide either what steps will be taken, or what steps to recommend to be taken, and that recommendation will be considered by the High Court.

Where allegations are proven against a nurse and midwife, the next steps to be taken are pursuant to Section 69 of the Act. This provides the range of sanctions that can be considered by the Board. Prior to deciding what sanction either to implement, or recommend, the Board will invite the nurse and midwife to attend at a full Board meeting. During this meeting you would be represented by the INMO, and could make submissions to the Board on what the appropriate sanction should be.

Recalling that in many circumstances, the FTPC recommends a sanction, it is up

to the Board to decide what sanction that it will implement or recommend, and it is free to depart from the views of the FTPC. In those circumstances the INMO generally makes a submission on behalf of the nurse or midwife, by either agreeing or disagreeing with the recommendations of the FTPC, and providing reasons for doing so.

Following consideration of those submissions, the report of the FTPC, and all the materials that the Committee had available to it, the Board deliberates in private as to what is the appropriate sanction to either impose or recommend. We are advised of their decision on a later date.

Sanctions

The range of sanctions that are available are to advise, admonish, or censure, all of which amount to written warnings, with each warning in sequence representing a more severe warning, with a censure being the most severe. The Board may also consider a censure in writing, alongside a fine, not exceeding €2,000.

Some people have been critical in relation to the availability of a fine, however, in our experience it offers an opportunity for the Board to deal in a proportionate manner, with the type of conduct which is deemed not suitable to be dealt with by a written warning alone, but which does not amount to conduct that would warrant a suspension from the Register or erasure from the Register.

It should be noted that where the recommendation to impose a fine is made, the Board does take an agreeable approach to the manner in which such a fine may be paid, and generally allows an extended period of time, over which it can be paid by direct debit.

In addition to the matters already referred to, or on their own, the Board may recommend the attachment of conditions to a nurse or midwives Registration, including restrictions in the practise of nursing and midwifery that may be engaged in by the nurse and midwife. The imposition of conditions is a relatively common sanction, and often involves a professional development plan, on-going monitoring, on-going attendance at occupational health, or the attendance at specific training courses. The Board may also recommend the transfer of a nurse or midwives Registration to another division.

At the higher end of the spectrum, the Board is in a position to recommend that a nurse or midwife be suspended from the Register for a specified period, or that nurses or midwives' registration be cancelled from the Register of Nurses or Midwives, or from a particular division of that Register.

These are obviously the most severe sanctions, as these prohibit a nurse or midwife from practising their profession. Additionally, and ancillary to these latter sanctions, the Board may recommend a prohibition on a person from applying for a specified period for the restoration of their name to a Register, or a division of the Register.

High Court

A decision to impose any sanction, above the issuing of an advice, admonishment, or censure on their own, requires the confirmation of the High Court. Following a decision to implement a sanction, again above an advice, admonishment, or censure, a nurse or midwife has 21 days in which to lodge an appeal of the decision of the Board to the High Court. In the event that a period of time elapses for an appeal to be lodged, the Board pursuant to Section 64 seeks confirmation from the High Court of the decision relating to the sanction to impose.

If the High Court confirms that sanction, which they almost invariably do, then pursuant to Section 76, the Board must, as soon as is practical, advise the nurse of the sanction, which the High Court has imposed, including the payment of a fine, attachment of conditions to Registration, or at the higher end of the spectrum, the transfer of a nurse to another division of the Register, their suspension from the Register, or their cancellation from the Register with or without a prohibition for applying for re-registration for a particular period of time.

Thankfully, the vast majority of registrants who are subject to a finding, and who have appropriately engaged with the FTPC, and shown the requisite level of insight and learning arising from their misconduct, are subject to sanctions ranging from advice up to a censure, including a fine and, in many cases, conditions being attached to their Registration.

Of course there are always cases where the Board considers suspending or erasing a registrants Registration, and these cases will always be at the more serious end of the scale of misconduct, and particularly so in circumstances where a nurse or midwife has not engaged with the process, or has not shown the appropriate level of insight and learning arising from their misconduct.

Informing other bodies/employers

Where the decision has been taken by the Board, or the Board with the approval of the High Court, to impose a sanction above advice or admonishment, ie, censure, censure and a fine, the attachment of conditions, suspension from the Register, transfer to another division, or erasure from the Register, then the Board are under an obligation, pursuant to statute, to notify the Minister for Health and the Health Service Executive in relation to the decision which has been taken.

In addition, where a nurse or midwife is employed by a body other than the Health Service Executive, and that employers name is known to the Board, they are also obliged to inform that party of such matters. Finally, in terms of bodies or persons who must be informed of such decisions, if the Board is aware that a nurse or midwife is registered in another jurisdiction, they must inform the registering body in that other jurisdiction.

Notification to the public

It is often of serious concern to nurses or midwives, whether a hearing took place in public or private, that the outcome of the hearing would be published on the website of the NMBI, or in other publications of the Board.

Section 83 of the Act stipulates what information the Board may publish in the public interest. In these circumstances the Board is empowered to, and it is stated that it shall if it is in the public interest to do so, notify the public when any sanctions are imposed over and above advice or admonishment.

The notification of the public in those circumstances generally involves the publication of the findings of the Fitness to Practise Committee, and in addition, now, Section 83 also provides that after consultation with the FTPC, the Board shall if it is in the public interest, publish a transcript of all or any part of the proceedings of the Committee at the Inquiry stage, whether with or without any information which would enable all or any of the parties to the proceedings to be identified.

Invasion of privacy

This latter provision is of significant concern, as it goes beyond providing information to the public in relation to the allegations which were proffered

against a registrant, and the findings and sanctions which were imposed arising from those allegations, and includes a verbatim transcript of every word said at the Inquiry, unless the Board determines, following consultation with the Fitness to Practise Committee, that some or all of that transcript should not be published. This represents the potential for an incredible invasion into the registrant's privacy, and it creates a permanent record of all that was said, which is available in the public domain. It should be noted that even within the criminal justice system, where justice is administered in public, it is not possible to obtain a transcript of all the evidence, or indeed any of the evidence, which is delivered during a criminal trial.

This, in our view, is a step too far, and if transcripts are published with relative frequency by the NMBI, it will lead to permanent records in relation to registrants, their professional lives, often their personal lives, and often the lives of those they serve and those with whom they live, and we do not believe that this a proportionate outcome to a fitness to practise process relating to the regulation of the professional's behaviour.

Criminal offence

One final piece to consider is the ability of the Board to consider circumstances where it is alleged that a nurse or midwife has been convicted of a relevant criminal offence. Section 55(1)(i) indicates that a ground of complaint to the Preliminary Proceedings Committee, includes a conviction in the State for an offence triable on indictment, or a conviction outside of the State for an offence consisting of acts or omissions that, if done in the State, would constitute an offence triable on indictment.

Any offence triable on indictment is one that may be tried before a jury. In this jurisdiction that includes a wide range of offences, and although some matters may be dealt with in the District Court before a judge alone, many of those offences may also, depending on the circumstances of the case, be tried before a jury, thus a wide range of criminal offences may be comprehended by this section.

If a complaint is received by the Preliminary Proceedings Committee, in relation to an allegation of conviction of such an offence, then the Committee immediately refer the matter to the overall Board of the NMBI, and the matter may not be dealt with through a fitness to practise process.

Once the Board receives a complaint in relation to such a matter they convene a meeting, at which the registrant will be invited to attend, represented by the INMO. If the Board is of the opinion that the nature of the offence that is the subject of the complaint, or the circumstances in which that offence was committed, renders the nurse or midwife permanently unfit to continue to practise nursing or midwifery, and that it is in the public interest to take immediate action, then the Board shall cancel the nurse or midwife's Registration, which will prevent them from practising in the future.

> "This represents a non-acceptable invasion of privacy of the registrant in our view, and is disproportionately punitive..."

If the Board is not of the opinion that the nature of the offence for which the nurse or midwife was convicted, or the circumstances in which it was committed, renders the nurse and midwife permanently unfit to continue to practise, then they refer the complaint to be dealt with in the normal way, pursuant to the fitness to practise process.

Therefore, where serious criminal offences have been committed, and a nurse or midwife is convicted, the Board is empowered to consider that matter without a fitness to practise hearing, and to make a finding that the nurse or midwife Registration be cancelled.

Conclusion

As can be seen the Nursing & Midwifery Board of Ireland, following a finding from the FTPC that a nurse is guilty of poor professional performance, professional misconduct, non-compliance with the Code, or has a relevant medical disability, has a wide range of sanctions available to them.

Where the sanction amounts to a written warning in the form of an advice, admonishment or censure alone, then the Board can impose this sanction, and is not required to obtain the permission of the High Court.

If the Board decides to impose a fine, to impose conditions, to suspend registration, erase registration, or transfer a person from one division to another, then the confirmation of the High Court is required. The Minister for Health, Health Service Executive, employer other than the Health Service Executive if known, and any other registering body in another jurisdiction, must be informed of sanctions which amount to more than an advice or an admonishment.

In other circumstances, the Board shall, if they determine it is in the public interest to do so, notify the public of the outcome of the fitness to practise hearing, including the sanctions imposed. And, of great concern, the Board also shall, if it is in the public interest to do so, publish the transcript of the entire hearing. This represents an unacceptable invasion of the privacy of a registrant in our view, and is disproportionately punitive towards a nurse or midwife.

Finally, and it would be presumed in the public interest, a nurse or midwife who is convicted of a serious criminal offence where the nature of that offence or the circumstances in which it is committed, in the view of the Board, renders them permanently unfit to practise nursing or midwifery, may have a recommendation from the entire Board to cancel their Registration, without a fitness to practise hearing.

The Fitness to Practise Committee, the overall Board of the NMBI, and ultimately the High Court, do in many instances impose proportionate sanctions on nurses and midwives, and in considering sanctions, it is our experience that one of the most important elements of a nurse or midwives' presentation before the Fitness to Practise Committee, and the Board itself, is insight into what was done wrong, the cause of wrongdoing, remediation of personal behaviour and practice to ensure no repetition of wrongdoing, and genuine remorse for what happened.

If these circumstances are present, it is only in the most serious of cases that the Board will consider suspending or removing a nurse or midwife's Registration, and in those circumstances we work to ensure that nurses and midwives are well represented, are able to articulate their position in relation to the wrongdoing which was found, and hopefully then to obtain the most proportionate outcome from what is a very serious process.

Edward Mathews is INMO director of social policy and regulation

Introducing Executive Council members

Moira Craig

CNM practice support nurse
Beaumont Hospital, Dublin

I trained as a registered general nurse in Beaumont Hospital, completed my bachelor of nursing studies in Dublin City University, and postgraduate diploma in emergency nursing in the RCSI. I currently work in Beaumont Hospital ED as a CNM practice support nurse.

I have been active in the INMO since 2004, firstly as a student, then as a branch officer, subsequently as a local nurse rep and then as an Executive Council member for the past five years.

During my time as an activist I have been heavily involved in advocating for improvements in working conditions, both at a local and national level. I have also maintained a keen interest in our student membership and ensuring they are both well organised and well represented.

As both an Executive Council member and local representative I have shared the knowledge taken from both roles to ensure I fervently represent the interests of our members locally and nationally.

Working in an ED, I see first-hand the level of investment that is required to improve the public health service. For the good of citizens, we must maintain a publicly owned and delivered serviceable health service.

On the issue of CPD requirements for nurses and midwives I want to ensure that the INMO is able to deliver all the educational needs of our members in this area.

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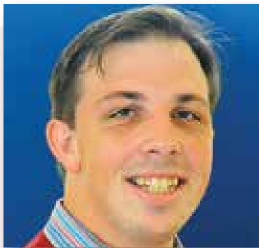

James Geoghegan

Acting CNM2
University Hospital Galway

I trained as an RGN in UHG/NUIG 2000-2003. I worked in a variety of surgical and medical wards in UHG since qualifying and I worked as an agency nurse in Sydney, Australia. I am currently working as an acting CNM II at University Hospital Galway in the medical short-stay unit.

I have been involved in the INMO since I was a student, serving as vice chair of the Student Section. I have previously been the chairperson and secretary of the Galway branch, and a member of the INMO Executive Council since 2010, serving as second vice president from 2012-2014.

For the remainder of my time on Executive Council, I will continue to be an advocate for younger nurses and midwives. As we are now slowly seeing the moratorium being lifted, it is imperative that we ensure all new entrants are incentivised to remain in our health service, and that the pay cuts for new entrants are reversed.

I aim to continue to highlight the difficulties faced by nurses/midwives on a daily basis within the workplace due to staffing shortages and other imposed service curtailments.

I will continue to advocate for proper international evidence-based practice staffing level guidelines for safe staffing of our wards and departments. Management must be reminded that we are a valuable asset to our health service and we should be respected for the work we do on a daily basis in very difficult circumstances.

I am committed to serve with my colleagues, on your behalf, on the Executive Council to ensure that the voice of the frontline is heard.

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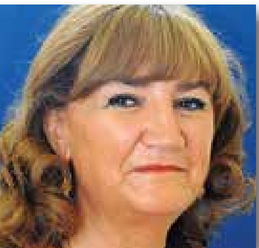

Martina Harkin Kelly

A/director/specialist co-ordinator/nurse educator, CNME
Sligo/Leitrim & West Cavan

I have more than 30 years of active involvement in the INMO. This is my second term on Executive Council, which has spanned some of the most difficult and challenging economic times in the history of collective bargaining. I have 15 years' union rep experience and held the position of Sligo Branch chair for four years. For me, grass roots involvement is the most rewarding aspect of being in the INMO.

Like many of my counterparts I have also lived through economic shocks having had to emigrate to the UK for four years of postgraduate experience in a variety of clinical settings. I wish to lead, inspire and motivate nurses and midwives collectively to positively challenge policy makers by working to defend and protect their rights as valued healthcare workers.

Nursing and midwifery require critical care as a professions and for me conducting a primary survey of needs is central to reigniting them in this country.

- Acknowledgement of the value of nurses/midwives by employers
- Bring back Irish-trained nurses/midwives and stop the brain drain
- Commitment from our leaders at a regulatory and Department level to navigate the profession
- Duty of candour – I will push for HSE management to be held accountable for inaction and lobby for legislation to be enacted as occurred in the UK after the Mid Staffordshire crisis
- Ensure an emphasis on workplace health and safety. This requires nurse/patient ratios
- Fully support the educational and training needs of all nurses and midwives vis-à-vis competency and CPD
- Gender imbalance: As 97% of our workforce is female, employers to create family-friendly environments and to support more flexible working environments. We no longer want to be patronised!

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Understanding the Code

In a continuing series examining the new Code of Professional Conduct and Ethics, **Edward Mathews** discusses personal responsibility

IN OUR exploration of the Code of Professional Conduct for registered nurses and midwives, this month's focus is on the second principle of the Code – Professional responsibility and accountability. In this discussion, we will confine ourselves to the relevant ethical values and the more general standards of conduct. In the next issue of *WIN* we will continue with the same principle and the remaining, more specific, standards of conduct.

Each principle in the Code underpins a set of ethical values, and associated standards of conduct. The ethical values state the primary goals and obligations of nurses and midwives, and the standards of conduct and professional practice flow from these values. They also show the attitudes and behaviours that members of the public have the right to expect from nurses and midwives.

It is important for all nurses and midwives to consider the totality of the contents of the Code, and to reflect on the principles, ethical values, and standards, in deciding how to practise nursing and midwifery.

Responsibility and accountability

The focus of this principle is professional responsibility and accountability for each individual nurse and midwife, their professional and personal integrity, their duty to advocate on behalf of patients, the professional boundaries that exist within nursing and midwifery, the importance of insurance for practice, and issues surrounding conscientious objections.

High standards of behaviour

There are five values underpinning the principle of professional responsibility and accountability, the first of which indicates that nurses and midwives are expected to show high standards of professional behaviour. This, in and of itself, is a serious invocation to each nurse and midwife to practice, on a day-to-day basis, to the highest standard possible.

In another respect this is a relatively nebulous phrase, which could have many meanings. Clearly though, the meaning is informed by history, theory, law, research, guidance, and most of all the practice of our professions. It is a phrase with no one meaning, and the meanings of professionalism will be as many and various as the interactions you experience every day.

Practice, attitudes and actions

The second value requires that nurses and midwives be professionally responsible and accountable for their practice, attitudes and actions including inactions and omissions. To be professionally responsible and accountable means, in the broadest sense, taking ownership of one's individual conduct, and while an individual's conduct may be explained, or influenced, by institutional settings, the behaviour of others, and the constraints which present on a day-to-day basis, each nurse and midwife, as an independent registered professional, must take ownership of their own practice.

In addition, this value refers to the attitudes and actions of a nurse or midwife, including their inactions and omissions. In many cases, where a nurse or midwife is called to account in relation to their fitness to practise, it is not only their day-to-day actions which are called into question, but also the manner in which they practise, that being the attitude they display. The matters that are called into question also often include what was done and what was not done.

It is important, in reflecting on this ethical value, that nurses and midwives are aware that they must take ownership of what they do and what they do not do, and how they go about this. They must also be in a position, if called upon to do so, to take responsibility for what they have done or failed to do, and to explain to others why they acted as they did.

Professional integrity

The next value requires that a nurse or midwife recognises the relationship between professional responsibility and accountability, and their own professional integrity. Professional integrity might be understood as a measure of the extent to which your own professional reputation and credibility remain intact. Thus, it is necessary, from the point of view of an overarching ethical viewpoint, that nurses and midwives recognise the necessity to be responsible and accountable for practice, attitudes, and actions, which include actions and omissions.

Further, this is inextricably linked to the manner in which one's professional

reputation and credibility remain intact, and indeed the extent to which the professions of nursing and midwifery credibility and reputation remain intact arising from what you did, and how you did it.

Advocating for patients

The next animating principle requires that nurses and midwives advocate for patients' rights. For many years this has been a hallmark of the professions, in that we are not, and should not be, silent observers of either the circumstances of care for an individual, or for a group of persons. We should consider the human dignity of each individual, and accordingly advocate for their best interests as expressed by them, or as understood through an alternative to personal expression, as discussed in a previous article.

Appropriate management of resources

The final animating ethical value requires that nurses and midwives recognise their role in the appropriate management healthcare resources, which increasingly in today's healthcare environment requires a nurse or midwife to be vigilant in relation to waste, in relation to the behaviour of others in the management of resources, and of course in relation to the appropriate use of resources within each individual clinical setting.

General standards of conduct

Turning to the more general standards of conduct associated with these values, the first associated standard requires that the nurse or midwife act within the law, and follow the rules and regulations of the Nursing and Midwifery Board of Ireland. The law regulates many areas of nurses and midwives' conduct, not least the requirement to be maintained on the Register in order to practice nursing or midwifery.

There are many rules and regulations of the Nursing & Midwifery Board of Ireland, which are separate to the guidelines and standards which are issued. These rules and regulations must be complied with, and a failure to do so calls into question a nurse or midwife's standard of behaviour, and professional integrity.

The law, aside from its particular relevance to nursing and midwifery, contains many general prohibitions relating to conduct by persons in our society and these are equally applicable to nurses and midwives.

It is important to bear in mind the effect of the law on day-to-day practice, including on matters such as the reporting of abuse of vulnerable adults and children, which we have dealt with in a previous article in *WIN*, and also on matters such as the protection of life during pregnancy, the prohibition and theft, rules relating to the treatment of individuals, and the prohibition of assaults, and many other matters which are prohibited by the general criminal law.

A somewhat related standard requires that a nurse or midwife abide by the ethical and professional values and standards of conduct and practice in the Code itself, and also that nurses and midwives abide by the standards and guidance set down by the Board.

The Code itself, and its relevance, is the subject matter of our current endeavour, but it will be immediately evident to nurses and midwives that the guidelines, which are many and various, of the NMBI do have an impact on day-to-day practise.

Without doubt the vast majority of registered nurses and midwives will undertake functions on a daily basis which are referable to guidelines relating to medication management and recording clinical practice, to name but two.

These guidelines provide a reference point for the nurse or midwife in determining whether their practice reaches the required level of professionalism, and, in addition, facilitates the Fitness to Practise Committee in doing likewise.

Also, the Board is now moving, in many instances, to issuing standards in relation to particular areas of practice, as opposed to guidance, and these are engineered to specifically guide the registrant, and the public, as to what types of behaviour should be expected from a nurse or midwife.

Individual nurses or midwives must be familiar with the contents of these documents so that they can regulate their behaviour so as to be responsible and accountable for their acts and omissions, to avoid being called to account by the Nursing and Midwifery Board of Ireland, or, if called to account, to ensure that you have an appropriate answer to a charge in relation to their fitness to practise.

Decisions and actions

In this area of professional responsibility and accountability, the standards of conduct also require that an individual nurse or midwife be responsible and accountable for their decisions and actions, including inactions and omissions, in day-to-day practise.

It is an inherent element of professional integrity, and the responsibility and accountability associated with any registered professional, that you must be in a position to stand over – and answer questions relating to – the decisions you make in relation to the care that you deliver, the things that you do, the things that you decide not to do, and overall be in a position to effectively defend the practice that you engage in on a day-to-day basis.

Ownership of practice

Inherent to the professional integrity of an individual nurse and midwife, or indeed any professional, is the ability to take ownership of one's practice, and to explain why one practised in the way one did, and ultimately to be able to assure the public that the decisions taken were not ad hoc, were guided by best practice, and can be stood over by the professional concerned.

The remaining standards of conduct under this principle are equally important, but more specific, and we will return to those next month.

Conclusion

In essence, Principle 2 is all about professionalism: what it is to be a professional; the hallmarks of a profession; and the ethical values of standards of conduct that should be expected of all professionals, and in particular nurses and midwives.

It is all about us taking responsibility for what we do or do not do, and being accountable for our actions and omissions. It refers to the maintenance of our own professional integrity, and ensuring that in doing so, we respect the human dignity of those we serve, the integrity of ourselves as professionals, the integrity of our profession as a whole.

The principles, associated values, and standards of conduct seek to ensure that those we serve can expect a professional service, occupied by professionals, who take decisions for which they are happy to take responsibility, and regarding which they may be held to account, and are happy to be held to account within a fair and transparent process.

Edward Matthews is INMO director of social policy and regulation

On the ground
with the president

ICN, Seoul, Korea

I ATTENDED the International Council of Nurses conference in Seoul, Korea – which had as its theme 'Global Citizen, Global Nursing' – along with Elizabeth Adams, INMO director of professional development and Dean Flanagan, INMO student and new graduate officer in his capacity as president of ENSA. This international gathering of thousands of nurses explored the importance of cross-cultural understanding and global co-operation in nursing. The conference provided opportunities for nurses to build relationships and to disseminate nursing knowledge and leadership across specialties, cultures and countries. The Council of National Representatives (CNR), ICN's global governing body meeting also took place. Conference participants who are members of ICN member associations were able to observe global nursing leaders identify the profession's priorities and future directions. The Irish Nurses and Midwives Organisation received a 'Membership Inclusiveness' Silver award at the CNR meeting to recognise our work towards inclusiveness at national level and improvement of the NNA coverage. The calculation of the level of award was based on the data provided to ICN through the census forms over the four years preceding the presentation of the award.

OHN Conference

It was a pleasure to address the recent Occupational Health Nurses Section annual conference which was held in Cork in May. The conference was very well attended and the programme was excellent. The conference theme was 'Common conditions and trends in the workplace'. We are grateful to Laya Healthcare which sponsored the poster competition. I would like to sincerely thank the organising committee – Margaret Morrissey, Anne Marie Graham and Una Feeney for their Trojan work in making the event a very successful day.

Pictured at the OHN Section conference were:(l-r): Margaret Morrissey, OHN Committee; Anne Marie Graham,OHN Committee; Deirdre Gleeson, speaker; Claire Mahon, INMO president; and Una Feeney,OHN Committee

National Women's Council of Ireland

I ALSO attended the NWCI's AGM which had as its theme 'So, Tell Me Why We Still Need Feminism?' The AGM explored the theme of 'Feminist Futures', which brought a huge gathering of women and men together to look at why we still need feminism today, considering what a feminist future would look like – the end of violence against women, placing a real value on care and care work, reproductive rights for all women, affordable, accessible childcare etc.

'Turn off the Red Light'

THE INMO is still actively involved in the Turn Off the Red Light campaign to end prostitution and sex trafficking in Ireland. The Organisation's motion to the recent National Women's Council of Ireland Conference was regarding the Enactment of Criminal Law (Sexual Offences) Bill 2014 – "*The INMO calls on the NWCI, considering its policy against women and prostitution, and its membership of Turn Off the Red Light and the European's Women's Lobby, to provide support and resources to ensure successful implementation of same.*" The significant and long-term health effects of selling one's body for sexual purposes is not acceptable, and cannot be normalised through legalisation.

It is absolutely necessary that the general scheme of the Criminal Law (Sexual Offences) Bill 2014 be passed urgently through the Oireachtas. On June 1, 2015 Northern Ireland brought into law the decriminalisation of prostitution and the criminalisation of the purchase of persons for the purposes of sexual exploitation.

RCN Northern Ireland Nurse of the Year award

I WAS delighted to attend this event on behalf of the INMO this year where nurses and care assistants received awards for their outstanding contribution to healthcare in the North. It is a key event in the nursing calendar for the RCN Northern Ireland.

Summer break

I SINCERELY hope that you all get some time to relax over the summer period and to get away from your very busy workplaces for a week or two.

Get in touch

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

Claire

Optimal cord clamping

'If the cord is white, the time is right' to clamp the umbilical cord post-partum, write **Amanda Burleigh**, **Hannah Tizard** and **Deirdre Munro**

THE umbilical cord is clamped and cut following birth of baby. Immediate cord clamping (ICC) occurs immediately, delayed cord clamping (DCC) occurs after one minute, up to five minutes or longer. Non-severance of the cord known as a lotus birth occurs when the umbilical cord is uncut after childbirth and the baby is attached to the placenta until the cord naturally separates at the umbilicus, usually a few days after birth. Optimal cord clamping (OCC) considers the optimum time for baby, currently deemed a salutogenic term and best practice. Timing and clamping of the umbilical cord can vary depending on policy and practice.

Midwife Amanda Burleigh spent a decade campaigning for babies to have more time attached to their umbilical cord before being clamped and cut. The National Institute for Health and Care Excellence (NICE) changed its guidelines, stating doctors and midwives should not routinely clamp the cord 'earlier than one minute from the birth of the baby', and should wait one to five minutes or longer if the mother requests it.

Background

Immediate Cord Clamping (ICC) has been practiced globally for 50-60 years since cytotocic drugs were introduced and active management of the third stage was recommended in all births to reduce incidence of post-partum haemorrhage (PPH). However, nobody considered the effect of immediate cord clamping on the baby. This management appeared to reduce the incidence of PPH and was adopted as routine practice.

Research

A Cochrane Systematic Review[1] showed no significant difference in PPH rates when comparing early and late cord clamping (between one to three minutes). Farrer et al[2] reported DCC deprives the foetus of up to 214g of cord blood, equating to approximately 30% of intended blood volume.

A randomised control trial by Andersson et al[3] report a higher incidence of iron deficiency anaemia at four months of age in the ICC group. Follow up identified decreased fine motor and social skills in boys at four years of age.[4] Prof Judith Mercer reports all babies benefit from DCC with fewer incidences of intra-ventricular haemorrhage and necrotising enterocolitis in premature babies and states all babies should have delayed cord clamping for at least five minutes.[5]

Recommendations

The WHO,[6] RCOG,[7] RCM,[8] European Resuscitation Council,[9] and now NICE,[10] recommend at least one minute delay before clamping

- Do not clamp the cord earlier than one minute from birth of baby unless there is concern about the integrity of the cord or baby has a heartbeat below 60 beats/min and not increasing.
- Clamp the cord before five minutes in order to perform controlled cord traction as part of active management
- Timing of clamping the umbilical cord and reasons for early clamping and cutting should be documented in the delivery and newborn notes
- Whenever possible resuscitation with the umbilical cord intact should be performed. NICE recommends all babies receive a delay of at least one minute before the cord is clamped, hospitals should devise ways of delivering this evidence based practice.

ICC and active management should occur in following scenarios:

- Haemorrhage
- Undelivered placenta within one hour of the birth of the baby
- Parental request (with informed choice)

Next steps

Informing parents of OCC benefits for premature and compromised babies may allay potential anxiety allowing resuscitation of the baby at the bedside with the cord intact.

What can you do?

- 'If the cord is white, the time is right' – practice OCC. The baby is entitled to receive their full blood benefit
- Be aware of physiology, new evidence and research
- Discuss OCC with mothers and partners antenatally, document preferences using #BloodtoBaby stickers, available on NHS Change Day website
- Join your hospital policy group, question how NICE guidelines for DCC can be introduced into local policy. Get involved, write new guidelines
- Oxytocics can be administered after the cord has stopped pulsating, defer administration with the anterior shoulder, wait until baby and cord are assessed
- Practice skin to skin
- Facilitate bonding, breastfeeding and microbiome transfer to baby
- Share your knowledge.

Delaying for one minute is a welcome change for all babies, facilitating transition from inter-uterine to extra-uterine life. As transfusion is known to continue during the first three to five minutes of life, we suggest this process is not interrupted.

Midwives should be competent in both active and physiological third stage of labour management.[8,11] "Physiological management can be seen as the logical ending to a normal physiological labour".

Practitioners have a responsibility to advocate for newborn babies and the future health of populations.

Amanda Burleigh is a midwife expert in optimal cord clamping, Royal College Midwives OCC Working Group, Hannah Tizard is a student midwife, University of Central Lancashire, Royal College of Midwives OCC Working Group, founder #BloodtoBaby campaign and Deirdre Munro is a midwife, member of the INMO Executive Council, the education officer of the Midwives Section and a lecturer at the University of Limerick

All authors are members of the #BloodtoBaby Campaign and the Global Village of Midwives #Globalvillagemidwives
Twitter: @GlobalvillageMW

References on request from nursing@medmedia.ie (Quote Midwifery Matters, WIN 2015; 23(6): 55

Putting your best foot forward

Dean Flanagan offers new nursing and midwifery graduates some practical advice on how to best prepare for the job market

MORE than 1,500 nursing and midwifery students will complete their degrees shortly after their final placements. Previously, this cohort of new graduates would have faced unemployment or job insecurity, however with the INMO's continued persistence all 2015 nursing graduates will be offered permanent contracts upon graduation. This is great news and hopefully a sign that things are brightening for the newest people entering the health service.

However, it has not been stated if all midwives will be offered a permanent contract. Rest assured that the INMO will continue to seek clarification on this important matter.

It is my opinion that we must support and invest in the next generation of Irish nurses and midwives. This need is highlighted by the sheer volume of Irish trained nurses and midwives who have emigrated to England and Australia.

I have had the privilege of visiting student nurses and midwives during their internships over the past two years and have found them to be very passionate about their chosen career path. Yet, when it came to trying to find work, the HSE did not give them a chance. This was not only throwing away public investment in their training and education, but it is also contributing to the country's overall shortage of nurses and midwives.

As a nation, it is now crucial that we start building a nursing and midwifery workforce for the future, giving graduates the training and experience they need to become the senior nurses and midwives of tomorrow.

What every nursing student should know when seeking employment

Following the good news that jobs will be offered to new graduates, you will need to get interview ready. Job interviews play a significant part on the path to becoming a professional after your studies and everybody should be prepared and feel comfortable with the interview process.

Do some research: This is actually one of the best things about the Irish internship process, as new graduates, you have an intimate working knowledge of Irish hospitals, unlike UK and Australian colleagues. The interview panel wants to see that you are familiar with the hospital when they're interviewing you.

Be prepared to answer questions like, 'What do you know about our policy on X or Y?'. The more you know about a hospital or healthcare setting, the better prepared you will be to demonstrate your sincere interest during the job interview.

Be comfortable with pauses: It is tempting to keep talking to fill silences because you are nervous, but if you've answered the question, pause and take a breath. More than likely the interviewer will come back into the conversation. If you are not sure whether you have done yourself justice with your answer, don't be afraid to ask the interviewer, 'Does that answer your question?'

Talk about your interests: Employers find it appealing when an interviewee is passionate about things other than their profession, whether it's the environment, humanitarian causes or a hobby.

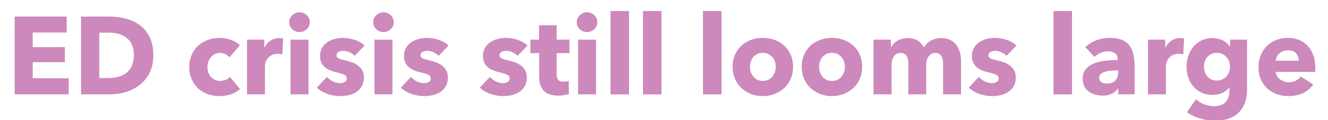
Be honest about your skills: If you haven't got the experience the job is seeking, be honest with the panel. This is important for you to remember, as you are a new graduate and not expected to know everything. However, tell the interviewer why you think you can do this job as well as someone who does have the experience.

You are not alone

Irish Nurses and Midwives Organisation
Working Together

Counselling, legal advice, domestic assistance and bodily injury cover

Free helplines provided by DAS, 365 days a year, 24/7
Tel: 1850 670 407 for counselling or 1850 670 707 for other services
See www.inmo.ie for further details



The worst ever trolley figures recorded for the month of May made headlines around the country. **Ann Keating** reports

THE Irish Examiner (June 13) covered our May analysis of Trolley/Ward watch – **7,700 patients waiting on trolleys – Worst ever figures for hospital admissions, says nurses organisation**. "More than 7,700 patients waited on trolleys for admission to hospital last month – the worst figures for the month of May since records began…The INMO said the May figures are "up a staggering 83% on May 2006, the year the then Minister for Health declared the crisis a national emergency… the INMO said the figures are up 31% on May 2014 and its executive council has called for urgent sustained action, including major investment, to tackle the issue." General secretary, Liam Doran said: "the government needs to take responsibility for this on-going crisis. The stated target of having a reduction in the level of daily overcrowding in emergency departments by October 1 is merely a pipe dream without investment in acute beds, step-down beds, enhanced community services and recruitment initiatives for nursing and other staff."

The *Limerick Post* (June 13) ran a story on the front page – **Hospital horror hits the elderly**. "The family of a 101-year-old woman from Clare said she had to wait five hours for an ambulance on Thursday to take her to UHL, and then spent 25 hours on a trolley in the emergency department." IRO Mary Fogarty said: "It's absolutely deplorable, disgraceful and inhumane that any health service could leave a woman of that age, 101 years old, on a trolley. Words just can't express it. We have repeatedly asked the HSE to prioritise patients in emergency departments for beds."

Concern for patient's welfare was a headline in the *Mid-Louth Independent* (June 10). "A local woman has told of her shock at conditions in the emergency department at Our Lady of Lourdes Hospital with an 84-year-old woman left without even a pillow as she waited on a trolley for more than 24 hours. The woman was attending the department with a pregnant relative who had a suspected clot. Despite the seriousness of her condition, the woman said her relative, who is six months pregnant, was sent home for a number of hours because there was no space for her to wait…the HSE said a dedicated team is being put together to visit hospital emergency departments with the worst levels of overcrowding." IRO Tony Fitzpatrick said: "…the measure is 'pointless' because the HSE already know what the problem is. He said the overcrowding is caused by a lack of acute beds and at least 30 beds are needed to ease the problem at the Lourdes."

The *Irish Sun* (June 6) reported on another elderly lady left on a trolley in Tallaght Hospital on this occasion – **Gran's human rights 'abused' – Doc slams 26 hour bed wait for 101 year-old**. "The treatment of a 101-year-old woman left lying on a hospital trolley for more than a day has been branded a human rights abuse." IRO Derek Reilly said: "The problem of overcrowding is going on now for ten years. Tallaght is no different than any other hospital but the reality is it just can't cope, and nurses are doing all they can."

Lansdowne Road Agreement

The Industrial Relations News (June 11) reported on the Lansdowne Agreement – **Nurses & midwives union's boost for Lansdowne Agreement.** "The executive of the INMO has "cautiously" recommended acceptance of the Lansdowne Road Agreement after an intense two-day executive meeting of the union earlier this week. The union's decision is a big boost to the government's chances of getting the deal ratified as the INMO was one of the unions who walked out of talks on 'Croke Park 2' over two years ago." Director of industrial relations, Phil Ni Sheaghdha said: "the lack of progress on the union's claim for restoration of the 37-hour week and failure to tackle nurse recruitment, were key factors in the executive's decision to stop short of fully endorsing the LRA. However, she said she sees the LRA as a start in the restoration of the cuts imposed over six years.

Midland Regional Hospital, Portlaoise

The Irish Times (June 4) featured an article on Portlaoise hospital – **Complex surgery to be moved from Portlaoise – Varadkar says changes at hospital are not being made for financial reasons** – Resources must be in place before any service transfers take place, says INMO. "Complex surgical procedures are to be moved out of the Midland Regional Hospital in Portlaoise, and the opening hours of its emergency department are expected to be reduced." Liam Doran said: "…before any services were relocated, the ability of the receiving hospital in terms of staffing and bed capacity needed to be examined… extra bed capacity, together with the additional staff required, must be in place before any service reconfiguration."

Belmont Park, Waterford

Finally *The Irish Examiner* (June 16) gave space to a story that members working in the Brothers of Charity Services in Belmont Park, Waterford will hold a lunchtime protest – **Nurses set to stage care centre protest**. "The action is designed to highlight their dissatisfaction at management's decision to downgrade one of the two night duty senior nurse positions within the service." IRO Mary Power said: "discussions with management had been unsuccessful."

Ann Keating is the INMO media relations officer, email: annkeating@inmo.ie

Still we work

Martina Harkin-Kelly describes the National Women's Council of Ireland's legacy project to represent women at work

ON Saturday, May 23 last I had the pleasure of being asked to represent the INMO at a National Women's Council of Ireland (NWCI) commissioned workshop entitled 'Still, we work' in Letterkenny's Cultural Building, Co Donegal.

The workshop, I had been informed, was to last two hours and was to be followed by a talk from Anne Tallentire, an artist originally from Armagh and now living and working in London who had been involved in the Legacy Project. I was intrigued and curious to know what the project was all about?

So, to shed some light, 'Still, we work' is a travelling exhibition of four art and research projects commissioned by the National Women's Council of Ireland looking at contemporary representations of women's work and the condition of women's labour in modern times.

The exhibition seeks to illustrate the often hidden or invisible work that women do as carers, in the domestic setting and in the community. It aims to give visibility to the experiences and the reality of women's working lives that is sometimes lost sight of.

These exhibition commissions were all carried out during the 40th anniversary year of the NWCI which coincided with the centenary of the 1913 Dublin Lockout. The NWCI was central to the development of the exhibitions which have been shown and re-shown around the country.

The culmination of work from various women's groups, including contributions from the INMO, has served as a discussion forum across NWCI membership and art groups.

The purpose of the workshop on May 23 in Letterkenny was for those in attendance to build a 'legacy box'. The box was created and designed to encapsulate the multitasking nature of women, in that it was crafted to ensure multifunctional use.

Fiona McDonald, an artist and architect, was commissioned to design the box that will support the storage, transportation and exhibition of the artists' pieces for 'Still, we work'. This is the eighth design by Fiona in her alternative series. For any readers interested in DIY, construction manuals for the whole series are available as open source material on her website: **www.fionamcdonald.ie**

Pictured at the NWCI workshop in Letterkenny, Co Donegal recently were (l-r): *Adeline Hegarty, workshop participant; Karon Brennan, workshop participant; Martina Harkin-Kelly, INMO Executive Council member; and Fiona McDonald, architect and artist*

Work in earnest

I arrived in best bib and tucker, ie. the gúna, at 10am to be greeted by Marie Barrett, organiser and artistic director of North 55. North 55 was founded in 2002 in Inishowen, Co Donegal. Its central tenet is the engagement of community development and the practice of Art. The name North 55 is significant as it refers to the line of latitude crossing the border between Derry and Donegal.

Two co-workshop members Adeline Hegarty and Karon Brennan arrived a little later, both were home craft workers. With introductions dispensed, Fiona explained our involvement and this immediately prompted me to make a wardrobe change – with work clothes on we began.

We beavered away on assembling the 'support surface box', which for all of us was a cathartic, empowering experience.

Working with the variety of construction materials and equipment was a true embodiment of the many themes in the legacy series: touch; organising; communicating; and empowering.

We laughed and talked and, of course, lost patience with the task as the afternoon moved on and the two-hour schedule was long gone out the window! But still we worked – drilling, hammering, painting, sanding and gluing not giving up and showing the true grit and determination of many women.

Finally, our labour paid off when around 4:30pm we had completed the task. The support surface box was finished and the sense of pride and satisfaction was etched on all our dusty, dirty and tired faces, as we proudly stood for a quick photo shoot. We were exhausted but the box was real and tangible – it was indeed a hub around which exchange had happened.

This workshop is the first of three planned events the other two are scheduled for Kilkenny and Limerick. My advice is if you get the opportunity to become involved it's one not to be missed!

Martina Harkin-Kelly is a member of the INMO Executive Council

MEATH

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Branch workplaces and areas covered

• Our Lady's Hospital Navan • Meath disability services for adults and children • Services for Older persons in Trim, Navan, Kells, Dunshaughlin and Morington • Public health and community nursing services • Private nursing homes • General practice

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Latest news

THE Meath Branch recently had the pleasure of hosting the ADC in the Knightsbrook Hotel, Trim.

The main issues facing the Meath Branch include regularisation of long-term acting posts, escalation, safe staffing levels and appropriate skill mix. The reconfiguration of Our Lady's Hospital, Navan within the new hospital groupings is also a concern for branch members. Staffing levels and skill mix are ongoing concerns for members working in the community care areas.

Our aim for 2015 is to actively encourage members to engage in branch meetings and use this forum in a proactive manner.

The current officers of the Meath Branch are as follows: Caroline Carpenter, chair; Dympna Fegan, vice chair; Anne Tully, secretary; Marie McConnell, vice secretary; Noeleen Kangley, treasurer; and Joan Kelly, vice treasurer.

Industrial relations update

Tony Fitzpatrick and Derek Reilly are the IROs for the Meath Branch.

Tony Fitzpatrick covers Co Meath while Derek Reilly covers ongoing issues of understaffing and overcrowding at Our Lady's Hospital, Navan, as it is now part of the Ireland East Hospital Group, as well as representing members on individual cases.

The Organisation is also involved in representing individual members in a number of HSE processes and is pursuing a significant number of individual claims and grievances.

The INMO is currently representing members on a number of issues in Co Meath including:

- Meath Disability Services – The INMO has commenced intensive engagement with management on staff redeployment; annual leave; vehicle checks; grading of persons in command; staffing and skill mix with additional staff secured; out-of-hours on-call payments for managers; and staff training
- Public health nurse and community registered general nurses' issues including ongoing engagement with HSE on working hours, community structures, privilege days and reform programmes
- Services for older persons including staffing, skill mix and rosters
- Meath palliative care: engagement has commenced on the reconfiguration of palliative care services in the North East with negotiation ongoing regarding the establishment of teams in Ashbourne and Kells.

Teaching nurses network

The TNN was set up to provide support for nurses teaching HCAs, many of whom go on to train as nurses or midwives, writes **Ingrid Condell**

TRAINING for nurses and midwives in Ireland is provided within the higher education sector. Training for healthcare assistants (HCAs) occurs within the further education and training sector, provided by SOLAS in conjunction with the 16 education and training boards nationally. Some training programmes are provided by private providers and are overseen by SOLAS.

Access to nurse and midwifery training programmes is through the CAO and, as is the case for other undergraduate courses, the allocation of places is points driven. The universities and institutes of technology also allocate a small number of places on their nursing and midwifery programmes each year for candidates who achieve a minimum of five distinctions in a QQI Level 5 Nursing Studies Major Award.

Achieving this does not guarantee a place on a level 8 programme however, as places are very limited and are allocated on a random selection basis. Candidates who have not achieved the required number of points in the Leaving Certificate often use this system as a second chance to gain access to a nursing or midwifery programme. However, many who manage to achieve the five distinctions, and more, are often disappointed as places are very limited.

Those who are unsuccessful in gaining a place may use their nursing studies award to help them gain a place on a nurse or midwifery training programme in the UK, or may use their qualification to work as a HCA.

Some will try again to gain a place on the level 8 programme as a mature student once they reach the age of 23. This requires the candidate to undergo a series of aptitude tests and, again, places are allocated on a points basis.

There appears to be a better chance of success for candidates taking this route as approximately 15% of places on degree programmes are allocated to mature applicants.

The introduction of the grade of healthcare professional known as healthcare assistant was first mooted in the Commission on Nursing in 1989 with the intention that the HCA role would be to support the nursing and midwifery function. HCAs work under the supervision of nurses and midwives, who delegate their duties.

The nationally recognised qualification to work as a HCA is the QQI level 5 Healthcare Support Major Award and the QQI level 5 Nursing Studies Award.

The education and training for these awards are delivered by nurses and teachers working in the further education and training sector. Nurses who teach in this sector generally work in a post Leaving Certificate (PLC) department of a vocational school or in a dedicated further education college. They often work in isolation from other nursing colleagues.

The Teaching Nurses Network (TNN) was founded by Bernadette Reid, a teacher at Waterford College of Further Education, in September 2009. The TNN held its inaugural meeting in September 2009 in Waterford College of Further Education.

The group was set up to be a learning forum and a resource for shared information. It provides support to nurses teaching nursing and healthcare support courses, and acts as a voice to collectively highlight issues with relevant bodies.

The group meets biannually and has recently launched its website: **www.teachingnursesnetwork.ie** The TNN's membership is growing with further education providers well represented nationally.

Its mission statement is: *The TNN provides a support forum for nurses educating learners in healthcare at level 4-6. Our aim is to promote, maintain and foster the delivery of quality standards for holistic care.*

As a group the TNN aims to maintain the high standards and quality of the programmes that they as nurses deliver.

Issues that have been highlighted to date include the allocation of undergraduate nursing and midwifery places to QQI students. This has recently been discussed with Judith Foley, acting chief education officer at the NMBI. This issue has also been discussed with the registrars of several universities and institutes of technology.

The evolving role of the HCA is an area of concern to stakeholders in the healthcare system and the issue of training, career structure and the regulation of HCAs has been raised by the TNN with both the NMBI and with the Department of Health. The network hopes in the future to be able to make a contribution to discussions relating to these issues.

The TNN is also interested in carrying out research to explore the role of the HCA in the different areas of service delivery.

Ingrid Condell is the current chairperson of the TNN and anyone interested in joining the group or contacting the group can do so by email at icondell@tipperaryetb.ie or through the website

Caring: the other big 'C'

Aoife McNamara and **Eileen O'Donovan** discuss the nurse's role, and the challenges faced, alongside the strategies and frameworks that are in place in cancer care in Ireland

EVERY nurse in Ireland will care for a cancer patient at some point in their career, perhaps even on a regular basis. Some will do so without any specialist training in this complex disease. Given the projected increasing incidence of cancer in Ireland over the next 10-15 years, there is an increasing requirement to strategically develop generalist, specialist and advanced practice roles in cancer care in the context of adopting a cancer control approach. This approach has the overall aim to 'enable all nurses to participate in cancer control, whether specialist or generalist and irrespective of where they work'.[1]

Cancer in Ireland

More than 30,000 people are diagnosed with cancer each year in Ireland. Cancer is the second leading cause of death in this country after diseases of the circulatory system.[2] These patients are normally diagnosed by surgeons or medical physicians, visit numerous medical facilities and departments and meet with any number of healthcare professionals before even being diagnosed. Some cancer patients never require an oncology consultation or visit to a cancer unit. The term 'cancer' covers over 200 different diseases, each with different symptoms, treatment plans and prognoses. In fact cancer is so complex that it is fair to say that no two cancer patients are the same, their disease is as unique as they are.

Traditionally, cancer has been treated with surgery, radiotherapy and drug therapy. Surgical and radiotherapy techniques have been developed to greater levels of precision than ever before and a new era of drug therapy referred to as 'personalised medicine' has evolved. These targeted therapies are essentially a more sophisticated version of chemotherapy and can specifically target cancer cells, ensuring the patient experiences fewer side effects. Patients in Ireland are now undergoing molecular testing prior to receiving these new drugs, ensuring in advance that the drug they are about to receive will work for their specific disease. These treatment modalities can be used individually or in combination to cure patients, to reduce their risk of cancer recurring or to treat difficult symptoms in patients with advanced disease.

The complexities of cancer symptoms, treatments, side effects and psychosocial issues are well recognised and require the input of multidisciplinary teams of specialists, both at hospital level and in the community.

In 2006 the second National Cancer Strategy 'A Strategy for Cancer Control in Ireland' reported that Ireland needed a comprehensive cancer control policy programme.[3] Following this, the National Cancer Control Programme (NCCP) was formed in 2007 to reorganise cancer care in Ireland. Eight hospitals were subsequently designated as cancer centres (with a satellite unit in Letterkenny General Hospital). There is at least one designated centre in each of the Department of Health's six Hospital Groups. However due to the number of patients and the complexities of the disease, cancer patients continue to require care in every hospital and GP service in Ireland.

It is also more evident that caring for cancer patients in the community is on the increase. Fortunately, to meet this need there is now a Community Nurse Education Programme for primary care nurses to support cancer patients in the community. The need for this programme illustrates the shift in the development of services in the community and the integration between designated cancer centres and local services.

Psychosocial impact of diagnosis

Cancer has a significant impact on the life of the patient and, for most, feelings such as distress and uncertainty about the future are commonplace.[4] Each stage of the disease brings different potential psychological crises.[5] Distress is considered so widespread among cancer patients, that some researchers have proposed it be considered the sixth vital sign.[6] The National Comprehensive Cancer Network (NCCN) defines distress as: 'a multifactorial

unpleasant emotional experience of a psychological, social and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness and fears, to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis'.[7]

Some 25-30% of newly diagnosed and recurrent patients experience significantly high levels of emotional distress.[8] Research reports that lung cancer patients as a group experience more distress than people with other cancers. This is due to stigma and blame, debilitating symptoms and a poor prognosis.[9] As a disease group, cancer patients in general experience similar issues.

Cancer is still a word people fear, many equate the disease with death so it is not surprising that between one-quarter and one-third of all cancer patients experience high levels of distress.

However, the majority of patients do not require formal psychological interventions but would benefit from the counselling skills of their healthcare professionals.[10] One of the most important things a healthcare professional can do is help a patient to make sense of their illness and treatment. Providing sensitively pitched information through skilled communication can reduce the patient's distress, give them a sense of control and help them to plan for the future.[11]

The National Cancer Forum has previously recognised the influential role the voluntary sector has played in the delivery of psychosocial care.[3] Few patients require the intervention of psycho-oncology services within the hospital, some will rely on the support of the Irish Cancer Society and local cancer support centres throughout the country. But for the majority of patients, their psychosocial needs will be managed by their family and friends and the healthcare professionals they meet at hospital level and in the community. The 2006 strategy recognised this and stated that healthcare professionals need training in communication skills to better assess their patients' distress.[3]

Evolving role of the nurse

In 2012 *A Strategy and Educational Framework for Nurses Caring for People with Cancer in Ireland* was published.[1] This recognised the need to strategically develop the role of all nurses in cancer care, irrespective of where they work and whether they are specialist or generalist, and introduced a national educational framework for all nurses caring for cancer patients.

A professional development model for nursing patients with cancer in Ireland was created which recommends that all nurses, regardless of their role, obtain generic competencies to meet the needs of this particular cohort. This includes basic communications skills, providing psychosocial support and conceptualising the meaning of cancer.[12] However it is not just the patients who require support.

In Ireland, the role of the nurse is constantly evolving and there are now frameworks in place to facilitate this evolution however we, as professionals, have a duty of care to ourselves and need to be more focused on a balance allowing for 'self care' within our roles.

'Care giving' has a cost and there is a multitude of factors that could result in burnout among staff working in oncology and palliative care, including constant exposure to death, identifying with particular families or patients, over investing in work, concurrent stressors in one's personal life, work environment issues such as team or role conflict, and work overload.[12]

In 2009 a study performed on interdisciplinary oncology staff working in an inpatient oncology unit and palliative care unit found that 63% of staff reported high levels of stress in their work. Shockingly, 80% of participants reported that their workload was a significant barrier to the delivery of emotional support at end of life.[13] Research on burnout and compassion fatigue primarily focuses on oncology and palliative care staff. However in the current climate of staff shortages and increasing workloads, it is likely that nurses in all roles are equally affected.

Irish Association for Nurses in Oncology

Operating since 1982, the Irish Association for Nurses in Oncology (IANO) is a non-profit organisation that promotes continuing nurse education and provides a forum for exchange of knowledge for members of the oncology nursing profession. Our members are nurses working in both a specialist and non-specialist capacity. They work in hospitals, in the community, in education and in administration. As an association we are conscious that patients with cancer are being cared for in most wards in every general hospital, in institutions for older people and the general community. The education and support of nurses working in these particular environments is crucial.

The IANO is co-ordinated by an elected national executive committee, comprising 13 voluntary representatives. In 2012, the IANO affiliated with five special interest groups (SIGs): the Irish Breast Care Nurses Group, the Irish Lung Cancer Nurses Group, the Colorectal Cancer Nurses Group, the Irish Gynaecology Oncology Nurses Group, and the Oncology Research Nurses Group. In addition, there are also five regional IANO networks around the country: Cork; South East; Limerick; West; and North West. These SIGs and networks are represented on the national executive committee.

Our annual conference (NMBI category 1 approved) is held each spring and includes a variety of topics and expert presenters from Ireland and abroad. It features SIG parallel break-out sessions, a poster session and commercial exhibits. Our SIGs and networks also arrange educational events and bursaries throughout the year and we run regular European Oncology Nursing Society education programmes.

The IANO has been successful in its bid to host the 2016 European Oncology Nursing Society congress in Dublin. This will be an excellent opportunity to showcase the quality of cancer care delivered by nurses in Ireland as well as a chance to network with and learn from our European colleagues. Professional registered nurses interested or involved in the care of patients with cancer are eligible for membership of the IANO. Membership is established and sustained with an annual membership fee (€35). Membership of the IANO also entitles you to be a member of the regional networks and SIGs as well as free attendance at the annual conference.

Nurses are central to the delivery of high quality cancer services and the ongoing goal of the NCCP is to enable nurses to develop and maintain necessary competencies, at the appropriate level, to deliver quality and seamless cancer care throughout the Irish health service.[1]

To learn more about the IANO visit **www.iano.ie** or **www.facebook.com/IANOIRELAND**

Eileen O'Donovan is a clinical research coordinator in the Clinical Research Centre, St Vincent's University Hospital, and president of the IANO. Aoife McNamara is information development manager in the Irish Cancer Society and is secretary of the IANO

References are available on request from nursing @ medmedia.ie (Quote: O'Donovan E, McNamara A. WIN 2015; 23(6): 64-65)

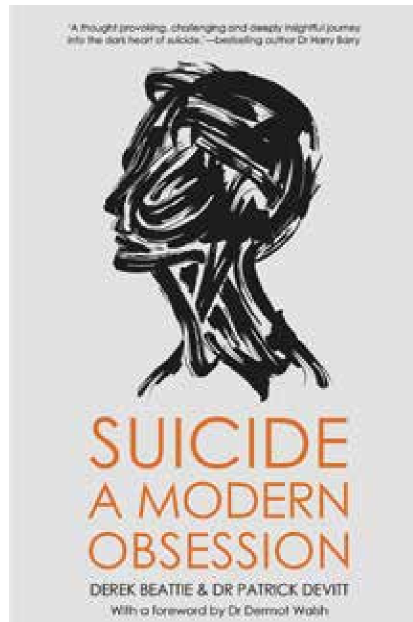
Suicide – beyond the panic

SUICIDE is an emotive, complex and tragic subject, generating extensive media coverage and fraught public debate. Social researcher Derek Beattie and consultant psychiatrist Dr Patrick Devitt, in their thoughtful analysis, propose that this debate (they call it a 'moral panic') and the understandable sensitivities may sometimes get in the way of rational analysis.

Their book asks questions such as whether it is ever acceptable for a person to kill themselves, how do Ireland's suicide rates, especially among young men, compare to rates in other countries, and whether it is possible to prevent suicide.

The authors stress that while it is difficult for those who have lost someone to suicide, is still a relatively rare event. They query why there is more public interest in suicide than road traffic deaths, where the annual numbers in most developed countries are 'just about' comparable. (In fact official annual figures for suicide in Ireland is around two and a half times that of road deaths, but this is a minor cavil).

On the issue of suicide risk and the recent abortion legislation, the authors controversially suggest that any notion that some Irish women will not feign suicidal ideation to access abortion is far-fetched. "This is human nature, it is universal and not everybody will resist." The authors also say that not only are the provisions for abortion based on suicide risk in the new law founded on shaky assumptions, but this begs the question of whether we can we expect the State to introduce other evidence-based policies relating to suicide when, in the abortion law, evidence was not assessed properly or ignored.



The authors admit that Ireland's actual suicide toll may be higher than official numbers suggest. However, they say claims by advocates that the numbers are substantially higher are likely exaggerated.

They stress that while suicide ought to be discouraged, excess publicity about it may be making it more acceptable. They suggest that some well-intentioned media campaigns or fundraising initiatives on suicide prevention may not always be helpful. The authors say they agree with philosopher Jennifer Hecht's view that maintaining a taboo around taking one's life can be helpful, and this is not at odds with the admirable efforts to destigmatise mental illness and help-seeking behaviour.

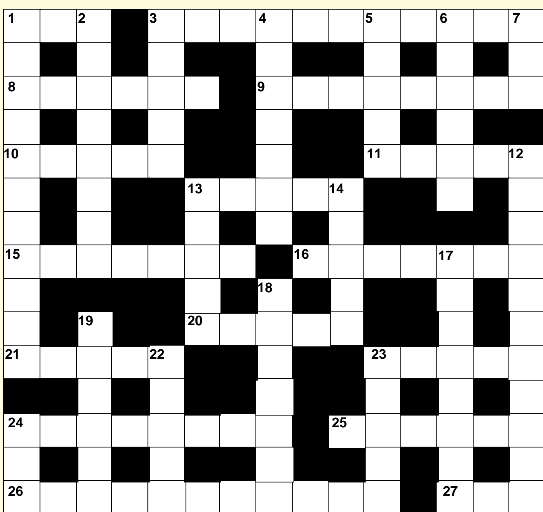
While some of its conclusions may not accord with everyone's views, and on occasion appear contradictory, the book generally provides a clear and sober, if not always 'politically correct' analysis of what is a divisive and difficult issue.

– Niall Hunter

Suicide – A Modern Obsession. Derek Beattie and Dr Patrick Devitt. Published by Liberties Press. Price €14.99
ISBN: 9781909718296

Crossword Competition

WIN A €30 BOOK TOKEN



Across

1. Look through these to see a lion scrub up (10)
6. Hares' home (4)
10 & 11. Surgical procedure seen about the department, following a dislocated elbow (5,9)
12. Call in for a quick visit (3,4)
15. Noblemen adjusted the laser (5)
17. Gone, without the necessary permission (1.1.1.1.1.)
18. The national airline of Israel (2,2)
19. More ancient (5)
21. A famous cheese (7)
23. Part of a teapot (5)
24. It's usually topped with cream and fruit (4)
25. Ceremonial garment (4)
26. Fictional detective, played by the late John Thaw (5)
28. Might Norma do for this job? (7)
33. Major Egyptian waterway (4,5)
34. Shade of brown (5)
35. Mediocre (2-2)
36. In a cemetery you'll see them - the bosses in Jagger's group? (10)

Down

1. Infant (4)
2. This spud was certainly not bought second-hand! (3,6)
3. Stringed instrument (5)
4. Big regal upset (5)
5. Potential danger (4)
7. Type of willow (5)
8. Italian soup (10)
9. Can he clone like this to create a distinct layer? (7)
13. Enormous (4)
14. Strengthened, recovered after a setback (7)
16. People who always expect the worst (10)
20. This dog is not so much 'one in a million' as 'one in one-hundred and one'! (9)
21. Extend (7)
22. The capital of Norway (4)
27. Smells of smoke (5)
29. Leered at the ruined lodge (5)
30. Automaton (5)
31. On a single occasion (4)
32. Untidy place where the officers meet (4)

Solutions to June crossword:

Across:
1. Cow 3. One-stop shop 8. Pelvis 9. Chairman 10. Argue 11. Miler 13. Vital 15. Algebra 16. Dwindle 20. Skier 21. Break 23. Wider 24. Swan Lake 25. Linnet 26. Achievement 27. Mod

Down
1. Captain Ahab 2. Wolfgang 3. Opine 4. Sockets 5. Prism 6. Homily 7. Pun 12. Redecorated 13. Virus 14. Lower 17. Duodenum 18. Mid-term 19. Seraph 22. Kylie 23. Whist 24. Spa

The winner of the June crossword is: Patty Pierce, Templeogue Dublin

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

The prize will go to the first all correct entry opened.
Closing date: **Friday, August 21, 2015**
Post your entry to: **Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin**

New endowment for Girl Child Fund

Fund has enabled over 180 girls in developing countries to finish school

THE International Council of Nurses and the Florence Nightingale International Foundation recently announced the launch of an FNIF Endowment Fund in order to support more girls in the Girl Child Education Fund (GCEF).

The GCEF, which celebrates its 10th anniversary this year, supports the primary and secondary schooling of girls under the age of 18 in developing countries whose parent or parents who were nurses have died, paying for fees, uniforms, shoes and books. The fund has enabled over 180 girls to complete secondary school, and is currently supporting 115 girls.

The FNIF Endowment Fund aims to raise $10 million over the next three years. The interest on this amount will provide funding to cover the schooling of at least 500 girls a year. The launch was announced during the FNIF fundraising lunch at the ICN Conference in Seoul. Pfizer, a long-time supporter of the GCEF, announced a donation of US$15,000 at the lunch. This was followed by pledges and donations by other guests in the room totalling over $70,000. FNIF and ICN Board members have already pledged more than $60,000 to the fund.

Judith Shamian, ICN and FNIF president said: "We are so excited about this new fund that will help so many more girls to complete secondary school and get one step closer to achieving their dreams. We are grateful to all those who have committed to support the fund and look forward to reaching our goal of $10 million!"

Nurses are at the forefront of care, risking their lives to diseases such as AIDS, tuberculosis, malaria and viruses such as Ebola. Their premature deaths leave behind orphaned children, and many of these, particularly the girls, will be taken out of school unless we can help.

Richard Flavell, FNIF Board member, who announced the launch, said to participants, "FNIF is determined to expand its support to the orphaned daughters of nurses, and I very much hope that you will assist us in achieving this."

Mercy Katindi, a graduate from the GCEF who is currently in university in the Republic of Korea studying computer science, gave a moving speech at the Lunch. She told the audience, "for the girls in the GCEF, you are our heroes!"

More information on the Girl Child Education Fund and the FNIF Endowment Fund can be found at: **www.icn.ch/what-we-do/girl-child-education-fund**

Language of suicide matters

IN MAY I attended the OHN Section conference in Cork. It was my first outing to such an event since my beautiful son Eoin died by suicide 18 months previously. I kept to myself and managed to get through the full day without leaving any sessions.

On a number of occasions throughout the day I had to hold myself together and stop the tears coming. Suicide did come up and two of the speakers referred to a person 'committing suicide' or having 'committed suicide'.

I am calling on members of the INMO to ask medical professionals to stop using language such as this. A criminal commits a crime and suicide is not a crime. Language is extremely powerful and to use it inaccurately is insensitive and contributes to the stigma associated with suicide. If medical professionals are using this term it somehow makes it okay for everyone else.

My son Eoin suffered deep emotional pain along with depression and anxiety, dying by suicide he did not 'commit' a crime. Please think about this. I could say a lot more on the subject, but I believe as professionals, INMO members will understand what I am trying to say. I know that no one meant any harm, but to change attitudes maybe we need to change the language we use also.

– Suzanne Taylor

Paid home-care system in Ireland is not addressing needs of older adults

The AIGNA committee members pictured at their recent conference in Dublin

OLDER Irish adults with personal care needs are not having these needs addressed by the formal paid home care system in Ireland according to Dr Catriona Murphy HRB Research Fellow, Trinity College, Dublin.

The failure to address this type of need in the community was likely to trigger demand for long-term residential care earlier than anticipated, she told the 7th annual conference of the All Ireland Gerontological Nurses Association (AIGNA) in Dublin recently. Dr Murphy said the home care received by older people focused predominantly on help with daily living rather than personal care and they were much less likely to get into a home-care system if they were not living alone.

Research indicated that approximately 80% of home-based social care for older adults was provided informally by unpaid family and friends. The first wave of information from the Irish Longitudinal Study on Ageing, suggested that formal paid care was used by a minimum of 8.3 % of older adults and that over 30% of those aged 85 plus in Ireland were receiving formal home-based social care.

Dr Assumpta Ryan, AIGNA president, and reader at the School of Nursing and Institute of Nursing Research at the University of Ulster, said that it was very important that we addressed the future shape which home care, day care, acute care and long-term care should take in the north and south of the island.

MONEY MATTERS

Travel insurance

Ivan Ahern discusses the importance of arranging travel insurance before your trip

TRAVEL insurance can afford you great peace of mind for those things that we hope may never happen while we enjoy our summer vacation. Whether you're planning a break at home or abroad, you should consider getting travel insurance to cover you against losses such as damaged or delayed luggage, cancelled flights, delayed or missed departure, loss or theft of money or passports, or illness or injury.

With this in mind we have put together some questions and answers that might help you in getting a policy that is right for you.

Policy types

Normally policies are broken into two types, single trip and annual multi-trip policies. While single and annual multi-trip policy benefits can vary, you may save money by selecting a multi-trip policy if you think you may be travelling away on holiday more than once in the year.

Countries covered

Most policies will cover you while you are in Europe but if you are going further afield check to make sure your policy gives you worldwide cover. What's more, it's worth remembering that your policy will also cover you if you are holidaying in the beautiful Emerald Isle.

Holiday cancellation

Cancellation cover provides cover for your flights and accommodation in the event that you are unable to travel for specific 'insured' reasons. One such reason could be 'unforeseen emergencies' such as illness, injury or death of a travel companion or relative.

Common misconceptions are that travel insurance provides cover if you cancel your holiday due to business obligations, deciding not to travel or if your airline goes out of business. Unfortunately, you may not be covered by your travel insurance for these reasons.

Main benefits

There are many benefits to travel insurance and these can vary depending on the policy type and the level of cover you wish to have. Below are some key benefits you should look for:

- Medical and other expenses outside the Republic of Ireland
- Personal belongings and baggage
- Cancelling your trip
- Delayed baggage
- Personal money
- Passport and travel documents
- Hospital benefit
- Cutting your trip short
- Missed departure
- Missed connection
- Travel delay
- Abandoning your trip
- Personal accident
- Legal expenses.

Getting the best price?

The price will always depend on the policy type and the cover it provides, but you may be able to save some money if you also have a health insurance policy. Be sure to note it when you are taking out a travel insurance policy.

Also, Cornmarket is currently offering great discounts on travel insurance if you buy online from now until the end of August. These include:

- A 10% discount[1] off a new single trip or extended stay travel insurance policy, when you enter promotion code FGH73iJK
- A 20% discount[2] off a new annual multi-trip travel insurance policy, when you enter promotion code 20%OFFCM

For more information or to get a quote, see **www.cornmarket.ie/travel-insurance**

Ivan Ahern is a director of Cornmarket Group Financial Services Ltd

References

1. 10% discount is only available online at www.cornmarket.ie off the current AIG Europe Limited single and extended stay travel insurance premium available through Cornmarket.

2. 20% discount is only available online at www.cornmarket.ie off the current AIG Europe Limited annual multi-trip travel insurance premium available through Cornmarket. Offers are only available to customers taking out a new travel insurance policy through Cornmarket & underwritten by AIG Europe Limited between April 1, 2015 and August 31, 2015. Discount must be requested at quotation stage and cannot be issued retrospectively. Only one promotion code can be used with each eligible proposal. AIG Europe Limited is authorised by the Prudential Regulation Authority of the United Kingdom, and is regulated by the Central Bank of Ireland for conduct of business rules. Cornmarket Group Financial Services Ltd is regulated by the Central Bank of Ireland. A member of the Irish Life Group Ltd. Telephone calls may be recorded for quality control and training purposes.

August

Saturday 8
International Nurses Section meeting, 11am Waterford Regional Hospital. Contact: jean@inmo.ie or Tel: 01 6640648 for further details

September

Tuesday 8
Care of the Older Person Section workshop on Risk Assessment INMO HQ. 11am-1pm. Booking is essential. Contact: jean@inmo.ie or Tel: 01 6640648 for further details

Thursday 10
Retired Nurses Section meeting. INMO HQ. 11am-1pm. Contact: jean@inmo.ie or Tel: 01 6640648 for further details

Saturday 12
PHN Section meeting. INMO HQ. 11am-1pm. Contact: jean@inmo.ie or Tel: 01 6640648 for further details

Saturday 12
Community RGN Section meeting. INMO HQ 11am-1pm.Contact: jean@inmo.ie or Tel: 01 6640648 for further details

Monday 14
Nurse/Midwife Education Section meeting. INMO HQ 11.30am. Contact: jean@inmo.ie or Tel: 01 6640648 for further details

Wednesday 16
RNID Section workshop on capacity and consent. 10am - 1pm. Contact: marian@inmo.ie for further details

Saturday 19
CNM CMM Section meeting. INMO HQ. 11am-1pm. Contact: jean@inmo.ie or Tel: 01 6640648 for further details

Monday 28
National Children's Nurses Section meeting. Venue to be confirmed. Contact: jean@inmo.ie or Tel: 01 6640648 for further details

Wednesday 30
Telephone Triage Nurses Section Conference. Castletroy Park hotel. Contact: jean@inmo.ie or Tel: 01 6640648 for details

October

Saturday 10
School Nurses Section meeting from 10am, INMO HQ on Preparing for HIQA inspections. Contact: jean@inmo.ie or Tel: 01 6640648 for details

Thursday 15
All Ireland Midwifery conference. Contact: jean@inmo.ie or Tel: 01 6640648 for further details

Friday 16 and Saturday 17
Third Level Student Health Nurses Section. INMO HQ. Contact: jean@inmo.ie or Tel: 01 6640648 for further details

Saturday 17
ODN Section meeting, Sligo. Contact: jean@inmo.ie or Tel: 01 6640648 for further details

Thursday 22
Student Allocations Officers meeting. INMO HQ from 12 – 3pm. Contact: jean@inmo.ie or Tel: 01 6640648 for further details

Thursday 22
CPC Section conference. INMO HQ 11am-1pm. Contact: jean@inmo.ie or Tel: 01 6640648 for further details

INMO Professional Development Centre Library Opening Hours

July/August
Monday-Thursday: 8.30am-5pm
Friday: 8.30am-4.30pm

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

INMO Membership Fees 2015

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

November

Thursday 12
Retired Section conference. INMO HQ from 10am – 4pm. Contact: jean@inmo.ie or Tel: 01 6640648 for further details

Saturday 14
PHN Section meeting. INMO HQ. From 11am-1pm. Contact: jean@inmo.ie or Tel: 01 6640648 for further details

Whipps Cross, UK

- Whipps Cross Hospital, London, set 32, September 1973 to 1976 are planning to get together in September/ October 2015.Please contact Claire or Joan if interested.
- Claire: Tel: 086 3154664 or email: Laughlin.claire @qmail.com
- Joan: Tel: 087 2965951

www.nurse2nurse.ie

Frequently Asked Questions

PROPOSED LANSDOWNE ROAD AGREEMENT (LRA) –

Questions/Answers for Consideration by INMO Members

Q.1 As the Haddington Road Agreement (HRA) is not over, why do we have proposals at this stage?

A: All public service unions, including the INMO, agreed they would seek the benefit of any recovery in the Irish economy for members who have been subjected to income reductions, introduced by Government, via Financial Emergency Measures in the Public Interest Legislation (FEMPI) since 2009.

In recent months it became apparent the economy is recovering and, therefore, the process, leading to these proposals, commenced. The proposals, now for consideration, provide for the first phase of pay restoration, of the earlier cuts, on 1st January 2016, which is six months before the HRA was originally due to expire.

Q.2 Will the Haddington Road Agreement expire in July 2016?

A: If these proposals are accepted the Public Service Stability Agreement and the Haddington Road Agreement would be extended until September 2018 with amendments in key areas.

Q.3 Do these proposals put forward changes to terms and conditions of employment?

A: No. Terms of conditions of employment are not altered in this agreement.

Q.4 What are the pay increases proposed in this agreement?

A (1): The pay increases proposed in this agreement are as follows:

2016:

(i) From 1st January 2016, the pension levy (currently paid on all earnings over €15,000 per annum) will not apply on **earnings below €24,750.**

(ii) From 1st September 2016 the pension levy will not apply to earnings below **€28,750.**

The value of the removal of the pension levy, on earnings up to €24,750 on 1st January 2016, will be approximately €600 per annum, for nurses and midwives earning above that amount, with a further €400 resulting from the increase of the exemption to €28,750 per annum from September 2016.

This will result in an annual benefit of approximately €1,000 per annum to all nurses and midwives currently earning over €15,000.

(iii) On 1st January 2016 there will also be an increase for **annualised (full-time) salaries** as follows:
- salaries up to €24,000 will increase by 2.5%;
- salaries between €24,000 and €31,000 will increase by 1%.

A (2): ***2017:***

On 1st September 2017 all annualised salaries, up to €65,000, are increased by €1,000.
This is viewed as being the first phase in restoring the pay cuts applied to these grades under the FEMPI legislation. Pro-rata entitlements will apply to part-time nurses/midwives.

These changes/increases, which will increase the take home pay of public servants, will apply to all grades/groups/categories of staff earning less than €65,000.

Under the Haddington Road Agreement the pay reductions applied on salaries between €65,000 and €100,000 are to be returned after the expiry of the Haddington Road Agreement in two phases nine months apart.

Q.5 How will these pension levy adjustments and pay restorations apply to nursing/ midwifery pay?

A: The following table sets out the adjustment as it will apply:

Income on Pay Salaries below €31,000

	€27,211	€29,205	€30,234
2016	€954	€996	€1005
2017	€497	€567	€566

2018	€666	€600	€600
Cumulative Effect	€2117	€2163	€2171
Percentage	7.7%	7.4 %	7.1 %

Income on Pay Salaries above €30,000

	€30,000	€60,000	>€65,000
2016	€1,003	€733	€733
2017	€567	€567	€267*
2018	€600	€595	0*
Cumulative Effect	2170	€1895	€1000
Percentage	7.2%	3.15%	1.5%

**For staff earning more than €65,000, 50% pay restoration on 1st April 2017 and 50% pay restoration on 1st January 2018 (HRA).*

Income on Pay Part Time Workers

	€18,068 (S/N Point 5)	€23,777 (CNM1 Point 5)	€25,437 (CNM2 Point 5)
2016	€76.70	€503	€622
2017	€167	€167	€212
2018	€333	€333	€333
Cumulative Effect	€577	€1003	€1167
Percentage	3.1%	4.2%	4.6%

(These are approximate amounts as those part time workers earning premiums, will see a greater benefit resulting from the pension levy adjustments. The final take-home increase may vary depending upon the individual's tax rate.)

Q.6 Was the Annual Retention Fee with An Bórd Altranais agus Cnamhnachais, (Nursing Midwifery Board of Ireland) raised?

A: Yes, the INMO raised this issue and secured agreement that if these proposal are accepted there will be no increase, from the current €100 fee, over the period 2015 to the expiry of the agreement i.e. 2015, 2016, 2017 and 2018.

Q.7 Are working hours addressed in this proposed agreement?

A: The INMO raised our demand to reduce working hours during these talks. However the government side refused to discuss the reductions of the working week for any grade.
The INMO therefore sought a measurement, as is set out in the HRA, of all hours worked by nurses and midwives to ensure all attendance hours are captured. The employer agreed to this and if these proposals are accepted this process will commence in September 2015 and be completed in June 2016. As we all know many nurses and midwives, are attending for, and not getting paid for, hours additional to rostered hours. This process will capture this and compensate nurses and midwives for additional working time.

Q.8 What reference is made to the restoration of time and 1/6 between 6 – 8 p.m. and the agreement regarding transfer of four tasks from medical staff to nursing/ midwifery staff to fund this restoration set out in the HRA?

A (1): The measurement of potential savings arising from the transfer of four tasks (first dose IV, IV cannulation, Phlebotomy and Delegated Discharge), medical staff to nursing/ midwifery staff is part of the HRA. It is further agreed that these tasks will not transfer if this measurement and compensation agreement is not in place.

The INMO and other unions representing nurses and doctors, IMO and SIPTU nursing, have measured the savings and the health service has not agreed with the findings. Therefore the process has been hindered, delayed and frustrated by management who reject evidence presented by the INMO, and others, of real savings that could be achieved.

Some local management continue to seek task transfer anyway, without the measurement of potential savings being agreed. The INMO continues to advise members that they should not accept the transfer of any of these tasks, until this measurement exercise is completed and an agreement reached in respect of the additional staffing requirement together with the restoration of time and one-sixth.

A (2): The Lansdowne Road Agreement proposals focus on this issue and propose that:
a. it is chaired by an independent person, to ensure the issues are examined correctly and in accordance with the HRA agreement;
b. examine the outcome of the process to date;
c. establish if further information is required;
d. identify the wider benefits to the health service of this method of working; and
e. complete the process, which will be led on the HSE side by the HSE Director of HR, within a three month time –frame.

The INMO believes that this proposal will progress this issue and assist in getting the savings measured leading to the required additional staffing and restoration of time and one-sixth as part of any task transfer.

Q.9 Were the issues of pay for undergraduate nurses/midwives and incremental credit for the 36 week placement raised as part of these talks?
A: Yes, as recommended by the Labour Court in May 2015, following two hearings of these issues when referred by the INMO, the matters were raised during the Lansdowne Road talks. Agreement was reached on direct discussion with the Department of Health and the HSE, on these issues **and** their effect on nursing/ midwifery recruitment and retention. If the LRA proposals are accepted, by INMO members, these talks will commence with an outcome within three months.

Q.10 What about Nurse/Midwife Management Structures and the pay of Group Directors of Nursing?
A. Yes, a conciliation conference on the issue took place and it was agreed that an independent party will examine the issues relating to the pay of the appointed Group Directors within a short period - 21 days - and issue a determination in respect of this issue. There is also provision for a further process, to be completed by the end of July, regarding the whole issue of nurse/ midwife management structures within both the newly formed Hospital Groups and Community Health Organisations (CHOs).

Q.11 Does the Lansdowne Road Agreement affect increments?
A: No. Under the Haddington Road Agreement increment delays were imposed on staff on an incremental scale. The incremental freeze, once completed as set out in the Haddington Road Agreement, will not be repeated. The Lansdowne Road Agreement, if accepted, will not impose any further delay or freezing of increments.

Q.12 Does the LRA proposals address Outsourcing?
A: Yes. The commitments on consultation prior to any decision to outsource, in the HRA, are strengthened in the LRA proposals. Specifically it is reaffirmed that direct labour will be used to the greatest extent possible. Where a dispute arises, in respect of the application of this commitment, it will be referred to the revised dispute resolution mechanism set out in the LRA proposals. In addition when employers are considering outsourcing the examinations of costs must exclude the cost of labour i.e. basic pay, pensions, premiums and leave.

Q.13 Is there any change to the manner of resolving disputes set out in the HRA?
A: No, the procedures which are set out, specifically for Nursing and Midwifery in appendix 7 of the HRA, remain in place. This is confirmed in the Labour Relations Commission introduction to the LRA proposals.

Q.14 Is there a general no strike clause in the LRA proposals?
A: No, as with the clause in the HRA and the agreement before it, the Public Service Agreement 2010-14, strikes and industrial action are precluded only in respect of matters covered by the agreement where the parties are acting in accordance with its provisions. There is no prohibition on strikes, or other forms of industrial action, on any issues not covered by the LRA Proposals i.e. staffing/overcrowding.

Q.15 Will pensioners benefit from this LRA proposal?
A: Government met public service pensioner representatives separately and confirmed that it would adjust the level imposed on pensioners/the PSPR. On Tuesday the 16th of June 2015, the government confirmed agreement to proposals to change income levys at which the PSPR will apply. The government state that the following impact will result. On the 1st January 2016 – a return of €400 to most PSPR impacted pensioners on the 1st January 2017, a return of €500 to most PSPR impacted pensioners and on the 1st January 2018, a return of €780, to most PSPR impacted pensioners and/or removing pensioners from the PSPR net entirely. These provisions are not set out as part of the LRA proposal and are therefore not covered by it. Information on the exact details of these adjustments are available on the Department of Public Expenditure and Reform website.

Q.16 Will these proposals directly apply in the private sector and section 39 organisations?
A: No, unless there is a specific agreement in place stating that any adjustment will apply. The INMO will meet members in these organisations, on conclusion of the public service ballot, and see if they wish to pursue implementation. This will be a matter which will be discussed in the context of measures put in place over the lifetime of the HRA in these locations/employments.

Q.17 Is there any commitment in the text that employers will support training and continuous development?

A: Yes, the proposals at point 2.5 confirms that the public service will facilitate improved training and continuous development for staff.

Q.18 What is the INMO Executive council recommending and why?

A: The Organisation's Executive Council considered the proposals and all related matters arising from them for nurses and midwives in great detail. Following this comprehensive examination the Executive Council has decided to recommend acceptance of these proposals.

The decision to recommend **acceptance** was taken in full recognition of the fact that the proposals are minimalist and it remains the INMO view that the government should have been much more positive in this first step to restore the pay, and conditions of employment, that were cut in recent years. However, recognising the wider context, the Executive Council decided to recommend acceptance recognising the following:

- *The government made it quite clear, that in beginning the process of restoring pay, it could only do so within the budgetary limits now laid down under EU procedures.*
- *The weighting towards the lower paid, within the public service, was viewed as being correct and appropriate in this first phase of restoration.*
- *The agreement that the NMBI annual fee would be frozen at €100 for the lifetime of this agreement, if these proposals are accepted. This will effectively mean the fee will remain at €100 up to and including 2018.*
- *The commitment in the text that employers will support training and continuous development is critical in the context of Continuing Professional Development (CPD) obligations which will emerge, for nurses/midwives, in the next two/three years.*
- *The process of measuring all hours actually worked, when nurses/midwives attend for work, is very necessary as a first step in our campaign to have our working week reduced to 37 hours in line with all other health professionals.*
- *The commitment to complete the process of measuring all issues arising from the agreed transfer of four tasks, from doctors to nurses/midwives, with an independent chair and only by agreement, is viewed as critical.*
- *The process to address senior nurse/midwife management issues, including adjudication, on an interim payment to Group Directors.*
- *The procedure to address issues affecting undergraduate and new graduate nurses, recognising the recruitment/ retention measures now required, is also welcome.*

Q.19 Who can vote on this agreement?

A: INMO members, who are working in the public service and are affected by the terms, including 4th year student nurses on 36 week clinical work placement, will be balloted. Private sector and retired members will not be balloted as the proposal do not cover issues relating to them. Details of Regional meetings where balloting will be conducted are listed here:

DATE	TIME	VENUE
Monday, 29th June	8.00 pm	Mount Errigal Hotel, Letterkenny
Monday, 29th June	8.00 pm	Tower Hotel, Waterford
Tuesday, 30th June	7.30 pm	Tara Room, Ardboyne Hotel, Navan
Tuesday, 30th June	8.00 pm	Clarion Hotel, Pegasus 1 Suite, Sligo
Wednesday, 1st July	7.30 pm	Clonmel Park Hotel, Clonmel
Thursday, 2nd July	8.00 pm	INMO Head Office
Thursday, 2nd July	8.00 pm	Kinglsey Hotel, Cork
Monday, 6th July	7.00 pm	Bridge House Hotel, Tullamore
Monday, 6th July	8.00 pm	Manor West Hotel, Tralee
Tuesday, 7th July	7.30 pm	Clayton Hotel, Galway
Tuesday, 7th July	7.00 pm	South Court Hotel, Limerick
Thursday, 9th July	8.00 pm	Lecture Hall, Mayo General Hospital

Details of additional local meetings and workplace balloting arrangements will be notified to you by your local INMO rep.

Q.20 How will the public service unions generally count the vote?

A: All unions will count their votes separately. The INMO overall result will determine our vote at the Public Services Committee (PSC) of ICTU. The final vote will be arrived at by the majority of votes cast at the PSC by all Public Service Unions affiliated to ICTU.