€5.75 Vol 29 No 6 July/August 2021

INMO
Journal of the
Irish Nurses and
Midwives Organisation

Latest INMO CPD education programme
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Breastfeeding and the microbiome
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Global action required on midwife shortage

*vs willpower alone.

Nicorette QuickMist1 mg/spray, oromucosal spray, solution and Nicorette QuickMist Cool Berry 1 mg/spray, oromucosal spray, solution. Composition: One spray delivers 1 mg nicotine in 0.07 ml solution. 1 ml solution contains 13.6 mg nicotine. Excipient with known effect: Ethanol (less than 100 mg of ethanol/spray). Propylene glycol, Butylated hydroxytoluene. Pharmaceutical form: Oromucosal spray, solution. A clear to weakly opalescent, colourless to yellow solution. **Indications:** For the treatment of tobacco dependence in adults by relief of nicotine withdrawal symptoms, including cravings, during a quit attempt. Permanent cessation of tobacco use is the eventual objective. Nicorette QuickMist should preferably be used in conjunction with a behavioral support program. Dosage: Subjects should stop smoking completely during the course of treatment with Nicorette QuickMist. Adults and Elderly: The following chart lists the recommended usage schedule for the oromucosal spray during full treatment (Step I) and during tapering (Step II and Step III). Up to 4 sprays per hour may be used. Do not exceed 2 sprays per dosing episode and do not exceed 64 sprays (4 sprays per hour, over 16 hours) in any 24-hour period. **Step I: Weeks 1-6:** Use 1 or 2 sprays when cigarettes normally would have been smoked or if cravings emerge. If after a single spray cravings are not controlled within a few minutes, a second spray should be used. If 2 sprays are required, future doses may be delivered as 2 consecutive sprays. Most smokers will require 1-2 sprays every 30 minutes to 1 hour. **Step II: Weeks 7-9:** Start reducing the number of sprays per day. By the end of week 9 subjects should be using HALF the average number of sprays per day that was used in Step I. **Step III: Weeks 10-12:** Continue reducing the number of sprays per day so that subjects are not using more than 4 sprays per day during week 12. When subjects have reduced to 2-4 sprays per day, oromucosal spray use should be discontinued. To help stay smoke free after Step III, subjects may continue to use the oromucosal spray in situations when they are strongly tempted to smoke. One spray may be used in situations where there is an urge to smoke, with a second spray if one spray does not help within a few minutes. No more than four sprays per day should be used during this period. Regular use of the oromucosal spray beyond 6 months is generally not recommended. Some ex-smokers may need treatment with the oromucosal spray longer to avoid returning to smoking. Any remaining oromucosal spray should be retained to be used in the event of sudden cravings. Paediatric population: Do not administer this medicine to persons under 18 years of age. There is no experience of treating adolescents under the age of 18 with this medicine. Method of administration: After priming, point the spray nozzle as close to the open mouth as possible. Press firmly the top of the dispenser and release one spray into the mouth, avoiding the lips. Subjects should not inhale while spraying to avoid getting spray into the respiratory tract. For best results, do not swallow for a few seconds after spraying. Subjects should not eat or drink when administering the oromucosal spray. Behavioural therapy advice and support will normally improve the success rate. **Contraindications:** Hypersensitivity to nicotine or to any of the excipients. Children under the age of 18 years. Those who have never smoked. **Special warnings and precautions for use:** This medicine should not be used by non-smokers. The benefits of quitting smoking outweigh any risks associated with correctly administered nicotine replacement therapy (NRT). A risk-benefit assessment should be made by an appropriate healthcare professional for patients with the following conditions: Cardiovascular disease: Dependent smokers with a recent myocardial infarction, unstable or worsening angina including Prinzmetal's angina, severe cardiac arrhythmias, recent cerebrovascular accident and/or who suffer with uncontrolled hypertension should be encouraged to stop smoking with non-pharmacological interventions (such as counselling). If this fails, the oromucosal spray may be considered but as data on safety in this patient group are limited, initiation should only be under close medical supervision. Diabetes Mellitus. Patients with diabetes mellitus should be advised to monitor their blood sugar levels more closely than usual when smoking is stopped and NRT is initiated as reduction in nicotine induced catecholamine release can affect carbohydrate metabolism. Allergic reactions: Susceptibility to angioedema and urticaria. Renal and hepatic impairment: Use with caution in patients with moderate to severe hepatic impairment and/or severe renal impairment as the clearance of nicotine or its metabolites may be decreased with the potential for increased adverse effects. Phaeochromocytoma and uncontrolled hyperthyroidism: Use with caution in patients with uncontrolled hyperthyroidism or phaeochromocytoma as nicotine causes release of catecholamines. Gastrointestinal Disease: Nicotine may exacerbate symptoms in patients suffering from oesophagitis, gastric or peptic ulcers and NRT preparations should be used with caution in these conditions. Paediatric population: Danger in children: Doses of nicotine tolerated by smokers can produce severe toxicity in children that may be fatal. Products containing nicotine should not be left where they may be handled or ingested by children. Transferred dependence: Transferred dependence can occur but is both less harmful and easier to break than smoking dependence. Stopping smoking: Polycyclic aromatic hydrocarbons in tobacco smoke induce the metabolism of drugs metabolised by CYP 1A2 (and possibly by CYP 1A1). When a smoker stops smoking, this may result in slower metabolism and a consequent rise in blood levels of such drugs. This is of potential clinical importance for products with a narrow therapeutic window, e.g. theophylline, tacrine, clozapine and ropinirole. The plasma concentration of other medicinal products metabolised in part by CYP1A2 e.g. imipramine, olanzapine, clomipramine and fluvoxamine may also increase on cessation of smoking, although data to support this are lacking and the possible clinical significance of this effect for these drugs is unknown. Limited data indicate that the metabolism of flecainide and pentazocine may also be induced by smoking. Excipients: The oromucosal spray contains small amounts of ethanol (alcohol), less than 100 mg per dose (1 or 2 sprays). This medicinal product contains less than 1 mmol sodium (23 mg) per spray, i.e. essentially 'sodium- free'. This medicine contains 12 mg propylene glycol in each spray which is equivalent to 157 mg/mL. Due to the presence of butylated hydroxytoluene, Nicorette QuickMist may cause local skin reactions (e.g. contact dermatitis), or irritation to the eyes and mucous membranes. Care should be taken not to spray the eyes whilst administering the oromucosal spray.**Undesirable effects:** Effects of smoking cessation: Regardless of the means used, a variety of symptoms are known to be associated with quitting habitual tobacco use. These include emotional or cognitive effects such as dysphoria or depressed mood; insomnia; irritability, frustration or anger; anxiety; difficulty concentrating, and restlessness or impatience. There may also be physical effects such as decreased heart rate; increased appetite or weight gain, dizziness or presyncopal symptoms, cough, constipation, gingival bleeding or apthous ulceration, or nasopharyngitis. In addition, and of clinical significance, nicotine cravings may result in profound urges to smoke. This medicine may cause adverse reactions similar to those associated with nicotine given by other means and these are mainly dose-dependent. Allergic reactions such as angioedema, urticaria or anaphylaxis may occur in susceptible individuals. Local adverse effects of administration are similar to those seen with other orally delivered forms. During the first few days of treatment irritation in the mouth and throat may be experienced, and hiccups are particularly common. Tolerance is normal with continued use. Daily collection of data from trial subjects demonstrated that very commonly occurring adverse events were reported with onset in the first 2-3 weeks of use of the oromucosal spray, and declined thereafter. Adverse reactions with oromucosal nicotine formulations identified from clinical trials and during post-marketing experience are presented below. The frequency category has been estimated from clinical trials for the adverse reactions identified during post-marketing experience. Very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1 000 to <1/100); rare (≥1/10 000 to <1/1 000); very rare (<1/10 000); not known (cannot be estimated from the available data). **Immune system disorders** Common Hypersensitivity Not known Allergic reactions including angioedema and anaphylaxis **Psychiatric disorders** Uncommon Abnormal dream **Nervous system disorders** Very common Headache Common Dysgeusia, paraesthesia **Eye disorders** Not known Blurred vision, lacrimation increased **Cardiac disorders** Uncommon Palpitations, tachycardia Not known Atrial fibrillation **Vascular disorders** Uncommon Flushing, hypertension **Respiratory, thoracic and mediastinal disorders** Very common: Hiccups, throat irritation Uncommon Bronchospasm, rhinorrea, dysphonia, dyspnoea, nasal congestion, oropharyngeal pain, sneezing, throat tightness Common: cough **Gastrointestinal disorders** Very common Nausea Common Abdominal pain, dry mouth, diarrhoea, dyspepsia, flatulence, salivary hypersecretion, stomatitis, vomiting Uncommon Eructation, gingival bleeding, glossitis, oral mucosal blistering and exfoliation, paraesthesia oral Rare Dysphagia, hypoaesthesia oral, retching Not known Dry throat, gastrointestinal discomfort, lip pain **Skin and subcutaneous tissue disorders** Uncommon Hyperhidrosis, pruritus, rash, urticaria Not known Erythema **General disorders and administration site conditions** Common Burning sensation, fatigue Uncommon Asthenia, chest discomfort and pain, malaise. **MAH:** Johnson & Johnson (Ireland) Limited, Airton Road, Tallaght, Dublin 24, Ireland. **PA Number:** PA 330/37/13 & PA 330/37/16. **Date of revision of text:** PA 330/37/13: May 2019. PA 330/37/16: November 2019. Product not subject to medical prescription. Full prescribing information available upon request. IE-NI-2000040

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Sadbh Creed, staff midwife,
Cork University Maternity Hospital

guaranteed irish

WIN – World of Irish Nursing & Midwifery is distributed by controlled circulation to **more than 40,000** members of the INMO. It is published monthly (10 issues a year) and is registered at the GPO as a periodical. Its contents in full are Copyright© of MedMedia Ltd. No articles may be reproduced either in full or in part without the prior, written permission of the publishers. The views expressed in this publication are not necessarily those of the INMO. Annual Subscription: €155 incl. postage paid. Editorial Statement: *WIN* is produced by professional medical journalists working closely with individual nurses, midwives and officers on behalf of the INMO. Acceptance of an advertisement or article does not imply endorsement by the publishers or the Organisation.

Webinars and Conferences 2021

ONLINE INTERACTIVE CONFERENCES

All courses are Category 1 approved by NMBI

Whilst these events are currently planned as follows, the most current Public Health Advice will be fully adhered to and should the dates or the format in which the national conference is delivered change, we appreciate your understanding.

- **Telephone Triage Nurses Section** — **Monday, 20 September**
- **Directors and Assistant Directors Masterclass** — **Thursday, 30 September**
- **Public Health Nurses Section** — **Saturday, 16 October**
- **All Ireland Midwives Annual Conference** — **Thursday, 11 November**
- **Occupational Health Nurses Section** — **To be confirmed**
- **National Children's Nurses Section** — **Saturday, 20 November**

BOOKING YOUR PLACE IS ESSENTIAL

LIVE ONLINE EVENTS

FREE TO INMO MEMBERS

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(ISSN: 2009-4264)
Volume 29 Number 6
July/August 2021

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

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Budget 2022 must offer us certainty

OCTOBER'S budget is fast approaching, with health funding likely to be a core priority, as Covid-19 and the IT hack have piled huge costs onto our health service.

The main headline for health spending is usually a single number – how much the government plans to spend, but a smart government would also reform how they set budgets in the health service.

Health budgets are set annually, lurching from year to year, with no certainty in 2021 of what will be spent in 2022. Nurses and midwives know well that healthcare doesn't follow a neat calendar. Our sector requires more certainty and longer-term planning, hence the INMO has long called for multi-annual budgets to provide rolling certainty over a five-year period or more.

The government has consistently resisted such a system, but minds are beginning to change. Covid-19 has pushed our health service to its absolute limit, exposing gaps in the public infrastructure. It has left our workforce exhausted dealing with the uncertainty of when this period will end. The national reluctance to build a unified public health service is the backdrop to the preparedness of our health service when this crisis hit.

There will be other crises in future – we must prepare accordingly. A robust, universal healthcare model must be the legacy of this terrible pandemic. A recent *Lancet* article makes the point well: "Countries with a poor track record of universal health coverage (UHC) such as the US and Ireland have begun implementing UHC-style policies for outbreak response, including leveraging funds to provide Covid-19 testing that is universally free. These actions also suggest that the crisis might offer an opportunity to embrace reforms for UHC as a foundation for health systems that are unified and sufficiently publicly funded."

Ireland spends just under 10% of GDP on the public health service – below that of other countries. We need to spend roughly 14% to remove patient fees and provide capital investment in new beds and centres. If government parties are serious about implementing Sláintecare – they will have to pay for it too.

The INMO will be making a budget submission in the coming months. Aside from multi-annual budgeting and increases, our key demands will include:

- Recruitment and retention strategies to make nursing and midwifery careers more attractive
- Implementation of the safe staffing framework across the health service by 2022
- Increasing nursing and midwifery undergraduate places by 250 by 2022, plus extra places for healthcare workers looking to train as nurses and midwives
- Full implementation of the settlement terms of the nurses and midwives dispute in 2019, including on nursing and midwifery managers' pay
- Reducing working hours for nurses and midwives back to the pre-2013 levels
- Implementing Sláintecare and ending the privatised, two-tier service we have allowed develop.

The task of government will be to think of what a health service is based on, a service delivered by a workforce that is increasingly scarce and frankly exhausted. This budget must provide that workforce with some relief and certainty.

Multi-annual budgeting to allow the health service to build resilience, both to meet the next crisis and to ensure a public health system that leaves nobody behind. Budgeting for a health service as a stop-start system will inevitably lead nurses, midwives and other healthcare professionals to rethink the feasibility of continuing to offer so much.

Simply put: just rewards, properly funded planning and a say at the national table on service delivery options must be introduced for nurses and midwives in budget 2022. Without that, it will be difficult to persuade them to stay in this healthcare system that so desperately needs them.

Phil Ní Sheaghdha
General Secretary, INMO

Join our team!

We're hiring.

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

Deputy General Secretary

As a result of retirement, a vacancy has occurred for the post of Deputy General Secretary within the INMO.

General:
Within the INMO's industrial staff structure, the Deputy General Secretary will support, deputise and report directly to the General Secretary. As part of the Senior Management team the Deputy will undertake such managerial and operational duties required for effective running of the INMO as the General Secretary may delegate in the interest of its members.

The Deputy General Secretary is responsible, in conjunction with the General Secretary and Senior Management team for ensuring the effective leadership and management of the INMO and to participate in the creation of a shared strategic vision for the INMO and develop appropriate, deliverable implementation plans.

Essential requirements:

- A successful track record at senior level, preferably in a comparable membership Organisation senior management experience.
- A third level qualification in industrial relations or equivalent.
- A third level qualification in employment law.
- Significant and senior industrial relations experience and proven negotiation skills in a challenging / complex environment.
- Substantial practical negotiation experience with a national trade union or association or equivalent body.
- Knowledge and experience of the industrial relations institutions of the State and experience of dealing with diverse stakeholders in a complex membership Organisation.
- Strong communication skills both verbal and written.
- Ability to foster collaborative relationships across the Organisation, externally at boards and committees at which the Organisation is represented.
- Experience of representing organisations in the public domain and on media platforms.

Desirable requirements:

- Experience of negotiating within the Irish Health Sector
- Training and education skill and qualification in relation to delivery and design of training programs.

Head of Information and Research-IR

As a result of retirement, a vacancy has occurred for the full-time permanent post of Head of Information and Research – IR within the INMO. The post will be graded at Assistant Director of Industrial Relations level.

General:
Within the INMO's industrial staff structure, Assistant Director of IR will report to the Director of Industrial Relations and be accountable to the General Secretary.

Assignment:
The Information Office provides a comprehensive information and research service to members and staff of the INMO on industrial relations matters, nurses and midwives terms and conditions of employment and employment law. The Head of Information and Research (IR) is a senior post within the Organisation.

The requirements of the post are:

Essential requirements:

- Senior IR experience of negotiation
- Employment law qualification
- Understanding of the health services, grading and professional issues for nursing and midwifery
- Excellent writing skills
- Experience in team management

Desirable requirements:

- Evidence of previous team development skills
- Organisational and time management skills
- IT skills and utilisation of same for modern communication methods
- Training and teaching skills

Please submit your letter of application and a detailed CV to **gspaoffice@inmo.ie** no later than **5pm Friday 2nd July 2021**

A positive focus
with the president

Karen McGowan, INMO president

Continuing progress

LAST month saw the reopening of business and retail with further openings planned in the coming weeks. Vaccinations are progressing at a fast pace now but there is still a lot of uncertainty and fear among the public. We must continue this progress and stay strong against the virus.

The webinar season is truly underway. In June a vaccine information webinar was held with the HSE's chief clinical officer Colm Henry. A live questions and answers session drew good participation. I attended the EFNNMA general assembly with INMO head of education Steve Pitman, who has been elected to the executive board of EFNNMA. We wish him well in this role. INMO webinars have been busy with good attendances. There are lots more to look forward to so be sure to register early. The ICN nurse practitioner/advanced practitioner group met to plan for the 2022 conference which is progressing well.

The Answers for Cancers podcasting nurses

I SPOKE with Michelle Matthews, oncology clinical trials nurse in Mater Miseriacordiae University Hospital and Anne Marie Fay, oncology liaison nurse in the Mater Private Hospital, about their podcast *The Answers for Cancers*. The podcast explores what it means to have cancer in language we can all understand. As a result of the pandemic the way our hospitals are operating has changed drastically. Ms Matthews highlighted that the ability for newly diagnosed patients to absorb extra information on their own is overwhelming. Ms Fay explained that they were inundated with calls and that 'Dr Google' was frightening patients with the lack of trusted information.

Pictured (l to r) were: Michelle Matthews, oncology clinical trials nurse, and Anne Marie Fay, oncology liaison nurse

Both nurses came together with an idea to start a podcast so that they could give further support to patients and their relatives. This resource transitioned well as it has reliable evidenced based information which is available when the patient is ready for it.

"The project is well supported by consultants. They, like us, felt that there needed to be more information available for patients. This relieves some pressure on people in the service as it enables patients to go home, listen in and come back with questions at their next appointment," Ms Matthews said.

Ms Fay added: "The best information comes from the nurses working on the ground looking after these patients. I would love for other nurses to trust in themselves to impart their knowledge and join us on our podcast series. We took a leap of faith as we had never done anything like this before but we knew that this is what patients wanted and needed most."

Both nurses feel that starting the podcast has given them a level of confidence in addressing the often-difficult questions about issues such as fertility and erectile dysfunction. They say that knowing they have the tools and resources to direct the patient after their query is powerful.

The Answers for Cancers podcast is available on Spotify. You can get in touch by email: theanswersforcancerspodcast@gmail.com or Instagram: @theanswersforcancers_podcast

Executive Council update

THERE are a lot of national issues ongoing at the moment. The INMO is continuing to engage with employers and the HSE as much as possible to continue to keep our members safe. All active cases were discussed with support from the Organisation ongoing, despite the difficulties since the cyber-attack on the HSE.

The Executive Council also discussed the health and safety update. We are really pleased with the interest and momentum this important issue is gaining in hospitals. More than 33 INMO health and safety representatives have now received formal training. These reps are fast becoming an accepted and essential part of our working environments. Having the law behind the practical theory adds strength and surety to the role. The union will continue to promote health and safety issues in every workplace and will keep members updated.

The Executive Council discussed the Irish Congress of Trade Unions biennial conference taking place this year. Motions are being organised for this conference. We will provide further updates on this in the next issue of *WIN*.

The issues around emergency department overcrowding were discussed at a meeting with officers of the Emergency Department Nurses Section and Tony Fitzpatrick, INMO director of industrial relations. Many members report that Covid-19 is no longer the biggest problem, rather the age-old problem of hospital overcrowding has returned with a bang. We have seen a steady increase in presentations to emergency departments and the number of admitted patients waiting on trolleys has increased steadily in recent months.

The next meeting of the Executive Council will be held on July 12 and 13.

Get in touch

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

Dave Hughes is calling on members to sign a petition to convince the European Commission to support a waiver of intellectual property rights on Covid-19 vaccines and treatments

No profits on pandemic – call to waive patents on Covid-19 vaccines

ON May 5, 2021, US president Joe Biden's administration announced it would support efforts to waive intellectual property protections for Covid-19 vaccines in an effort to speed the end of the pandemic.

The president announced that the US government would not oppose lifting patent protection for Covid-19 vaccines and treatments in the World Trade Organization Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS).

On June 8, just before the G7 Summit, the president of the World Bank opposed any such waiver on the grounds that it might hamper future research and development in the pharmaceutical sector.

The European Parliament voted in favour of a waiver, but some member states and the European Commission (EC) are still opposed to or reticent about it.

The waiver was originally called for by India and South Africa and is supported by most NGOs, civil society organisations and trade unions.

The European Citizens Initiative Right to Cure campaign is aiming to ensure that the EC does everything in its power to make anti-pandemic vaccines and treatments a global public good, freely accessible to everyone.

The campaign has collected over 200,000 signatures to date but it needs one million signatures to mandate and compel the EC to support the waiver.

To sign the petition see: **www.noprofitonpandemic.eu**

The pandemic has highlighted the many conflicts between economic interests and public health protections. Daily we hear legitimate aspirations from economic sectors in our own country which have effectively been shut down for over a year, challenging the veracity of advice from the National Public Health Emergency Team (NPHET).

Chief among them is the aviation industry which has been devastated by the impact of the pandemic. Such conflicts and arguments have always been a feature of epidemics and pandemics which require curtailment of economic activity.

However, the insistence on highly profitable patents based on intellectual property rights for a Covid-19 vaccine which was largely developed quickly because of massive public funds from the major developed countries and philanthropic funding, is more than at bit tongue in cheek.

Growing concerns that big outbreaks in India and the Global South will allow the rise of vaccine-resistant strains of the deadly virus, which will undermine a global recovery, mean it makes sense for all countries to support the TRIPS waiver.

Those in favour argue that a temporary and targeted waiver of TRIPS' rules to allow countries to produce affordable versions of patented Covid-19 vaccines without fear of legal challenge would be an important step in the right direction.

We in Ireland have repeatedly shown overwhelming support for the EU. Brexit has reinforced that commitment. There is no doubt that the EU has brought peace and prosperity to the continent but increasingly the dominance of economic interests over the social agenda is alienating populations and reopening divisions within and between the nations that make up the EU. Hungry and Poland are increasingly leaning to right-wing populism and there is a rise of nationalism in regions of Spain and Italy.

The UK leaving the EU is the sharpest example of a population's disenchantment and perception of powerlessness being manipulated for political gain. The position ultimately adopted on the temporary vaccine waiver by the EC will be a test on whether the nations of Europe are subservient to big business interests at the expense of social society and in this case the human cost of Covid-19.

One million signatures on the **noprofitonpandemic.eu** petition could send a strong signal to the combined European leadership including Ireland (its greatest supporter at the moment), that humanitarian and people's social and economic welfare come first.

No country should be left behind because of money and if they are, the risk to the world remains. There really should be no profits on the pandemic.

Dave Hughes is deputy general secretary of the INMO

Is your INMO membership up to date?

Important message from the INMO

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

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

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

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

INMO calls for emergency meeting of national ED Taskforce

Need for a concrete plan to deal with hazardous overcrowding

CITING "hazardous conditions" in several emergency departments across the country, the INMO has called on the HSE to convene an emergency meeting of its ED Taskforce in order to tackle increasingly unsafe levels of hospital overcrowding.

In a letter to the HSE, the union outlined the risks to the health and safety of its members caused by the current pressure on emergency services.

Separately, the union called an emergency meeting of its ED Nurses Section to draw up a list of health and safety measures needed to protect both staff and patients.

Through its daily trolley/ward watch service, the INMO has reported that the numbers of admitted patients waiting for beds is increasing despite continued risk of Covid-19 transmission in hospitals. Some hospitals are approaching or surpassing pre-pandemic levels of overcrowding. The union outlined stark facts:

- In excess of 22,000 admitted patients have been treated on trolleys so far in 2021
- The numbers of patients treated on trolleys in June was almost double that for the same period last year, at the time of writing
- Total trolley figures for May 2021 (3,898) were more than three times higher than those in May 2020 (1,176).

INMO president Karen McGowan, who is an advanced nurse practitioner in emergency nursing, said: "Not only is this a very unsafe situation, but our members simply don't have the reserves to cope with this level of pressure anymore. This is the time for the HSE to start addressing the issue of burnout in its staff, not letting their working conditions get even worse.

"It is not acceptable for the HSE to rely on the goodwill and professionalism of nurses rather than develop a viable plan for safe staffing. Frontline workers have given 100% throughout the pandemic, and if conditions don't improve it will be very difficult to retain nurses and midwives in the health service over the coming years."

INMO general secretary Phil Ní Sheaghdha said: "This is not the time to be reckless with overcrowding and patient safety. The risk of Covid transmission in hospitals has not gone away, but we have seen overcrowding creep up steadily for over a year, without any meaningful action being taken.

"We are looking at highly transmissible variants, combined with a completely exhausted workforce. What we need from government and the HSE is a concrete plan to deal with this situation before it becomes even more dangerous."

G7 urged to put HCW safety at heart of health policy

THE global death toll from Covid-19 among healthcare workers requires dramatic action from the leaders of the Group of Seven (G7) major advanced nations, according to the International Council of Nurses (ICN).

Ahead of its recent summit held in the UK last month, the ICN called on the G7 to put the safety of healthcare workers (HCWs) "at the very heart" of healthcare policy.

The call to action comes on foot of the news that at least 115,000 HCWs have now died as a result of contracting Covid-19, many of them in the workplace.

World Health Organization (WHO) director general Dr Tedros Adhanom confirmed the most recent death toll at the World Health Assembly (WHA), which took place virtually at the end of May.

Also addressing the WHA, ICN chief executive Howard Catton said: "In his opening address, Dr Tedros told us that at least 115,000 health and care workers have died as a result of contracting Covid-19. I'm not aware of any occasion when so many died as a result of a single disease.

"The death toll is the equivalent of more than 200 healthcare workers dying every day since the start of the pandemic, yet still the reporting about infections and deaths is inadequate. Dr Tedros has said this lack of data is scandalous, and I agree with him: frankly, it's a disgrace."

WHO nursing strategy

Mr Catton led the ICN and its member associations in applauding the WHA's adoption of a new global nursing and midwifery strategy, which he said must be followed up by swift implementation by member states.

He said: "This was also the first time the Global Nursing and Midwifery Strategy was adopted unanimously on the floor of the WHA, and its message was clear: we must invest now in nursing education, leadership, jobs and practice, and we need member states to own their new strategy and implement it now."

The *Global Strategic Directions for Nursing and Midwifery 2021-2025* seeks to address many of the issues the ICN has campaigned on over the past 18 months, including:

- The global shortage of nurses
- The need for investment in nursing jobs, education, leadership and practice
- Nurses' safety during the pandemic
- The importance of establishing government-level chief nurses in every WHO member state.

ICN president Annette Kennedy said: "This global strategy has never been more important and we must implement it and take the actions forward. Unless governments and all stakeholders act now, the current situation with nurses being overworked, underpaid and undervalued will continue, with potentially disastrous consequences.

"Nurses are the lifeblood of health systems everywhere and they must be recognised for what they are – a precious commodity that needs to be nurtured and protected. The pandemic has shown the world how valuable nurses are to the health of nations; it is now up to each nation to show its nurses just how much they are valued."

• *See also page 18*

INMO director of industrial relations Tony Fitzpatrick updates members

Progress on theatre on-call issues

FOLLOWING the WRC proposal regarding theatre nurses of March 5, 2020 and subsequent circulars, officers of the INMO Operating Department Section and INMO representatives in theatre departments around the country have been updated via online meetings in recent weeks.

Several issues arising out of the WRC proposal document of March 5, which concerns a clarification of incorrect application of the on-call circular of 33/2003, need to be addressed at national level while others need to be progressed at local/hospital group level.

Local engagement with hospital groups and local hospitals is required on:

- Clause 2 – over-runs from theatre
- Clause 5 – question of need for two on-call services due to INMO concern about risks of having only one on-call team in place when there are two on-call services, ie. general surgery, as well as maternity and other specialist surgical services out of hours
- Clause 6 – training and education, including establishing the role of clinical facilitator in every theatre
- Clause 8 – frequency of on-call and excessive on-call expected of senior staff because of diminishing staffing and skill mix within theatre departments.

Issues to be pursued nationally via the National Joint Council (NJC) include:

- Clauses 3 & 4 – on annual leave calculation and the pensionability of on-call allowance
- Clause 7 – workplace planning of safe staffing in the perioperative setting.

The key issues of concern for theatre reps are the prevailing situation in theatre departments with Covid-19. Many departments are short staffed, with a diminishing skill mix, ie. fewer senior, experienced theatre nurses. Section officers outlined that nurse managers are now providing out of hours services which depletes the level of nursing leadership in core hours.

INMO officials will be engaging urgently with hospital groups to set up forums to deal with the matters that can be dealt with at local level.

The union is concerned at that some hospitals have failed to follow risk mitigation procedures and to address matters on their risk registrar.

On-call shortfalls

A few hospitals which have maternity departments continue to only have one on-call team for general and obstetric emergencies. These include Wexford, Portlaoise, Cavan and Kerry, and staff have outlined how this presents a significant risk that needs to be addressed.

There is an onus on management to put in place safe controls to mitigate the risk that exists. The INMO's claim regarding these departments is to have a second on-call team. While some services have recently added a fourth nurse to the on-call team to mitigate the associated risk, the INMO continues to press for two on-call teams.

Theatre reps and section officers have highlighted that this presents a problem with the availability of staff during the day, however, the matter of additional staffing should be pursued in tandem. If hospitals are providing a service, it should be fully staffed.

Compensatory rest time

Another matter that requires attention is the management of compensatory rest and sleep time. Most theatre departments operate as follows:

- Standby and on-call payments paid as set out in circular 33/2003 as clarified in the WRC agreement
- Time off in lieu (TOIL) accumulated by theatre nurses on the same basis, ie. time for time, in compliance with established practice and 1989 circular
- Compensatory rest for sleep time in compliance with the Organisation of Working Time Act 1997, with a provision of 11 hours. This is set out in HSE CERS circular 43/2020
- If the sleep time/compensatory rest encroaches on working time on the following day, it is still required as compensatory rest/sleep time, and the roster time will continue to be included in the theatre nurse's weekly rostered hours
- TOIL should not be utilised for this purpose – it should only be used once the compensatory rest/sleep time of 11 hours has been reached.

A small number of hospitals are out of line regarding the above and INMO officials and representatives are engaging at local level to bring these services in line with the rest of the country.

Other significant matters of concern including theatre overruns and management of theatre lists which are being dealt with at local level.

Negotiations on investigation processes near end

THE INMO and other unions sought a review via the National Joint Council (NJC) of disciplinary, Trust in Care and Dignity at Work investigation processes.

Originally, this was to address the significant delay in agreeing terms of reference, investigators and in concluding various investigations. Some matters were referred to third parties to get agreement on terms of reference and investigators.

The unions secured agreement that Kevin Duffy, former chair of the Labour Court, would review the process and his report was issued last year. There has been a significant number of engagements with the HSE with regards to finalising the processing around disciplinary, Trust in Care, and Dignity at Work investigations.

While these discussions are close to conclusion, some final points being addressed include:

- Pro forma terms of reference for disciplinary procedure
- Terms of Reference for Dignity at Work policy
- Proposed amendments to the disciplinary procedure for HSE employees
- Proposed amendments to Trust in Care policy
- Standard terms of reference in Trust in Care policy
- Proposed amendments for Dignity at Work policy.

This will ensure that future complaints and respondents will not have to endure protracted delays and all investigations will be conducted to the highest standards.

on recent national issues under discussion

Parental leave for early pandemic

THE health sector unions have secured the restoration of parental leave to healthcare workers (HCWs) who had no alternative but to take leave to care for children, in the circumstances specified below, from March 13 to May 26, 2020.

This is in addition to the unions securing via the WRC, CERS memo 51/2020, the agreement of the HSE to reinstate annual leave for those who had no alternative but to take leave to care for children, in the circumstances specified below, from March 13 to May 26, 2020.

The HSE, consistent with the position of our colleagues in the Department of Health, have considered the claim made by staff representatives, and has approved the extension of these provisions to include the reinstatement of parental leave, where all the conditions, set out below were met.

A DPER FAQ of April 26, 2020 outlined the obligation of the employer to ensure that working from home arrangements would apply in these circumstances. However, there may have been a lead-in period required in some areas, in order to set up such arrangements.

It has therefore been agreed that the reference period can extend to May 26, 2020:

- Where this leave was taken as a direct consequence of public health advice regarding the closure of schools, pre-schools, crèches and other childcare facilities
- Where all other alternative options were explored, for example roster changes, working from home or any alternatives, and these were found to be unsuitable by the manager and/or the employee and as a consequence, leave was selected by the employee
- Parental leave will not be reinstated where such options were not considered by the employee, and where it can be demonstrated that they willingly opted for such leave, without proper consideration of alternative options
- There will be no reinstatement of any parental leave requested and approved prior to March 12, 2020
- With respect to NCHDs, in the event that an NCHD changed their employment location since the period of parental leave, the terms of this agreement will apply to that NCHD in their current employment location, subject to the employee submitting the verification required from the previous employer
- The granting of parental leave is subject to the provisions of the Parental Leave Act 1998.

Local management should proactively address these matters expeditiously and judiciously at local level.

In exceptional cases which cannot be resolved locally, a joint management/union dispute resolution group will examine any issues arising.

Experiencing difficulties paying?

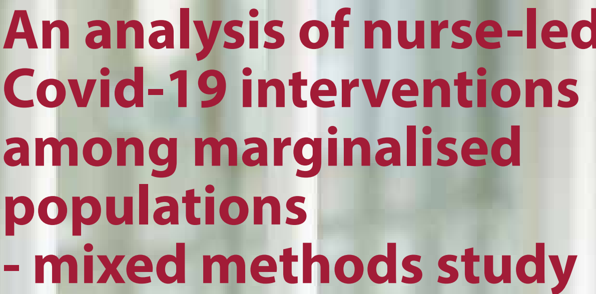
For cyber security reasons, in the interests of protecting the integrity of individual banking credentials, new restrictions have been imposed on payment systems. The INMO will no longer be able to accept payments over the phone. Payments can be made by:

- Monthly salary deduction, using the deduction at source form available from INMO (Not all work locations offer this facility so an alternative would be by monthly standing bankers order through your bank)
- Monthly standing bankers order, using form available from the INMO
- Cheque payable to INMO
- Postal order payable to INMO
- Bank draft payable to INMO
- Online via our website (using your unique quick payment code available from the INMO).

If paying online, your bank security will require that the billing details on the card you are using are the same as those used to register membership with INMO.

We apologise for any inconvenience, but heightened awareness of cyber security is in all of our interests. We must implement the highest standard of protection for our members.

NMIH



An analysis of nurse-led Covid-19 interventions among marginalised populations - mixed methods study

Funded by: Research Collaborative in Quality and Patient Safety (RCQPS) https://www.rcpi.ie/research/research-collaborative-in-quality-and-patient-safety/

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Co-investigators: Niamh Murphy, Dublin Simon; Emma Coughlan, Safetynet Primary Care; Maxine Radcliffe, Homeless Healthlink CHO7, HSE; Noelle Woods, Peter Mc Verry Trust (PMVT); Chris O Donnell, peer researcher; Sarah Jayne Miggin, Inclusion Health, Mater Hospital; Anne Marie Lawlee, Inclusion Health St James' Hospital; Steve Pitman, INMO; Mary Rose Sweeney, SNPCH, DCU; Denise Proudfoot, SNPCH, DCU.

Collaborators: Elizabeth Pena PMVT; Raul Menendez, Homeless Healthlink CHO7, HSE; Lydia Barry, Safetynet Primary Care, Sinead Grogan, Safetynet Primary Care; Caroline Mulqueen, Safetynet Primary Care; Lauren Fitzsimmons, Safetynet Primary Care; Michelle Connolly, Dublin Simon; Precious Chisango, Dublin Simon.

Background

COVID-19 presents health/healthcare challenges worldwide across a range of populations and practitioners. Rates and severity of ill health are generally higher among people who are socially marginalised, for example people who are homeless, migrants, travellers, people with addictions and mental illness.

Nurses and midwives are at the forefront of planning, delivering and evaluating health promotion/healthcare among hard to reach populations in a wide range of healthcare settings. This survey, which is part of a wider study; An analysis of nurse-led COVID-19 interventions among marginalised populations – a mixed methods study, aims to examine the experiences and support needs of nurses and midwives working during the COVID-19 pandemic. Findings will inform ongoing policy and practice development in this area. This study has been approved by Dublin City University Ethics committee DCUREC/2020/117. More details concerning the overall study can be sought from briege.casey@dcu.ie.

What does taking part involve?

If you are over 18 years of age and have worked as a nurse during the COVID-19 pandemic in Ireland, we would be extremely grateful for your help in completing this online survey to learn more about your experiences, opinions and support needs. You may not have provided healthcare directly to marginalized populations during the COVID-19 pandemic. In any case, this survey still applies to you. We are interested in the experiences and support needs of all nurses and Midwives working during COVID-19. If you consent to participate, completing the questionnaire will take approximately 30 minutes of your time. Your participation is entirely voluntary, anonymous and confidential. You can find further information about the survey and the survey link below.

Take the survey here!

Go to **https://dcusciencehealth.qualtrics.com/jfe/form/SV_ehDduAvQqiS6Mwm**

On **Android** and **iPhone** scan the QR Code Image using the built-In scanner in your phone's camera app. 1. Launch your phone's Camera app. 2. Point your camera to the QR code. 3. Your phone will recognize the code and take you straight to the survey.

Thank you.

INMO's input on Covid experience proves invaluable on political stage

Beibhinn Dunne presents a roundup of key INMO submissions to the Oireachtas and other national committees during the pandemic

THROUGHOUT the unprecedented level of healthcare planning necessitated by the Covid-19 pandemic since early last year, the INMO has been called on by the Oireachtas and other planning bodies to share nurses and midwives' knowledge and experiences of working on the frontline.

The INMO's role as an advocate for members and patients alike has long made the union a vital contributor to national discussions on healthcare policy and planning.

Oireachtas Committee on Covid-19 Response

The Organisation made several submissions in 2020 and 2021 to the Oireachtas Committee on Covid-19 Response on critical issues such as infection rates among healthcare workers, capacity of the health service and childcare for HCWs.

It also made submissions on infection risk and disease in HCWs; retention of private hospitals under public control; testing and contact tracing; and nursing homes and Covid-19.

Several INMO representatives appeared in person before Oireachtas committees. General secretary Phil Ní Sheaghdha testified before the Oireachtas Committee on Covid-19 Response in June 2020, in relation to providing childcare for frontline workers and the government's response to the effects of school closures on frontline HCWs.

The union also appeared at a hearing later in June 2020 on capacity in healthcare facilities.

In July 2020 Ms Ní Sheaghdha again appeared before the Committee, along with INMO member Siobhan Murphy, to discuss the high rates of Covid-19 infection among HCWs, leading the public discussion on 'long Covid' among frontline staff and the responsibility of the state and health employers to support nurses and midwives who had acquired Covid-19 at work.

Ms Ní Sheaghdha appeared before the Oireachtas committee again in October 2020 to discuss workforce planning issues. She highlighted how understaffing in the health service was exacerbated by absences due to Covid-19, and the importance of increasing staffing to meet bed capacity plans set out in Budget 2021.

Oireachtas Joint Committee on Health

In February 2021, the general secretary, alongside INMO president Karen McGowan and director of industrial relations Tony Fitzpatrick, appeared before the Oireachtas Joint Committee on Health to discuss protection and support for frontline HCWs, as well as to highlight the impact of Covid-19 on missed care in health facilities and the effects of the vaccine rollout on healthcare provision.

The INMO's contributions to these vital discussions received widespread media coverage, reflecting value placed on INMO members' experiences within Irish policy making.

Submissions to other bodies

The INMO also made written submissions on the current non-Covid healthcare and social policy landscape, including:

- The Covid-19 Nursing Homes Expert Panel

INMO general secretary Phil Ní Sheaghdha addressing the Oireachtas Committee on Covid-19 Response in June 2020 in relation to childcare for frontline healthcare workers

- The National Children's Nursing Strategy
- The Joint Committee on Disability Matters on the lived experience of people with disabilities
- Legislation to create apprenticeships in healthcare
- Public consultation on statutory sick pay
- National planning documents such as the Department of Health Statement of Strategy and the HIQA consultation on National Standards for the Care and Support of Children using Health and Social Care Services.

The INMO also represented members on gender equality and leadership, including contributions to the Citizens' Assembly on Gender Equality and consultation on building a family-friendly parliament.

Expert Group on Nursing and Midwifery

The INMO also made a written submission to the Expert Group on Nursing and Midwifery regarding the implementation of the 2019 strike settlement and remuneration for nurse and midwife managers, public health nurses and senior nursing and midwifery grades, which informed the 2021 Building Momentum public service pay proposals accepted by INMO members earlier this year.

Over the course of the pandemic, the experiences and knowledge of nurses and midwives have been sought by planning bodies and decision-makers to provide accounts of frontline pandemic care and to inform best practice in clinical planning and co-ordination.

The invaluable work of INMO members, their unwavering commitment and their expert practice throughout the pandemic have also highlighted the need for nurse- and midwife-led decision-making in clinical settings, as well as the importance of members' professional insight in shaping best practice.

As we proceed into the final stages of vaccine rollout the INMO will continue to ensure its members' voices are represented in the same meaningful way they have been heard throughout the pandemic, and that the lessons learned in healthcare are applied to improve the health service for patients and staff post Covid-19.

Senior nurse manager post saved from redundancy in Mullingar

AN ATTEMPT to make a senior nurse manager's post redundant at St Francis Private Hospital, Mullingar has been overturned, following intervention by the INMO.

At short notice, a senior nurse manager was notified of her proposed redundancy in St Francis Hospital, Mullingar. Following a long period in receivership, the hospital was taken over by Charter Medical late last year. In May the hospital's board of management conducted a review of its financial status and proposed a number of redundancies, including the senior nurse manager's post, in what they called a cost-saving effort.

Following this announcement, the INMO engaged in a 14-day consultation period with the employer on behalf of the member. The INMO was concerned to be told that the hospital did not warrant the position of a senior nurse manager. The union informed management that its attempt to abolish a head of function post had generated a level of unrest among existing staff who had lost confidence in their employer.

At no stage during the consultation period was any reasonable alternative role offered to our member. Management advised, in the event of the redundancy taking place, the senior nurse manager's role was to be redistributed to non-nursing managers and existing nursing staff would report to the chief executive as an interim measure.

The INMO stated its members would not report to a non-nursing individual and the absence of the senior nurse manager position would leave the hospital without any nursing management structures and argued this was objectively dangerous.

Karen Clarke, INMO IRE: "Absence of the senior nurse manager position would have left the hospital without any nursing management structures, which was objectively dangerous"

The INMO wrote to the employer stating it did not accept the redundancy package put forward by management. The union argued the proposed redundancy was not a genuine one, as essentially the role was to remain and be redistributed to other managers within the hospital. Furthermore, the union had concerns about the selection criteria for redundancy, which it considered to be unfair.

The issue was referred to the WRC for an urgent conciliation hearing as no progress or agreement was being reached during the consultation period.

Prior to the 14-day consultation period concluding the INMO was advised by the employer a change in the hospital management structures had taken place and the board of management now acknowledged and recognised the senior nurse manager position and value.

The employer confirmed the redundancy was no longer being considered and that the role was preserved. The employer immediately withdrew the threat of redundancy and the member has since returned to her position within the hospital following this process.

– Karen Clarke, INMO IRE

INMO pressure secures more staffing in CUH

CORK University Hospital experienced significant staffing difficulties over recent months and this was particularly evident in CATH Lab Services. INMO members raised their concerns in relation to the difficulties around on-call services and with the assistance and support of the union, additional staffing has been prioritised and provided for CATH Lab services in CUH. The INMO secured this on behalf of our members following engagement at local level.

– Liam Conway, INMO IRO

Bon Secours agrees risk assessment for pregnant workers during Covid

THE urgent matter of paid leave for nurses who are pregnant was successfully negotiated with Bon Secours Health System Group in recent weeks.

This will now result in staff who are pregnant being risk assessed for their fitness to work during the Covid-19 pandemic, and consideration being given to the provision of work in a suitable alternative location or in a remote working situation.

In the event that the employer is unable to provide or maintain an alternative work opportunity, nurses who are pregnant will be provided with full pay for the duration of their pregnancy, linked to the Bon Secours sick leave arrangements, for the period associated with the occupational health recommendation.

Subsequent to return from maternity leave by each employee, the period associated with this sick leave related to Covid/pregnancy time, will be disregarded and not reckoned against a nurse's sick leave history.

This agreement is subject to review in early September 2021.

Specialist qualification allowance

Meanwhile, the INMO recently successfully negotiated application of the specialist qualification allowance for two INMO members working in Bon Secours Services in Cork.

As the members are employed in a specialist area appropriate to their postgraduate qualification, they are entitled to payment of the specialist qualification allowance and have been awarded same, with three years retrospection.

– Mary Power, INMO assistant director of IR

Problems highlighted with rollout of new payroll system in South East

Noel Treanor reports on findings of INMO survey on NiSRP

A LACK of training, difficulties with recording annual leave and an increased workload for nurse managers were the chief problems identified with the HSE's new payroll system NiSRP since it went live in the South East in September 2020.

Following receipt of a high number of complaints and queries from members, the INMO undertook a survey to identify the problems and work towards agreeing a solution with the HSE.

The initial implementation of the HSE's National Integrated Staff Records and Pay Programme (NiSRP) was completed in the East in May 2019. The system was then rolled-out in the South East in September 2020, and further areas are to follow. The aim of the system is for rosters and payroll to be generated online, with online access to payslips.

Queries received by the INMO mainly related to difficulties in accessing payslips and in understanding annual leave. In addition, the system required extra work by nurse/midwife managers, and management was reportedly failing to address issues arising.

The survey was sent to all INMO representatives and officers in the South East region. In addition, it was sent to nurse managers who had contacted the INMO identifying issues with the system. Reps and officers completed the survey on behalf of their unit/area. Results represent approximately 500 members in the region, covering all sectors.

Payslips

In respect of understanding payslips, just over half of respondents (55%) could access their payslips appropriately and the majority (77%) found the new payslips easy to understand. However, a number expressed difficulties with either reading their payslip or accessing it online. It appeared that there was a lack of training on the system, and its introduction during the pandemic did not help.

To address this the INMO proposed that targeted training events be rolled out to areas/units that express difficulty in understanding payslips. These areas are to be agreed between the INMO and management.

It was also proposed that the employer determines where connectivity and hardware issues are a barrier to accessing payslips and addresses this.

Annual leave

The majority (71%) of respondents indicated that annual leave was not easy to record, with almost all (90%) indicating that the amount of outstanding leave was unclear.

Almost half (47%) indicated that the system does not properly record the carry over of leave and two-thirds (67%) indicated that it was unclear if annual leave had been granted. In addition, 64% of respondents indicated that there was duplication between NiSRP and a paper system.

It was proposed that the correlation between actual annual leave and recorded annual leave be addressed as a matter of urgency as it appears to be a systemic issue. In addition, the system for applying for and granting annual leave, and recording same, must be reviewed to ensure it is clear, efficient and expeditious.

Role of manager

Three-quarters (75%) of respondents indicated that the role of the person undertaking the off-duty had changed, with the majority (90%) indicating that it had become more onerous. The role of the manager, particularly in respect of data entry was particularly contentious.

The HSE was called on to reiterate its communication that the role of the line manager/CNM/person in charge should not change or have changed as a consequence of the introduction of NiSRP.

In addition, the INMO proposed that a training programme recommences for all pertinent line managers. Where it is reported that additional clerical functions have been imposed on the line manager, a joint management/union entity needs to review each instance.

Outstanding issues

Three-quarters (75%) of respondents indicated that payroll issues that existed prior to the introduction of NiSRP (annual leave/TOIL etc) had not been rectified. Furthermore, the majority (89%) indicated that issues arising as a consequence of the new system had not been rectified.

Moreover, many members do not know who to go to in order to get issues addressed.

Each area should have a notified person whose responsibility it is to address issues that have not been resolved by the line manager. This person should receive appropriate training for that role and staff be made aware of their identity for each area.

Final comments from respondents were extensive and displayed exasperation with the new system, its introduction during the pandemic, failure to follow up with appropriate training, and the failure to fix anomalies that arose, particularly in regard to issues such as TOIL and nursing/midwifery specific allowances.

Conclusion

While on the whole, the new payslip system was seen as easier to understand, there are difficulties in some areas, mainly due to insufficient training and connectivity issues.

The issue of annual leave and carry over seems to be a consistent issue across the region, likely due to a system not being in place for real time recording of annual leave. In addition, training and supports have not been put in place for managers to deal with this.

There was nearly universal agreement that the role of the manager has become more onerous and that there has been an additional administrative function imposed on them. This is due to nurse managers not being given administrative support to deal with data input requirements.

Some outstanding issues still need resolution involving specific specialties, including theatre and public health nursing which have different systems in place.

The INMO is seeking that the HSE initiate a joint oversight forum to ensure that the proposals outlined above are implemented. This would act as an appeal mechanism where local issues are not addressed.

INMO members who have continuing difficulties with regards to NiSRP are asked to contact their local rep.

Noel Treanor is an INMO industrial relations officer

Attention All

GP Practice Nurses

To ensure that you are part of the GP Practice Nurse Section and to receive regular updates from your National Section please check that you are aligned to the National Section.

If you are not sure, please contact **membership@inmo.ie**

Your INMO membership & affiliation to the GP Practice Nurses Section entitles you to:

- **Fitness to Practise Defence** - providing advice and full representation in circumstances where you are referred to the Fitness to Practise procedures of NMBI.
- **Employment Issues** - comprehensive collective and individual supports including access to INMO information office (01) 6640610/19 and INMO official representation on matters including contracts, salary, terms & conditions and employment rights.
- **Networking** with like-minded members through the National Section Network offering support in the form of structured meetings and professional development. A core function of the GP Practice Nurses Section is to advocate for our members.
- **Professional Development** - access to INMO suite of CPD programmes, conferences and workshops (currently all online, with many offering the option to playback at your convenience).
- **Library** - access to a comprehensive library service including, literature searches / remote consultations / reference desk queries along with access to resources through our dedicated website www.nurse2nurse.ie.

If you wish to get involved in the National GP Practice Nurses Section, **we would really like to hear from you.**

Please contact **INMO Section Development Officer** by emailing: **Jean.Carroll@inmo.ie**

WRC rules CNS posts in ID services must be filled

THE INMO has successfully secured the retention of clinical nurse specialist (CNS) posts in the Daughters of Charity Services in Limerick/North Tipperary following referral to the conciliation services at the WRC.

The non-filling of these promotional nursing positions following retirements as far back as 2018 have been raised by local INMO representatives since that time and local meetings with management failed to secure commitments on replacements.

At conciliation, the INMO argued that these positions are central to the improvement in the services for persons with an intellectual disability as set out in the HSE report *Shaping the Future of Intellectual Disability Nursing*. The WRC proposal sets out that management is to fill 2.77 WTE vacant CNS positions. Further local engagement is to take place in relation to a vacated CNS position in the Early Learning/Children's Services.

– Karen Liston, INMO IRE

Dispute over outsourcing of care in Mayo

THE INMO has referred a dispute on the outsourcing of the HSE Community Palliative Care Services in Mayo to a Section 39 organisation to the Health Services Oversight Body.

The dispute centres on the fact that all arising vacant positions will not be aligned to the HSE terms and conditions of employment.

In addition, employees would no longer have public sector status following this outsourcing of services.

UHL payment delays under focus

The INMO has requested engagement with University Hospital Limerick regarding significant delays in payments for additional hours worked by nurses at the request of management.

In addition, such payments need to be made easier to decipher and check on payslips. Engagement is awaited.

– Mary Fogarty, INMO assistant director of IR

Concern over changes at Croom Hospital

THE INMO has requested the WRC Conciliation Services to assist the union in having meaningful engagement with the HSE on issues arising at Croom Orthopaedic Hospital, which is managed by UL Hospital Group.

The union wants detailed discussion on plans to open a new theatre department at the hospital, which would increase activity. In addition, it wants clarification on revised management structures and agreement on staffing levels.

Nurse members working at the hospital are being left completely in the dark on what management's plans entail. This is despite the requirement to have genuine information and consultation structures and to engage with the INMO with the purpose of agreeing matters in advance.

A range of concerns exist with INMO members seeking adherence to best practice in staffing levels for all areas of the theatres suites, education and training for staff, governance arrangements and workload needs.

– Mary Fogarty, INMO assistant director of IR

Cyber security changes to INMO payments

THE INMO can no longer accept membership payments over the phone. New restrictions have been imposed on payment systems in the interests of protecting the integrity of individual banking credentials and for cyber security reasons.

Payments can now be made online via the INMO website **www.inmo.ie** or through salary deduction, standing order, cheque, postal order or by bank draft. If paying online, bank security will require that the billing details on the card being used are the same as those used to register membership with INMO.

The INMO apologises for any inconvenience caused to members and stated that heightened awareness of cyber security is in members' interests. The union recognised the need to implement the highest standard of protection for members. *See page 11*

Nurses and midwives in action around the world

Australia
- Nurses choosing better-paid shifts at vaccination hubs adding to crisis in Australian public hospitals
- Nurses and midwives rally over staffing ratios
- Nursing union calls for greater work flexibility so aging workforce is retained for longer

Brazil
- Nurse stoppages in protest over floor-level salary

Canada
- Overwhelming majority of nurses favour strike action
- Nurses union worry lifting of state's mask order will put people at risk
- Nursing shortage worsens in Newfoundland, union says

Dominican Republic
- National Union of Nursing Workers announced a 48-hour strike

New Zealand
- Thousands of nurses go on strike in New Zealand

Philippines
- Government urged to provide nurses higher salary and more benefits amid pandemic
- Philippines raises cap on health professionals going abroad

South Africa
- Nurses 'overwhelmed, at risk of burnout' as cases soar

Spain
- Union estimates that nurses work up to 1,500 overtime hours a day

UK
- 'Undervalued' nurses depart, leaving NHS with staffing shortage

US
- California Nurses Association urges people to continue wearing masks

Nursing and midwifery at G20

The G20 2021 summit was sent a strong message that investing in nursing and midwifery is an investment in health for all

REPRESENTATIVES of nursing and midwifery, in an historic first, were invited by the Italian G20 presidency and the European Commission to present at the day-long conference aimed at co-ordinating worldwide efforts against the Covid-19 pandemic.

At the event on May 21, 2021, Elizabeth Adams, president of the European Federation of Nurses Associations (EFN), presented on nurses and midwives' perspectives at the pre Global Health Summit, which was held in Villa Pamphili in Rome and chaired by Italian prime minister Mario Draghi and president of the European Commission Ursula von der Leyen. In attendance were global leaders of the G20, heads of international and regional organisations and representatives of global health bodies.

In preparation for the event Ms Adams was invited by INMO president Karen McGowan and general secretary Phil Ní Sheaghdha to attend the union's recent annual delegate conference to hear the frontline experiences of members, and their exceptional challenges and sacrifices to protect the health of the population.

The importance of articulating nurses and midwives' lived experiences as well as their innovative solutions was essential to inform global leaders of the reality of frontline healthcare to enhance worldwide efforts against the pandemic and stress the critical importance of future preparedness.

In his opening remarks at the pre-Summit, Mr Draghi recognised the vital importance of nurses and midwives and thanked them sincerely for their valuable contribution.

Ms von der Leyen spoke about how the pandemic had taught us "how much we need each other, and how much government leaders must work with health experts and scientists".

Ms Adams addressed the G20 heads of states and governments to inform their considerations on contributing to the Rome Declaration (to be agreed at the summit) and demonstrate the significant benefits of investing in nursing and midwifery.

Ms Adams stated that Covid-19 presented an unprecedented challenge to an already fragile health system. She reflected on the devastating suffering of individuals and their families, with some health systems being overwhelmed. She discussed inequality of access to care, equipment, including vaccines, and other infrastructural challenges such as the stark digital divide between countries and fragmentation across ecosystems.

Ms Adams stressed that global financial planning that included the voices of nurses and midwives would enhance a future fit-for-purpose and well-prepared health workforce. This would include capacity for any unexpected crisis and protect the G20 pillars: people, planet and the prosperity of our world. She highlighted that nurses and midwives were the largest health workforce in many countries, providing around the clock care every day of the year. Nearly every citizen at some point in their life will benefit from the expertise of a nurse.

Ms Adams spoke of how millions of nurses and midwives worldwide had faced high exposure to Covid-19, with reports of up to 40% of nurses in some countries contracting the virus, thousands of nurses dying from exposure at work, and millions more experiencing an impact on their mental health. Many also now have long-Covid, often with career-ending consequences.

Prior to the pandemic the WHO estimated a shortage of approximately 10 million nurses by 2030, this could soon rise to 14 million. Well prepared and educated nurses equate to lower patient mortality rates and better patient outcomes. Therefore, strategies for retention and recruitment of nurses and midwives is a vital pillar to ensuring the building of a healthier, safer, fairer, resilient and more sustainable health systems.

Ms Adams said that nurses and midwives had the courage to care during the pandemic and the global leaders were challenged to have the courage to work in collaboration with nurses and midwives to deliver a better and safer future for all.

"As our political and global policy leaders, you are witnesses to the brave, heroic, compassionate commitment of nurses who care for the most vulnerable, preserve millions of lives on a daily basis, and provide comfort and dignified care at end of life. I know the admiration and trust you have in the professions. The greatest recognition you can afford to nurses and midwives is to incorporate their problem-solving expertise, experience and leadership into the policy development phase as the end-users to translate policy into practice," she said.

Ms Adams welcomed the commitments of the Rome Declaration that provided recommendations and priorities for global health-related policies in the future. In agreeing the Declaration, global leaders stated that they "Convey our condolences for lives lost and express our appreciation for healthcare and all frontline workers' vital efforts in responding to the pandemic".

The G20 leaders supported the full implementation of universal health coverage and a multisectoral, all-of-government, all-of-society, evidence-based, one health approach to health security. The Declaration reconfirmed the commitment to global solidarity, equity, and multilateral co-operation; to effective governance; to put people at the centre of preparedness and equip them to respond effectively; to build on science and evidence-based policies and create trust; and to promote sustained financing for global health.

The Rome Declaration has the potential to create a high-level framework for political accountability that redefines the way countries deal with health emergencies – including valuing and recognising the importance of working in partnership and collaboration with nurses and midwives.

Ms Adams stated that "investing in nursing and midwifery is a certain investment in the health of G20 nations and people around the planet."

Midwife shortage: Global action required

Freda Hughes and the **INMO library team** discuss the recent report on worldwide midwifery services which shows that investing in and empowering midwives could alleviate some of the problems faced

AS HEALTHCARE services around the world continue to reel from the Covid-19 pandemic, it has been revealed that we are facing a global shortage of almost one million midwives. This alarming statistic was one of the conclusions of the latest *State of the World's Midwifery Report*.

The 2021 document builds on previous reports and aims to record the whole world's sexual, reproductive, maternal, newborn and adolescent health (SRMNAH) workforce, with a particular focus on midwives.

The report – produced by United Nations Fund for Population Activities, the International Confederation of Midwives (ICM), the World Health Organization and Novametrics – contains data from 194 countries and aims to chart progress and map trends since the inaugural 2011 publication. It also identifies the barriers and challenges to future advancement.

SRMNAH is an essential component of the UN's sustainable development goals. The analysis indicates a global needs-based shortage of 1.1 million 'dedicated SRMNAH equivalent' workers. The most significant shortage, some 900,000, applies to midwives and the wider midwifery workforce.

The SRMNAH workforce is projected to be capable of meeting only 82% of the world's need by 2030.

The Covid-19 pandemic has reduced workforce availability significantly. Workers need protection from infection and support to cope with stress and trauma brought on by working on the frontlines during a pandemic. Covid-19 has highlighted the importance of investing in primary health, in which midwives play a central role.

There is still a lack of action towards critical areas recommended in the 2011 report, including costing midwifery and midwives in national health plans and improving workforce data.

The report established that investing in midwives facilitates positive birth experiences, improves health outcomes, augments workforce supply, favours inclusive and equitable growth, facilitates economic stabilisation and can have a positive macroeconomic impact. The wide range of contributions that midwives can make to SRMNAH and broader health goals makes them an obvious focus for investment.

In many countries, midwives are not authorised to perform tasks typically considered part of the midwife's scope of practice. This is most common in the Americas, European and the Eastern Mediterranean regions as well as in high-income countries. Therefore the report recommends investment in education and regulation of midwives to ensure high-quality care worldwide.

The report identified that midwives could meet about 90% of the global need for essential SRMNAH interventions, yet they account for just 8% of this workforce. Factors preventing the workforce from meeting all of the need include insufficient numbers, skill mix and inequitable distribution.

Some population groups risk their access to healthcare workers, including midwives, being restricted due to characteristics including age, poverty, geographical location, disability, ethnicity, conflict, sexual orientation, gender identity and religion. This workforce requires a supportive policy and working environment, and education to meet the specific needs of these groups, and thus provide quality care accessible and acceptable to all.

From the report's findings the need to empower midwives was striking. Midwives are more likely to be women (93% globally) and they experience considerable gender disparities in pay rates, career pathways and decision-making power. Only half of reporting countries have midwife leaders within their national ministry of health. A gender-related transformative policy environment is required to address these inequalities, recognising the value of the work and guaranteeing human rights.

The report concludes that investment is needed in four key areas. These areas are:

- Health workforce planning, management and regulation
- High-quality education and training of midwives
- Midwife-led improvements to service delivery
- Midwifery leadership and governance.

Speaking on the launch of the report, Dr Franka Cadée, president of the International Confederation of Midwives, said: "As autonomous, primary care providers, midwives are continually overlooked and ignored. It's time for governments to acknowledge the evidence surrounding the life-promoting, life-saving impact of midwife-led care and take action on the State of the World's Midwifery Report's recommendations.

"The International Confederation of Midwives is committed to leveraging the strength of our global midwife community to carry forward these powerful findings and inspire country-level change. However, this work is not possible without commitment from decision makers and those with the resources to invest in midwives and the quality care they provide to birthing women."

See the full report at: **https://internationalmidwives.org/partners-and-collaborations/collaborations/sowmy-2021.html**

Introducing Executive Council members

Caroline Gourley

Interim director of nursing, CHO Dublin North City and Centre

CAROLINE Gourley oversees four assisted community units with a total of 130 beds. The four facilities are all residential care of the older person (COOP) units that also provide day services, situated in Lusk, Glasnevin and the Navan Road in north Dublin.

There are several psychiatric nurses in Ms Gourley's extended family; this inspired her to go into general nursing. She moved to Ipswich in the UK in the 1980s to begin her training. She holds a diploma in first-line supervisory management, a BSc in nursing management and an MSc in palliative care. She has been an INMO rep at hospital and branch level since 1990 and is chairperson of the COOP Section.

Ms Gourley also sits on the National Taskforce on Staffing and Skill Mix and is part of Professional and Regulatory Committee. She said that joining the Executive Council has been an enlightening and enriching experience. She has enjoyed the social justice aspects of the work and was heartened by the solidarity among nursing and midwifery unions worldwide.

Ms Gourley said: "I'm passionate about the wellbeing of our long-term residents and that can only be achieved through safe staffing. We need proper staffing ratios across the board, not just in COOP. I will use my roles on the Executive Council and the national taskforce to fight for this."

Ms Gourley's message to her peers was: "Keep going. We're starting to see the light at the end of the tunnel with vaccinations well underway. Older people's services have been decimated since the pandemic. It has revealed the need for more community-based care. Nurses and midwives have worked so hard but I would particularly like those in our sector to know they are represented and that their voices are being heard."

Grace Oduwole

Assistant director of nursing, Bellvilla Community Nursing Unit

GRACE Oduwole's older sister, who was also a nurse, inspired her to go into the profession. Ms Oduwole came to Ireland in 2001 after working for 14 years at University College Hospital, Ibadan, Nigeria as a nurse and midwife.

Ms Oduwole has a degree in nursing studies from Trinity College Dublin and an MSc in nursing from the Royal College of Surgeons (RCSI), as well as a BSc and MSc in nurse management, which she completed in 2019. She is vice chair of the International Section having previously served as secretary.

Ms Oduwole said: "I'd like to acknowledge the impact the INMO's support has on us international nurses. It makes such a difference to have that support when you're working in a new country. I am proud to take my seat on the Executive Council as I think it's important for international nurses to see themselves represented."

Ms Oduwole said she would love to see more international nurses and midwives become active with the INMO. While many are members, she believes they would benefit by joining their local branch or a relevant section. She would like to see more nurses and midwives in leadership roles and feels the union can support them in achieving this through education, support and networking. She is aware the professions are under-represented at policy level and would like to see this change.

"We work in stressful professions and I would like to see us speaking with one voice. The INMO is the best vehicle for this as it only represents nurses and midwives and we speak as one clear, professional voice," said Ms Oduwole.

"I'm so proud of our members who have shown such exceptional dedication and strength during the pandemic. They have sacrificed so much, and now it's time for our government to recognise and reward that."

Michael Whyte

CNM1, John Paul ID Services, Co Galway

Originally from Cork, Michael Whyte has worked in the ID sector for more than 20 years. He began his career as a care assistant before qualifying as a nurse in 2002. His sister is a midwife and while he was not drawn to general nursing, he says he has found his calling working in the ID sector.

Mr Whyte met his wife, who is also a nurse, while training in Limerick. They later moved to Galway for work.

Mr Whyte has always been an active member of the INMO, including being a member of the RNID Section and the Galway Branch. He was instrumental in organising RNID representation on the picket lines during the 2019 strike campaign. He originally joined the union because of a workplace issue but now he believes that all nurses and midwives must be unionised to protect their rights and entitlements.

Mr Whyte said: "When I had an issue at work I was reminded that there is strength in numbers and that at any time in your life you may need trade union support. With the INMO you have the strength of unity and a singular strong voice representing you."

Mr Whyte says RNID members feel under-represented and that the service they provide can be quite different from other aspects of nursing. He says he also hopes to provide a voice for ID clients on the Executive Council.

"I have witnessed the dedication of staff in RNID throughout the pandemic. We worked tirelessly as a group of nurses, focused on the protection of the people whom we support. We have gone out of our way not to put our clients and our families at risk.

"I worry about the potential burnout coming down the line for many nurses and midwives. We have constantly put others first but if we don't look after ourselves we won't be able to look after others," he said.

Updated code of conduct

Edward Mathews takes a look at the NMBI's recently revised Code of Professional Conduct and Ethics

THE Board of the NMBI has published a revised *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives*. This is an important document guiding your practice daily as it sets out the principles, ethical values and standards against which your conduct is judged by the NMBI. While the Code is quite similar to the previous version, the following changes should be noted:

Principle 1: Respect for the dignity of the person

- *Respect for the Dignity of the Person, Standard of Conduct 4* – this is a new provision requiring that nurses and midwives respect a woman's legal right to termination of pregnancy in accordance with the law
- *Respect for the Dignity of the Person, Standard of Conduct 7* – this is a new, and further, articulation of the right to conscientious objection by a nurse or midwife
- *Respect for the Dignity of the Person, Standard of Conduct 14* – this is new provision regarding the duty to ensure that the rights and interests of those who lack capacity are at the centre of all decision-making processes concerning their care and welfare
- *Respect for the Dignity of the Person, Supporting Guidance – Advanced Healthcare Directives* – there is additional guidance for those in whom there is a capacity concern in the context of advanced healthcare directives, with specific reference to – the role of the of the Assisted Decision Making (Capacity) Act 2015, the relevance of functional capacity assessments in a time and issue specific way, that cognitive impairments are only relevant if they affect capacity and the role of the decision support service.

Principle 2 – Professional responsibility and accountability

- *Professional Responsibility and Accountability – Standard 4*, this is a new provision dealing with a duty to protect one's own health and safety and that of the wider community. It deals with extreme infectious clinical situations where adequate and sufficient PPE is not available, the requirement to raise the issue with one's manager and a recognition that if the matter is not resolved those difficult decisions may need to be made quickly to preserve the safety of the patient, one's own personal safety and the safety of others. In such circumstances the provision guides a nurse or midwife to their professional responsibility and accountability, the duty to report concerns, the duty to practise in a safe and competent way in accordance with the best available evidence and practice standards to ensure safe, quality care. Further, a nurse or midwife is guided to the requirement to communicate with colleagues in the provision of safe, quality care; the importance of documentation and communication of care in a clear, objective, accurate and timely manner within a legal and ethical framework; the requirement to address differences of professional opinion by discussion and informed debate in a timely and appropriate manner; and the requirement to take action to protect patients put at risk by colleagues' actions, omissions or incompetence and to report the matter appropriately
- *Professional Responsibility and Accountability – Standard 6*, the first part of this standard is a re-articulation of the right to conscientious objection, which existed in the previous Code. There is then an additional provision dealing specifically with the issue of conscientious objection to carrying out or participating in a termination of pregnancy and the requirement in law to make arrangements for the transfer of the care of the woman as may be necessary to allow her to avail of a termination. This additional provision, specifically on participating in a termination of pregnancy, exists in addition to the general conscientious objection provisions, does not detract from the general conscientious objection provisions, but does make provision for the duty to transfer care as required by law.

Principle 3 – Quality of Practice

- *Quality of Practice – Supporting Guidance* – there is additional guidance which refers to the making of an open disclosure pursuant to the Civil Liability (Amendment) Act 2017. In accordance with the Act, it is important to note that such a disclosure or apology shall not constitute an express or implied admission of fault, professional misconduct, poor professional performance or unfitness to practise in any complaint subsequently made to a regulatory body. This is a provision in the Act secured through the actions of the INMO.

There are also inclusions of new and updated references and resources, as well as references to legislation enacted since 2015 which is of relevance, including:

- Assisted Decision Making (Capacity) Act 2015
- Civil Liability (Amendment) Act 2017
- Data Protection Acts 1988-2018
- Freedom of Information Act 2014
- Health (Regulation of Termination of Pregnancy) Act 2018
- UN Convention on the Rights of Persons with Disabilities, 2007 (ratified by the Irish government in 2018).

The INMO secured an opportunity to comment on the changes to the Code. It is our assessment that in the main the amendments to the Code merely reflect necessary updates in keeping with legislative changes in our society and which touch on the practice of nurses and midwives.

The inclusion of a provision dealing with a shortage of PPE in certain circumstances is notable, however, one would comment that the Code, while recognising the situation of nurses and midwives in such circumstances, could have gone further in providing clear guidance instead of directing the professional to a range of considerations.

In saying this, one is conscious of the many situations that may arise, however in the round it is important that the challenges of such circumstances are noted and – while responsibility and accountability will not slip away – it is at least now explicitly recognised that peculiar and difficult challenges present for our members in such circumstances and must be taken into account. This is similar to the guidance we secured from the Board earlier in the pandemic to ensure that these circumstances were explicitly recognised so that our members were better protected.

Edward Mathews is the INMO director of professional and regulatory services

Assessing the decision-making capacity of patients

Edward Mathews discusses the impact the Assisted Decision Making (Capacity) Act 2015 will have on practice when fully commenced

MEMBERS will be aware of the significant impact the Assisted Decision Making (Capacity) Act 2015 has had in ensuring that patients are facilitated to make decisions for themselves and to participate in decision making to the maximum extent possible. Members will also be aware that capacity assessments take a functional approach as opposed to a status approach; therefore capacity is to be assessed in each context that it arises, rather than as a one-off decision or assessment.

This approach looks at each decision that must be made and the capacity of a person to participate to the maximum extent possible in that decision-making process – including with assistance. This has become an important area of professional practice for nurses and midwives across health and social services in Ireland, and it is notable that the Act finds a prominent place in the revised Code of Conduct and Ethics for Registered Nurses and Registered Midwives issued this year.

While the Act introduces very substantial changes, several of which have been commenced or implemented, it is lamentable that the Act has largely not commenced. Work is ongoing in the hope that it will be fully commenced in June of 2022 – a priority for the current government in its Programme for Government.

In this context, the Decision Support Service (DSS) is an important development for the full implementation of the Act and for facilitating those who may require decision-making support arising from concerns regarding their capacity or other matters.

The head of the DSS provided an update to the Oireachtas recently on matters relating to the Act and the service that are of interest to members.

Abolition of wards of court

One of the key changes that will follow on from the full implementation of the Act will be the abolition of the ward of court system; it is estimated there are approximately 2,300 such adult wards at present.

Additionally, the functional assessment of capacity is currently in place, arising from the 2015 Act, and a person's capacity is assessed based on their ability to understand the nature and consequences of the decision in the context of the choices available at the time the decision is to be made.

Incapacity will not be a status classification; capacity must be assessed in relation to each decision and in the context in which it arises. There are important guiding principles contained within the legislation:

- Presumption of capacity until the contrary is established
- That a person won't be considered to lack capacity unless all practicable steps have been taken to help them to have capacity in the context of the decision at hand
- A person will not be considered to lack capacity on the basis of having made or being likely to make unwise decisions
- A minimal restriction of the relevant person's rights and freedom of action, respect for dignity, integrity, privacy, autonomy and control over one's affairs
- Respect for a person's past, will and preferences
- A requirement to act in good faith and for the benefit of the relevant person.

Supported decision-making

There still may be circumstances where it is judged that a person does not have capacity, and there is a three-tier framework of support envisaged under the Act when it is commenced. Supports for decisions are categorised in two ways: the first relating to property and affairs and the second relating to personal welfare, including healthcare. The graduated framework will support decisions in relation to both categories going forward. At the lowest and least formal level of support, the relevant person may appoint a decision-making assistant to help them gather and interpret information and communicate their decision. In this context the person is still the decision-maker. At the middle tier, a person may register a co-decision-making agreement, under which specified decisions are made jointly with an appointed, trusted person. At the upper level, there is provision for an application to the Circuit Court by any person who has a *bona fide* interest in the person's welfare.

The applicant will often be a family member or carer, or the HSE as is the case in a significant number of wardship applications. In this context, the Circuit Court may make a declaration that the relevant person lacks capacity in respect of a specified decision. In that context, the court may either make a decision or appoint a decision-making representative to make decisions on the person's behalf, under the supervision of the DSS, which is being established nationally.

It should be noted that in relation to the top tier of support, the United Nations committee with responsibility for the Convention of Rights of Persons with Disabilities interpreted Article 12 of that Convention as prohibiting substituted decision-making by another person. At the time of ratification of the Convention in Ireland, the state entered a declaration permitting the retention of substitute decision-making in appropriate circumstances and subject to appropriate and effective safeguards. Therefore, in operating the top tier of support, the Circuit Court must be cognisant – and indeed those involved in seeking the assistance of the Court must also be aware – that substituted decision making should be a last resort and that the court's assistance should also be sought only as a last resort.

In adjudicating on any application, the

court must apply all the guiding principles, having regard to the will and preferences of the person. Additionally, this must be limited where possible in terms of time and scope and should be subject to periodic review.

This represents a sea change when compared to the historical system of wardship and will no doubt have a substantial impact on nursing and midwifery practice in certain contexts.

Advanced planning

Two constructs are available to facilitate advanced planning by persons in relation to future circumstances where they may lack capacity: the first is a provision for an enduring power of attorney and the 2015 Act extends the potential scope of such enduring powers of attorney to include decisions on healthcare matters. In the future, such attorneys acting under these provisions will be supervised by the DSS.

In addition, the Act makes specific provision for advanced healthcare directives and now places these on a statutory basis. The responsible authority for such directives will be the Department of Health. In the context of the legislation, such advanced healthcare directives allow a person to be treated according to their will and preferences and to provide healthcare professionals with information about their future treatment choices. Furthermore, a person may also appoint an agent, known as a designated healthcare representative to ensure their directive is complied with.

There is provision within the Act for the Department of Health to issue regulations governing the operation of such directives, including the notification of the making of such a directive to the director of the DSS, and for the maintenance by the director of that service of a register of advanced healthcare directives. The DSS director has urged the Department to issue such regulations to assist both persons and healthcare professionals in the future. Additionally, members will be familiar with these directives and their relevance. The duty to comply with them is also recognised by the NMBI Code.

It is notable that comment is made on a provision of the 2015 Act which indicates that an advanced healthcare directive is not effective if a person is detained under the Mental Health Acts and purporting to refuse mental health treatment. The Mental Health Commission and the DSS have both called for an amendment of this section of the 2015 Act to ensure that the will and preference of individuals is respected, and they have classed this provision of the 2015 Act as discriminatory.

The director of the DSS provided an update to the Oireachtas in relation to ongoing work to establish the support service, including an action plan and various issues relating to budget, governance and the proposed approach of the service. While much work remains to be completed and provisions of the legislation are yet to be commenced, this is an area where changes have occurred in relation to capacity assessments. Further changes meanwhile, will no doubt affect practice in a way that seeks to ensure respect for the rights and freedoms of individuals.

These rights and freedoms are key facets of nursing and midwifery practice – and implementation of the legislative changes are important duties which form a central plank of the ethics and guidance contained in the Code to guide our practice.

Edward Mathews is INMO director of professional and regulatory services

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Urgent action needed on Traveller health inequality

To mark International Day of the World's Indigenous Peoples, **Lynsey Kavanagh** and **Ronnie Fay** discuss why the health inequalities facing the Traveller community must be urgently tackled

IRISH Travellers are a vibrant 36,000 strong, minority ethnic group, indigenous to the island of Ireland, maintaining a shared history, language, traditions and culture.[1] However, despite representing less than one percent of the population, Travellers have been recognised as one of the most marginalised and disadvantaged groups in Ireland, experiencing structural and systematic racism and discrimination.[2-6]

Research since the 1980s has unveiled stark health inequalities for Travellers due to structural inequalities and failure to address the social determinants of health, including poor accommodation conditions, lower educational attainment, racism, discrimination, poverty and higher rates of unemployment.[7] In 2010 the All-Ireland Traveller Health Study (AITHS), *a copy of which is held by Missy Collins of Pavee Point pictured above*, found that at all ages and for all causes of death, Travellers experience a higher mortality than the general population.[8]

All Ireland Traveller Health Study - findings[9]

- Travellers had a greater burden of chronic diseases, with COPD four times higher and asthma three times higher than the general population
- 134 excess Traveller deaths per year
- Traveller mortality is three and a half times higher
- Only 3% of Travellers are over the age of 65
- Life expectancy at birth for male Travellers is 62, some 15 years less than men in the general population; for female Travellers it is 70, 12 years less than women in the general population
- Suicide rate among Traveller men is more than six and a half times higher and accounts for over one in 10 of Traveller deaths
- The infant mortality rate for Travellers is more than three and a half times the national rate and nearly three times the EU average.

The authors of the AITHS report concluded that health inequalities cannot be decoupled from the wider social determinants of health.

Ten years since the publication of the AITHS, Traveller health inequalities remain the same and in some instances, due to improvements in the national population, health disparities have even widened. The AITHS documented that Travellers are dying of the same causes as the general population (cancer, respiratory and cardiovascular diseases) however at a much faster rate, which is a strong indication of institutional racism and discrimination at policy and service levels.

The report confirmed that although mainstream health services were available to Travellers, various barriers – institutional, cultural, social and structural – restrict equality of access and outcomes for Travellers, including discrimination and lack of trust in healthcare providers.

- Only 41% of Travellers reported having complete trust in health professionals, compared to 82% of the majority population
- More than half worried about 'experiencing unfair treatment' in the health services
- Over 50% of Travellers had concerns about the quality of care they received when they engaged with health services
- Seven out of 10 (67%) of health service providers agreed that discrimination against Travellers occurs in their services.

Despite this evidence, recommendations of the report were never implemented. State funding for all Traveller health and other initiatives was disproportionately cut back during the post-2008 financial crisis compared to other areas of government policy.[10]

Key resources for Traveller health, including dedicated public health nurses (PHNs) for Travellers were lost and posts were not filled when vacancies occurred.

This left a clear gap in services as these posts were effective in creating the conditions for many Travellers to access mainstream services in partnership with Traveller Primary Health Care Projects.

This disinvestment coupled with inaction by the state and lack of political will is costing the Traveller Community over 100 excess deaths per year. Lives that we cannot afford to lose.

Midwives and nurses know all too well the reality of these shocking health statistics as many have worked closely with local Traveller organisations and Primary Health Care Projects (PHCPs) over the years. The PHCPs are where the vast majority (83%) of Travellers receive their health information,[11] with their healthcare staff often going above and beyond their remit to support Traveller families.

Impact of Covid-19 on Travellers

In 2020, the arrival of Covid-19 to Ireland had the potential to create a perfect storm for the rapid spread of disease among Travellers, given their severely overcrowded and poorer living conditions, poorer health status and poor health literacy.

Traveller organisations, Traveller PHCPs and Traveller Health Units proactively responded and mobilised across the country, working collectively to ensure that Travellers, especially those who are most vulnerable, are protected. Working in partnership with the HSE and other government departments and using an interagency approach, underpinned by a social determinants focus, this work resulted in policy and service provision changes which has had tangible outcomes for Travellers and Roma on the ground, including:

- Ensuring Travellers and Roma were named under vulnerable groups and included in the work of the National Public Health Emergency Team's (NPHET) vulnerable people subgroup
- Ensuring Travellers and Roma were identified as priority groups for Covid-19 testing and vaccinations
- A national ban on Traveller evictions during the Covid-19 crisis, including Travellers living on the side of the road or doubling up on sites in emergency legislation
- Recognition of Traveller Primary Health Care Workers as frontline health workers and priority access for vaccinations
- Issuance of PPE to all Traveller Primary Health Care Workers
- Development of culturally appropriate Covid-19 health education materials
- Inclusion of an ethnic identifier in Covid-19 data collection systems.

While we know that Travellers, Roma and other marginalised groups have been disproportionately impacted by Covid-19,[12,13,14] we believe that in the absence of such a strong Traveller health infrastructure, Covid-19 would have had a much worse impact on the Traveller Community. It underscores the importance of a whole-of-government and interagency approach in responding to these challenges given the public health issue at hand.

Lessons from Covid-19

Since the emergence of the crisis, we have seen goodwill, support and collaboration from colleagues in the HSE and other government departments, in working with us to ensure that Traveller and Roma health concerns relating to Covid-19 are addressed.

We also witnessed the positive involvement of public health doctors in addressing the living conditions of Travellers and Roma. The authority they brought to the concerns, which have been raised by Traveller organisations over many years, was welcomed. We also witnessed local authorities providing essential services such as running water, sanitation and electricity within a matter of weeks – when public health doctors were involved – despite Travellers and Traveller organisations advocating for such basic services for many years.

We know that those most marginalised have suffered disproportionately during Covid-19 and therefore positive action measures need to be taken to address these concerns. It is important that a whole-of-government approach to health becomes a legacy of Covid-19 and the approach of inter-agency working and pooling of resources continues to be used proactively at both national and local levels in addressing Traveller and Roma marginalisation and protecting their human rights into the future.

In terms of addressing the longstanding Traveller health inequalities in the context of Covid-19, a number of urgent actions must be taken, including:

- Urgent publication and implementation of the National Traveller Health Action Plan
- The Traveller specific health infrastructure, including Traveller Health Units and Traveller PHCPs, should be protected and receive increased resources for their expansion and development
- Re-appointment of designated Traveller PHNs for Travellers in each CHO
- Public health departments to continue their engagement and ongoing involvement with Traveller Health Units and Traveller organisations to address Traveller health inequalities.

Lynsey Kavanagh and Ronnie Fay, Pavee Point Traveller and Roma Centre

Missy Collins who features in the photo, is a Traveller community health worker, Traveller Primary Health Care Project, Pavee Point Traveller and Roma Centre

Pavee Point Traveller and Roma Centre is a non-governmental organisation committed to the attainment of human rights for Irish Travellers and Roma. The organisation works from a community development perspective and promotes the realisation of human rights and equality for Travellers and Roma in Ireland. The group is comprised of Travellers, Roma and members of the majority population, who work together in partnership to address the needs of Travellers and Roma as minority ethnic groups experiencing exclusion, marginalisation and racism. We, alongside many other Traveller organisations at local and national levels, have a strong history in fighting to respect, protect and fulfil Traveller human rights. Pavee Point has a long track record and a particular competence in addressing Traveller health inequalities and the Right to Health

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Spotlight on: Caroline Kehoe

'There is a link between living conditions and poor outcomes'

CAROLINE Kehoe is a public health nurse (PHN) with responsibility for Traveller health in the Waterford region. She works closely with the primary healthcare workers from the two Traveller development projects in the area. She also links in with a variety of different agencies and community groups to ensure multidisciplinary care and support is provided to the Traveller community. Some of the primary healthcare workers are Travellers themselves and she says that this helps with building and maintaining relationships and trust with the community.

"I love working with Travellers and feel that they are greatly misunderstood and misrepresented. More positive cultural promotion would be great but also education on Traveller health and cultural issues in training for people in professions who will deal with the Traveller community day to day would be really beneficial. It's about building up trust and building relationships," she said.

Before Ms Kehoe took up the position in 2018, the post had been unfilled for a number of years. She therefore began by working directly with Travellers to assess their needs. Child health developmental checks and support with attending appointments (notifications of these are not always delivered correctly to halting sites) form a significant part of her day-to-day work. She has a seat on the Waterford Traveller Inter-Agency Group which meets once a month to develop a cohesive work plan to support the community.

Ms Kehoe said poverty and discrimination play a significant role in poor health outcomes among Travellers. She tries to organise information evenings on specific health issues for Travellers and invites community dietitians, physiotherapists and other healthcare professionals to get involved in working with the community. She also set up a parent and toddler group and linked in with another PHN who runs a weaning clinic for breastfeeding mums so that Travellers could be encouraged to join.

Ms Kehoe's aim is to link various services in the city in order to open more doors for Travellers. She also set up a women's group in Dungarvan to provide a place where women could get to know each other and meet community representatives like the community Garda, as well as reps from Women's Aid and Barnardos.

"Accommodation issues are huge and form the backdrop to everything else. There's so little progress and it's unbelievable that families are expected to live like that in 2021. Without proper sewage and sanitation or cooking facilities, families cannot take care of their health. There is a direct correlation between the living conditions forced on these people and their poor health outcomes.

"Many reports have been compiled over the years, such as the *All-Ireland Traveller Health Report*, but when these reports are not actioned it leads to frustration and problems persist and get worse," she told *WIN*.

Ms Kehoe feels that community nurses are well placed to assess and determine the needs of the communities they work with and that they should be part of the planning process when service provision is being decided. She said they will also be an essential part of the rollout of Sláintecare and would like to see greater respect for the vital role they play within the health service.

Ms Kehoe, like many other PHNs, has been redeployed to a Covid-19 test centre. She acknowledged that the PHN role in tackling the Covid-19 pandemic has often been overlooked.

Ms Kehoe volunteered with the civil defence from age 15, which gave her a taste for nursing. She trained in Our Lady of Lourdes Hospital in Drogheda and later moved to Australia where she worked as an agency nurse for a year. She subsequently returned to Waterford and worked in orthopaedics before moving to Dublin to train as a midwife in the Rotunda in 2000.

Caroline Kehoe: *"I would love to see more nurses in leadership roles."*

Having worked as a midwife for a few years, Ms Kehoe earned a postgraduate diploma in public health nursing from UCC and returned to work in Waterford for a number of years before applying for her current post in 2018.

Ms Kehoe joined the INMO while training in the 1990s and is active with the Waterford Branch, which she has represented at the ADC a number of times.

She would like to see more nurses in leadership and representative roles but knows that they need more than just the support of the union to achieve this.

"I would love to see more nurses in leadership roles, but targeted education and support to facilitate their development is necessary. Staffing issues are also a barrier to leadership for many as our workload is so immense. If someone moves into a leadership role, it will inevitably involve more paperwork and management. Patient care must not suffer but it will if extra time and/or staff are not allocated to allow nurses to take on advanced practice roles," she said.

This article is part of our series on Nursing Now, a worldwide campaign that aims to achieve recognition of nurses' contribution to healthcare, gender equality, the economy and wider society. The campaign's aim is to improve health by raising the profile of nurses, influencing policymakers and supporting nurses to lead a global movement. Please visit ***www.nursingnowireland.ie*** *All interviews are carried out by Freda Hughes (freda.hughes@inmo.ie)*

All-Ireland Midwifery Conference to hear from WHO midwifery advisor

WORLD Health Organization (WHO) midwifery advisor Fran McConville will be the guest speaker at the 2021 All-Ireland Midwifery Conference, which will take place online on Thursday, November 11 with the theme 'Respond, Recover, Re-imagine'.

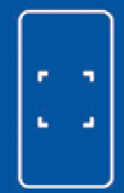
Ms McConville will discuss the State of the World's Midwifery (SoWMy) 2021 report, which is available online at **www.unfpa.org/sowmy** *(see also page 19)*.In addition, Truda Thommesen and Lisa Alpini-Weldand, regional International Confederation of Midwives (ICM) representatives, will look at the *SoWMy* report from a regional perspective.

Steve Pitman, INMO head of education and professional development, and Patricia Gillen from the University of Ulster will present the results of a workforce wellbeing survey that sought feedback from nurses and midwives north and south of the border.

There will also be a number of active sessions, including art therapy, poetry and mindfulness, as well as a poster competition. Full details are available on the INMO website. The closing date for poster submission is Friday, October 15. Contact jean.carroll@inmo.ie for a copy of the competition guidelines.

Bookings for this event are live on Eventbrite *(use the QR code above to access the registration webpage)*.

SCAN TO REGISTER FOR THIS EVENT



Open the camera on your phone and hover over the QR code above.

Luke O'Neill to speak at upcoming Telephone Triage Section webinar

LUKE O'Neill, professor of biochemistry in the School of Biochemistry and Immunology at Trinity College Dublin, will be among the lineup of speakers at the Telephone Triage (TT) Section's annual webinar on Monday, September 20.

Prof O'Neill, who is also an author and a commentator on Covid-19, will share the most up-to-date information on the virus, vaccinations and lessons learned from the pandemic.

The webinar will also hear from GP Caroline McMonagle, who will present on the topic of rashes. It has been several years since this topic was last discussed at a TT Section meeting, so Dr McMonagle will provide an overview of recent developments in this area.

Aparna Shukla will conduct a mindfulness session on the day. A TT nurse and midwife herself, Ms Shukla will share some useful exercises for practising mindfulness.

The topics of cancer and anxiety will also be covered. Anxiety has become a particularly pertinent issue throughout the pandemic, with a marked increase in the number of clients reporting anxiety over the phone to TT nurses during lockdown.

The webinar is free to attend and will be recorded for those who can't attend the live event.

Bookings are essential and can be made by visiting **www.inmoprofessional.ie** or by contacting the INMO directly.

ED Section hosts successful webinar

Pictured at the ED Section webinar in June were (l-r): Mary Dunne, section secretary and Executive Council member; Karen McGowan, INMO president; Mick Schnackenberg, section chair; Ruth O'Dea, training manager, Womens Aid; Kelly Doherty, advanced clinical practitioner in emergency medicine, Royal Victoria Hospital, Belfast; Colin Williamson, consultant nurse, major trauma rehabilitation and Linsey Sheerin, service manager for urgent and emergency care, both from the Royal Victoria Hospital; Phil Ní Sheaghdha, INMO general secretary; Steve Pitman, INMO head of professional development; Jonathan Chick, consultant psychiatrist; and Oliver Allen, ED nurse and Executive Council member. See ***www.inmoprofessional.ie*** for more details

CRGN Section seeks new members

THE Community RGN Section was founded by INMO member Marie Lucy O'Connor. Starting with just four active members, membership has now reached 200 but the section is aiming to increase this further.

Section member Kelly Keville told *WIN*: "I would encourage all RGNs to join the section. It provides a forum for peer support and problem solving, while the opportunities to network are really useful. We strive to enhance the CRGN role through professional development and ensuring we avail of allowances for specialist roles within the profession."

The CRGN Section is working with the INMO to ensure CRGNs are remunerated on a par with their colleagues in other areas. A disparity currently exists due to a variance in practices and entitlements in some services.

You can email membership@inmo.ie to join the section and k.keville@hotmail.com to join the section WhatsApp group.

LIVE ONLINE EVENTS

It's Summertime!

INMO Summer

Online Programmes 2021

We are delighted to announce that we will continue to offer online programmes and support for nurses and midwives over the summer months.

We have several new programmes developed by our expert facilitators, created to assist you in broadening and keeping your skills up to date. All programmes are category 1 approved by the Nursing and Midwifery Board of Ireland.

Log on to www.inmoprofessional.ie/course for information and programme content. On completing a programme, a digital certificate of participation will be emailed to you along with allocated CEUs.

Enrol now and don't forget to avail of our special offer.

SPECIAL OFFER

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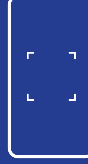


INMO EDUCATION PROGRAMMES

INMO Professional

Continuing professional development for nurses and midwives

Keep up to date with new online courses from INMO Professional

Tools for Safe Practice for Nurses and Midwives

Wednesday, July 14, 2021

We continue to offer this programme free to INMO members (fee for non-members: €65). This course provides safe practice tools to protect the nurse, midwife and patient in the context of staff shortages and skill mix realignment. It will ensure participants have an understanding of the processes involved with patient alerts, clinical incidents and thorough assessment, while remaining focused on the patient. It addresses patient and staff safety and provides five key tools in the areas of documentation, clinical incident reporting, safety statements and best practice guidelines regarding assessment and communication practices. This programme is category 1 approved by the NMBI and awarded three CEUs.

Programmes FREE for INMO members

Online Education for Intern Students

INMO Professional has several online programmes specifically designed for intern students taking place over the summer months. They cover the following topics: tools for safe practice, interview techniques, documentation, mindfulness, salary information and helpful sessions providing advice to new graduates so that they have the best experience possible. See *page 40* for more information or visit **www.inmoprofessional.ie**

Retirement Planning Webinar

Thursday, October 28, 2021

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

Maintaining your competency, maintaining your registration

PULL OUT

Steve Pitman
Head of Education and Professional Development

THE Covid-19 vaccination programme is gathering pace, with people in their 20s expected to be vaccinated by the end of July or early in August. This will allow Irish society and the economy to start to open up again. However, caution is still required due to the spread of the Delta variant.

The virus continues to have a devastating impact globally, with many countries experiencing difficulties in coping with high infection rates, accessing vaccines and rolling out vaccination programmes. Global solidarity is fundamental to tackling the virus and curtailing its spread. Access to technologies that enable developing countries to produce their own supplies is increasingly recognised as being central to ensuring that everyone can be vaccinated.

Training and courses

INMO Professional continues to develop new and innovative training programmes for members. We will be continuing to run online courses throughout July and August and as the country starts to ease Covid-19 restrictions, we will be planning to offer on-site training again at the Richmond Education and Event Centre (subject to government guidance). Due to the hugely successful online training, we anticipate that INMO Professional will offer both online and in-person training moving forward.

Clinical nurse and midwife specialists

The clinical nurse and midwife specialist roles have been established for more than 20 years. The framework for establishing clinical nurse/midwife specialist posts was developed by the National Council for Nursing and Midwifery and was last updated in 2008.

The 2019 Department of Health policy, *Development of Graduate to Advanced Nursing and Midwifery Practice*, acknowledged that the clinical nurse/midwife specialist role has continued to evolve and develop over the past decade. The report recommended that the Nursing and Midwifery Board of Ireland (NMBI) develop a "process to annotate the name of a nurse or midwife who successfully completes credentialed education particularly related to skills acquisition".

A review of the clinical nurse/midwife role is currently underway and the NMBI is developing new standards and requirements for postgraduate nursing and midwifery education programmes. It is anticipated that an update on this work will be available over the coming months.

Advanced practice

The 11th International Council of Nurses (ICN) Nurse Practitioner/Advanced Practice Nursing Network Conference will take place from August 29 to September 1, 2021. This virtual event replaces the conference that was scheduled to take place in Halifax, Canada in 2020. The theme for the event is 'Envisioning Advanced Practice Nursing Beyond 2020: Wider Reach, Bigger Impact'.

The conference is one of the largest international meetings on advanced nursing practice, and networking is one of its cornerstones. Attendees will be able to partake in engaging interactive sessions and networking functions, all while connecting with colleagues from around the world from the comfort and safety of their home or office. Further information can be found at **https://npapn2021.com**

LGBT+ Networking Group

Following on from the INMO and LGBT Ireland Pride webinar on the June 25, the INMO is eager to continue the work of building the INMO LGBT+ Networking Group. If you are interested in becoming involved, please contact jean.carroll@inmo.ie

Climate change

The INMO has joined the Nurses Climate Challenge Europe initiative. The challenge aims to mobilise nurses across the continent to educate their fellow healthcare professionals on the impacts of climate change on human health. The Nurses Climate Challenge is part of the Healthcare Without Harm organisation, which is funded by the European Commission.

This campaign is linked with the Alliance of Nurses for Healthy Environments (ANHE) and the Nurse Drawdown campaign (**www.nursesdrawdown.org**), which the INMO already supports. Further information can be found at **www.eur.nursesclimatechallenge.org/**

Over the coming months, INMO Professional will be publishing more details about the Healthy Environment and Climate Change Campaign.

On-site Education

INMO Professional offers an extensive range of on-site programmes facilitated by expert practitioners. If you are interested in booking one, email marian.godley@inmo.ie or call 01 6640642.

Delivering courses and writing for *WIN*

We are eager to offer members the opportunity to work with INMO Professional in delivering education courses. If you are an advanced nurse or midwife practitioner, a clinical nurse/midwife specialist or a nurse/midwife with expertise in clinical or management practice, we would like to hear from you by email: education@inmo.ie or Tel: 01 6640642.

We are also interested in hearing from members who would like to write professional and clinical articles for *WIN*. Please email steve.pitman@inmo.ie

Online Education Programmes

Tel: 01 6640641/18
Email: education@inmo.ie

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

Check out our new online courses by logging on to
www.inmoprofessional.ie

Keep your CPD up to date • Extensive range of programmes • NMBI category 1 approved • Digital certification provided

Jul 6 **Complaints Management for Healthcare Staff (Acute or Residential Healthcare Settings)**

This short online programme is aimed at senior nurse managers within the acute or residential healthcare settings. The course is designed to provide them with the key skills of communication tools to minimise the negative impact complaints can have in their workplace. Therefore, effective management of complaints is central to improving services and prioritises an open, honest and transparent health service.

Jul 8 **Introduction to Oncology – Terminology and Patient Pathways**

This course will give you an understanding of the language of oncology in order to improve fluency with patients and colleagues and increase your insight into the oncology journey, helping you to improve patient outcomes.

Jul 13 **THRIVE – Experiential Workshop**

This course will provide you with supportive techniques for calmness and connection, breathing techniques for focus, balance and relaxation. You will understand emotional intelligence and how it relates to you and take a dive deep into the seven pillars of wellbeing.

Jul 14 **Tools for Safe Practice for Nurses and Midwives**

This programme provides safe practice tools to protect the nurse, midwife and patient within current healthcare settings. The programme is free to INMO members. Places must be booked online in advance of your attendance.

Jul 15 **Nutrition and Cancer Care: Nursing Roles and Interventions (Hospital, Residential and Community Settings)**

This programme is aimed at nurses who work in hospital, residential and community settings. It addresses the challenges of managing cancer patients' nutrition and will promote best practice in the provision of nutrition and cancer care in both the home and in hospital. The programme will provide guidance on assessment, care planning and monitoring of cancer patients' nutritional needs. It will identify current nutrition guidelines, the importance of nutrition in cancer care and the implementation of nursing strategies to tackle malnutrition.

Jul 15 **Diabetes CBT and general wellbeing**

This course is for nurses and midwives who have an interest in the management of a patient with diabetes. The literature would suggest that diabetes, chronic disease management and the self-care that is associated with it bring high incidence rates of depression, anxiety and negative thoughts. The use of different strategies, CBT and clinical trials look at the area of wellbeing and theories/models to help clients and healthcare providers formulate plans to look at these issues.

Jul 16 **Mindfulness-based Stress Reduction**

Mindfulness-based stress reduction (MBSR) is an evidence-based programme that offers secular, intensive mindfulness training to assist people with stress, anxiety, depression or pain, teaching nurses and midwives how to take better care of themselves to live healthier, more adaptive lives. This is a live, eight-week onlline course. See *page 56* for more details.

Jul 21 **Delegation Principles and Practices**

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

Official sponsors of the Richmond Education and Event Centre

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

Jul 22 **Introduction to Positive Behaviour Support**

This one-day programme explores the key components of compassion and their application in the care setting. Fee: €60 INMO members; €130 non-members.

Jul 27 **Introduction to Chemotherapy**

This short online introductory session will equip participating nurses and midwives with the main principles of chemotherapy, its side effects and how to feel safe and confident when handling these drugs. In return, participants will feel empowered to deliver improved care to your patients. This session will cover the pharmacology of chemotherapy, side effects and chemotherapy regimes and safe handling of cytotoxics.

Jul 29 **Recognition and Management of Sepsis**

This session will focus on early recognition and management of sepsis. Case studies will be included to create an interactive learning platform to engage participants throughout the session.

Aug 17 **Introduction to Effective Library Search Skills**

This short online course is aimed at nurses and midwives who would like to develop valuable lifelong information-seeking skills to get the most up-to-date information for clinical practice, reflection or policy development. This course will assist participants who are undertaking academic programmes.

Aug 17 **Virtual Asthma and COPD – Reviewing Virtually**

This short two-hour online educational programme will introduce the nurse to undertaking virtual reviews in clinical practice using a number of tools and resources to ensure patient needs are identified and met. The following will be covered: advantages and disadvantages of the different modalities for virtual consultations; SIMPLES – tool for virtual consultations and the tools required for virtual asthma and COPD reviews.

Aug 18 **Competency-based Interview Preparation for Nurses and Midwives**

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

Aug 19 **Infection Prevention and Control During Covid-19 Pandemic in Residential Care Settings**

Infection prevention and control is essential in order to prevent the spread of Covid-19. This short online course for nurses working in residential care settings will outline evidence-based and national guidance on infection prevention and control in residential care settings during the Covid-19 pandemic. Understanding infection control will provide the participant with the tools to prevent Covid-19 from spreading.

Aug 24 **Improve Your Academic Writing and Research Skills**

This short online course is designed for nurses and midwives who are undertaking third-level academic programmes. It will assist participants in completing their written assignments. The objective of the course is to help prepare the student for academic study, which requires efficient literature searching, research critique and accurate referencing skills. On the day there will also be a question and answer session to help you with any of your queries.

Aug 24 **Clinical Governance for Senior Nurse Managers (Acute or Residential Healthcare Settings)**

This short online programme is aimed towards senior nurse managers within the acute or residential healthcare settings to help them to be confident in building their skills and to have a keen knowledge of clinical governance. Clinical governance is the system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish.

Aug 25 **Tracheostomy Care Study Day**

This online course introduces a holistic and interdisciplinary approach to the management of the adult patient with a tracheostomy. Participants will be given the necessary knowledge, skills and confidence to assess, manage and evaluate the nursing care of a patient with tracheostomy.

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

Aug 31 **Medication Management Best Practice 2021 – Guidance for Nurses and Midwives**

This online education programme supports nurses and midwives in providing safe, evidence-based practice in the area of medication management. The programme will cover such topics as: principles of medication management; the medication management cycle; management of controlled drugs and medication safety. Participants will have the opportunity to update their knowledge in line with the most up-to-date NMBI *Guidance for Registered Nurses and Midwives Administration* and Health Information and Quality Authority requirements for medication management.

Sep 8 **Introduction to Wound Management for Nurses and Midwives**

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

Sep 9 **Navigating Your Way Through Conflict**

This course will help participants develop the insight and skills necessary to navigate conflict situations and reach satisfactory solutions. Workplaces can be the perfect breeding ground for conflict. As well as our skills, we bring our individual needs, ambitions, personalities, perspectives, backgrounds and vulnerabilities with us to work. It is hardly surprising, therefore, that conflict can arise as we interact with others. While some conflict can be healthy, unresolved conflict can lead to negative outcomes for our wellbeing.

Sep 9 **The Sociology of Health**

This course is an introduction to the sociology of health and illness. It examines the meaning of health, disease, illness and sickness. Impact of social inequality will also be explored along with other topics such as the sick role and the role of healthcare professionals.

Sep 14 **Owning Your Future – Taking Control**

The key learning outcome of this short session will be to support each participant to become aware of their competencies as an employee and to explore how they can increase their ability to take control of their careers in these uncertain times. The physical and mental strain of working in a pandemic has left little time for nurses and midwives to think about their careers. New skills and competencies have been acquired, common sense or tacit knowledge has played a key role in coping. Yet, little value may be put on these skills unless nurses and midwives recognise and articulate their value.

Sep 14 **Risk Management and Incident Reporting**

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

Sep 15 **Introduction to Treating and Preventing Pressure Ulcers**

This short online course will advise participants on pressure ulcer prevention. Topics covered on the day will include: causes of pressure ulcers, risk assessment, and prevention of pressure ulcers.

Sep 15 **Restrictive Practices in Residential Care Settings for Older People**

This short online course encourages participants to reflect on interventions that could be seen as restraining residents if viewed from a resident's perspective. Many interventions within healthcare environments can restrict movement of older people. They are unintentional and can be argued as in the best interest or for the protection of residents, for example, a nursing home locked at night to protect residents and staff from intruders.

Sep 16 **Nursing Patients with Disorders of the Renal System – An Introduction**

This programme focuses on developing the nurses' competency in the assessment and management of patients with both acute and chronic disorders of the renal system. It will assist in implementing evidence based practice while caring for this cohort of patients

Sep 21 **Change Management – Valuable Tools for Nurses and Midwives**

The aim of this course is to enhance your understanding of change management and strategies to improve the potential for successful change initiatives in helping them lead, develop and manage change in their workplace. Participants will gain valuable tools in how to understand the nature and process of change within the healthcare setting; appreciate the importance of managing stakeholders as part of the change process; apply change concepts within their clinical and managerial practice and reflect on their previous experience of change. They will leave with knowledge of how to best support their work colleagues on how to approach change positively.

Official sponsors of the Richmond Education and Events Centre

Sep 22 **Introduction to Leg Ulcer Management**

The effective management of complex leg ulcers requires specialist skills, knowledge and understanding. Topics covered in this short online programme will include pathophysiology, assessment and management of leg ulcers. Participanting nurses and midwives will have a better understanding of the theory and concepts of the different causes of leg ulcerations, a deeper understanding of the pathophysiology of leg ulceration, be aware of different non-invasive assessment for leg ulcerations and understand the importance of compression for venous leg ulcerations.

Sep 23 **Chronic Obstructive Pulmonary Disease (COPD) – Getting the Basics Right**

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

Sep 28 **Training Delivery and Evaluation** *(QQI Level 6)*

This five-day programme is now fully booked. INMO Professional plans to run the course again on the following dates: March 8, 9 and 10 and April 5 and 6, 2022.

Sep 28 **Understanding and Developing Care Plans for Nurses and Midwives**

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

Sep 29 **Introduction to Management and Leadership for Nurses and Midwives**

The aim of this short course is to identify managerial and leadership competencies for frontline managers and to explore how these are applied in practice. The course will include management theory, effective leadership and teamwork, as well as delegation and clinical supervision. Topic/content: management theory; effective leadership and team working; delegation and clinical supervision; understanding the nature and approaches to leadership; leading nursing and midwifery in your workplace; understanding yourself; leading others; professionalism, regulation and fitness to practice.

Oct 5 **Become More Assertive**

This short online programme is designed to help participating nurses and midwives to develop their skills in order to be more assertive and to help them to make decisions with conviction and deal with difficult situations. Learning outcomes: learn how to distinguish between assertive, passive and aggressive behaviours; learn how to assertively handle difficult situations; learn how to change your thinking and ultimately your behaviours and how to respond assertively to the associated behaviours in others and learn how to influence others positively.

Oct 5 **The Importance of Documentation – Getting it Right**

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

Oct 6 **End of Life Care and Covid-19**

This short online programme will outline the legal and professional requirements for end of life care in designated centres and identifies how to apply this practice to Covid-19. Participants will learn how to recognise signs and symptoms of deterioration through the programme, which will assess, monitor and review physical, psychological, social and spiritual areas of care at end of life for a person with Covid-19. It will cover the *Guidance for Registered Nurses and Midwives on Medication Administration* and national guidance. Participants will be able to identify and apply effective interpersonal communication with families of a loved one at the end of their life during this challenging period.

Oct 7 **Adult Asthma – Getting the Basics Right**

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

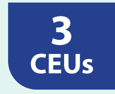
New Online Courses
July/August 2021

Online from 10am - 1pm

Fee for each course €30 INMO members; €65 for non members

All courses are Category 1 approved by NMBI

Nutrition and Cancer Care: Nursing Roles and Interventions



(hospital, residential and community services)

Thursday, 15 July 2021

This programme is aimed at nurses who work in hospital, residential and community settings. It addresses the challenges of managing cancer patient's nutrition and will promote best practice in the provision of nutrition and cancer care in both the home and in hospital.

Diabetes CBT and General Wellbeing

3 CEUs

Thursday, 15 July 2021

The literature would suggest that diabetes, chronic disease management and the self-care that is associated with it brings high incidence rates of depression, anxiety and negative thoughts. The use of different strategies, Cognitive Behavioural Therapy (CBT) and clinical trials look at the area of wellbeing and theories and models to help clients and healthcare providers try and formulate plans to look at these issues.

Recognition and Management of Sepsis

3 CEUs

Thursday, 29 July 2021

This online session will focus on early recognition and management of sepsis. Case studies will be included to create an interactive learning platform to engage participant throughout the session. Sepsis can occur at any age and in any clinical situation. Early identification of sepsis and the implementation of appropriate interventions in a timely manner can improve patient outcome.

Clinical Governance for Senior Nurse Managers

3 CEUs

(acute or residential healthcare settings)

Tuesday, 24 August 2021

This short online programme is aimed towards the most relevant to senior nurse managers to help them understand and be confident in building their skills and having a keen knowledge of clinical governance. Clinical Governance is the system through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish.

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Tel: 01 6640641/18 or go to www.inmoprofessional.ie

New Irish research – roundup of recent literature

This month the INMO library staff highlight some recently published Irish reports and articles, including some on Covid-19

Covid-19 Irish articles

- *Moore Z et al. Facial pressure injuries and the Covid-19 pandemic: skin protection care to enhance staff safety in an acute hospital setting. Journal of Wound Care 2021; 30(3), pp 162–170*
  The aim of this study was to determine the impact of a specially designed care bundle on the development of facial pressure injuries among frontline healthcare workers wearing PPE during the Covid-19 pandemic
- *Rodgers K et al. Managing an outbreak of Covid-19 in a learning disability setting', Learning Disability Practice 2021; pp. 12–18*
  This article describes the experience of preparing for and managing, a small Covid-19 outbreak that affected clients and staff in a learning disability setting
- *Brooke J, Clark M. Older people's early experience of household isolation and social distancing during Covid-19. Journal of Clinical Nursing 2020 (John Wiley & Sons Inc.); 29(21/22), pp. 4387–4402*
  This paper aims to explore older people's initial experience of household isolation, social distancing and 'cocooning,' and the plans they constructed to support them through the Covid-19 pandemic. The paper looks at changes experienced by those over the age of 70 during the first two weeks of household isolation, social distancing and cocooning in the UK and the Republic of Ireland, and their early perceptions and plans to support them through the pandemic
- *McMahon M et al. An audit of the well-being of staff working in intellectual disability settings in Ireland during the Covid-19 pandemic, Tizard Learning Disability Review 2020; 25(4), pp. 237–246*
  SARS-CoV-2 has infected millions of people worldwide. Individuals with intellectual disability are at a disproportionate risk of mortality, given the health inequalities they experience. This puts a significant burden of responsibility on staff who support these individuals. Consequently, this study aims to establish a baseline of the wellbeing of staff working in intellectual disability services in Ireland during the Covid-19 pandemic
- *Evaluation of the impact of implementing a draft policy to develop advanced nurse practitioners to meet health service needs – January 2020*
  The principal findings from this evaluation demonstrate that the introduction of the critical mass of advanced nurse practitioners (ANPs) is beginning to impact on a number of key patient outcomes. There is evidence in relation to the positive impact that the role is having on the patient experience and patient enablement. In addition, they provided high levels of patient education, continuity in the provision of patient care, the potential to avoid hospitalisations and decreasing patient complications. It is also evident from the evaluation that the critical mass of ANPs is at the introduction and early implementation phases of integration within the health services; however, the results from the evaluation point to the potential for the role to develop long-term sustainability as it becomes internalised into the health services in Ireland. Many of these innovative services are matching the key recommendations in Sláintecare; that is implementing services that bridge the gap between hospital and community settings, and reduce waiting times and hospital admissions. Recommendations include that the national rollout of a critical mass of ANPs continues and be further supported and strengthened, with the target of increasing the proportion of ANPs to 2% of the nursing workforce.

Code of Professional Conduct and Ethics – NMBI

The new Code of Professional Conduct and Ethics has been developed by the Nursing and Midwifery Board of Ireland (NMBI) and is effective from May 2021. It replaces the edition published in December 2014 and follows an extensive consultation process. The purpose of the Code is to guide nurses and midwives in their day-to-day practice and help them to understand their professional responsibilities in caring for patients in a safe, ethical and effective way. It is quite similar to the 2014 edition with some additions, including new and updated references and resources, as well as references to legislation enacted since 2015. Visit **www.nmbi.ie/Standards-Guidance/Code**

Library services

The library has a number of services to support your professional practice and educational requirements, including literature searching, document supply, reference desk assistance and searching consultations. To find out more, please contact the library staff by phone or email with your query. Tel: 016640614 Email: library@inmo.ie

Online – Introduction to Effective Library Search Skills

Next course date: Tuesday, August 17

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

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

Health and social care of marginalised groups

This month we feature two RCM i-learn modules – one that looks at asylum seekers and refugees, and another dealing with homelessness

WOMEN may have different gender-based reasons for claiming asylum to men which are not accepted under the Geneva Convention. Asylum seekers and refugees encounter greater barriers to accessing health services than Irish citizens: language issues, visa status and typically lower incomes are among the most common. Pregnant women usually feel more vulnerable and more isolated, and many are not aware of their basic rights.

According to a Maternal Death Enquiry report in 2017,[1] almost 39% of deaths were among women born outside Ireland, while this group represented 24% of all women giving birth. Some pregnant women may have been through traumatic experiences, leading to them fleeing their home. This may have been followed by a perilous journey and they may be pregnant as a result of rape.

During midwifery care episodes, especially during the initial booking interview, it is essential that communication with female asylum seekers and refugees is conducted in an appropriate and sensitive manner.

This module will provide participants with the opportunity to develop an insight into the life of a pregnant woman who is seeking asylum or is a refugee. It will take you on a journey to learn about why she may have fled her home country, the experiences she brings with her, what it is like to seek asylum and how, as a midwife, you can help to meet her holistic needs to ensure a healthy mother and baby.

This module will take approximately an hour and a half to complete.

Objectives

Having completed this i-learn module, you will have:

- Stated the difference between asylum seekers, refugees and other migrants
- Understood why asylum seeking and refugee women may seek asylum
- Understood the impact that the journey might have on the health and wellbeing of the pregnant asylum seeker/refugee
- Explained the asylum process and the impact of the 'four Ds' (dispersal, destitution, detention and deportation) on the health and wellbeing of pregnant asylum seekers/refugees
- Discussed the barriers to female asylum seekers and refugees accessing maternity and other health services
- Explored the specific health and social care needs of pregnant asylum seekers/refugees and how the midwife can address these
- Reflected on experiences of working as a midwife and how the lessons you have learned from this module can change attitudes and practice.

Homelessness

There are many causes of homelessness and homelessness does not necessarily mean 'roofless'. This short module will give participants an understanding of the definitions and causes of homelessness and how it may impact on women and families.

The module includes advice on how to provide woman-centred care to those who are experiencing homelessness or who are at risk of homelessness, with example scenarios and suggested interventions.

This module will take approximately 30 minutes to complete.

Objectives

By the end of this i-learn module, you will:

- Have an understanding of the key issues around homelessness
- Feel confident to provide woman-centred care to those who are experiencing homelessness or who are at risk of becoming homeless.

Irish information sources

Below are some information sources specifically with Irish information:

- Asylum Seekers and Refugees – **www.unhcr.org/the-asylum-process-in-ireland.html**
- Homelessness – **www.citizensinformation.ie/en/housing/losing_your_home/homelessness.html**

Reference

1. O'Hare MF, Manning E, Corcoran P, Greene RA on behalf of MDE Ireland. Confidential Maternal Death Enquiry in Ireland, Report for 2013 - 2015. Cork: MDE Ireland, December 2017

RCM i-learn access for INMO midwife members

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

Quality & Safety

A column by Maureen Flynn

Quality care metrics and SNOMED

THIS month we discuss quality care metrics (QCM). Many nurses and midwives, across all areas of practice, use a standardised approach to collect QCM data. With the backdrop of Covid-19, the need to be ready for the digital era has never been greater. An innovation is the use of the SNOMED platform which contains clinical terminology listings for use in electronic health records (EHRs). This means that nursing and midwifery terminology is now being coded similar to other health professionals.

SNOMED

The systemised nomenclature of medicine (SNOMED) clinical terminology (CT) enables QCM data to be recorded, stored, retrieved and managed for analytics in a standardised, reusable format. The platform contains the clinical reference terminology for use in electronic health records. This ensures consistency of healthcare data during transmission from one system to another. In April a new release of the Irish edition of SNOMED CT was published, which includes a reference set (refset) called the 'Ireland Nursing and Midwifery Quality Care-Metrics'.[1]

Background

In 2020, this work was introduced progressively in the HSE with the active support of the SNOMED CT National Release Centre working together with the HSE teams that are developing governance and standardisation around data. The resulting dataset specification management process is recognised as now becoming a great resource. The DSMP is built on four key principles which is the core to every system: data is an asset, accessible, shareable across and between institutions in accordance with legislation, common vocabulary and data definitions.[2]

The seven QCM datasets include; acute care, older persons services, children's services, intellectual disability services, public health nursing, mental health services and midwifery services. The acute care SNOMED CT listing is complete and available for use.[1]

Important

SNOMED CT represents coded terms that may be used within EHRs to capture, record, and share clinical data for use in healthcare organisations[3] and is recommended for the adoption by HIQA for Ireland.[4] Having the codes is a key component supporting ICT solutions that enable the retrieval of meaningful clinical information. This also improves the ability of nurses and midwives to code, retrieve and analyse clinical data.

This standardised refset adapted for an Irish health context is now available for system developers to use. This data illuminates the contribution of nursing to safe and effective care, and provides the evidence and assurance that quality of care provided is a priority for the professions.

Get involved

At your next team, unit or ward meeting you might like to talk about the QCM data for your area and explore how clinical terminology codes are being used in the data collected. You could also ask your nurse or midwife manager for more information on the data for your specialist area.

Further information

The SNOMED platform can be accessed via: **https://rb.gy/msplx4**

To read about this topic and the development of standardised language visit: **https://rb.gy/00em3y**

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

Acknowledgement: With thanks to Theresa Barry, Office of CIO; Loretto Grogan, director of nursing, national clinical information officer ONMSD; Michelle O'Hara Donnelly, acting NMPDU director North West; and NMPDU development officers, Deirdre Keown and Michelle Quinn (North West), Johanna Downey (South Cork/Kerry), Maria Flaherty and Thomas Glynn (Dublin North). With special thanks to Michelle O'Hara Donnelly and Deirdre Keown for collaboration in writing this column

References

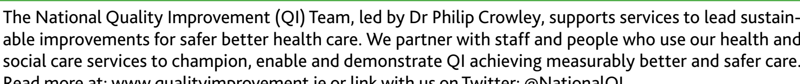
1.Ireland-nursing-and-midwifery-quality-care-metrics-dataset (acute) accessible at https://www.ehealthireland.ie/our-team/enterprise-architecture/snomed%20ct/ireland-nursing-and-midwifery-quality-care-metrics-dataset.pdf

2.Lambert, H. (2020) Dataset Management Specification Process accessible at https://www.ehealthireland.ie/news-media/news-archive/2020/helen-lambert-compliance-assurance-and-ig-lead-ea.pdf

3. https://www.ehealthireland.ie/our-team/enterprise-architecture/snomed%20ct/

4.HIQA (2014), Recommendations on SNOMED CT terminology 2014, accessible at https://www.hiqa.ie/reports-and-publications/health-information/hiqa-recommendations-snomed-ct

5.ONMSD and UCD (2020), "Representing what we do as nurses and midwives: nursing and midwifery terminology report 2020" accessible https://healthservice.hse.ie/filelibrary/onmsd/digital-leadership-group-nursing-and-midwifery-terminologies-report.pdf



The National Quality Improvement (QI) Team, led by Dr Philip Crowley, supports services to lead sustainable improvements for safer better health care. We partner with staff and people who use our health and social care services to champion, enable and demonstrate QI achieving measurably better and safer care. Read more at: www.qualityimprovement.ie or link with us on Twitter: @NationalQI

Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Parent's leave

Q. I am working in the public sector and currently on maternity leave. I have been informed that parent's leave has been extended to five weeks. How do I apply for this leave and will I be paid during this time, similar to maternity leave? Would it be possible for this leave to commence immediately after my maternity leave finishes?

With effect from April 1, 2021, employees who are 'relevant parents' are entitled to leave from work for the purposes of enabling them to provide, or assist in the provision of, care to the child within two years following the birth or adoption placement of the child.

This leave is referred to as 'parent's leave' and applies to births or adoptions that occur on or after November 1, 2019. The current entitlement for parent's leave has increased from two weeks to five weeks.

Unlike maternity leave, public health service employees are not entitled to payment from their employer during parent's leave. Where enough PRSI contributions have been made, you will be entitled to 'parent's benefit' from the Department of Employment Affairs and Social Protection, which is €245 per week. You can apply for parent's benefit online at **www.mywelfare.ie**

You will need:
- Your baby's PPS number
- The name and address of your employer and their employer registration number (ERN).

You must also declare that your parent's leave dates have been approved by your employer.

Parent's leave is separate to maternity leave. Parent's leave cannot commence while you are on maternity leave but can commence from the day maternity leave ends. You must make a separate application for parent's leave but you must give at least six weeks' written notice of your intention to take parent's leave, outlining the start date and the manner in which you intend to take this leave.

Parent's leave can be taken one week at a time or in a block of more than one week until you use your leave entitlement. If you have already taken two weeks of parent's leave you can still apply for the remaining three weeks, provided your child has not reached two years of age. Please note, however, that your employer, although they cannot refuse parent's leave, can postpone it once for up to 12 weeks but they must inform you in writing no later than four weeks before the intended start date of the leave.

Working while receiving carer's benefit

Q. I am currently working in the public health service and availing of carer's leave. This leave is unpaid but I am in receipt of carer's benefit. I am looking after a relative who is in need of full-time care. I would like to work a number of hours per week with my employer to supplement my carer's benefit and they have agreed to this. How many hours per week can I work without it affecting my carer's benefit?

The Department of Social Protection states you must not take part in employment, self-employment, voluntary work, training or education courses outside the home for more than 18.5 hours per week (increased from 15 hours to 18.5 hours in January 2020). The maximum amount you can earn is €332.50 per week (€332.50 is your net income after you have deducted income tax and Universal Social Charge, PRSI, superannuation [pension payments], pension levy, union dues, subscriptions to friendly societies and any health insurance contract premium from your total wage).

It should be noted that the earning maximum should not be exceeded as the Department of Social Protection will cease payment of benefits should this happen.

Know your rights and entitlements

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

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

Irish **Nurses** and **Midwives** Organisation

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These stand-alone programmes are specifically designed for intern students only.
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Organised by INMO Student/New Graduate Officer, Catherine O'Connor, with INMO Professional.

Online: 11.00am – 12.30pm* *(except Tools for Safe Practice 11.00am – 1.00pm)

JULY	**Thurs 08/07**	**Interview Techniques for Intern Students**
	Tues 20/07	**The Importance of Documentation for Intern Students**
	Fri 23/07	**Becoming New Graduates Webinar**
	Wed 28/07	**Mindful Presence for Nursing and Midwifery Students**
AUG	**Thurs 26/08**	**Tools for Safe Practice for Intern Students**
	Tbc	**Information Session on Salary Scales for New Graduates**

Attendees will receive an INMO Professional certificate of attendance as a record of continuing professional development.

For more information on the programme content, log on to **www.inmoprofessional.ie**
A link of how to log on will be sent to you prior to the event(s) you booked.

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If so, do you want to join the nurse and midwifery education section?

Contact **membership@inmo.ie** to align to the section.

Vast majority of interns unhappy with pandemic pay

Catherine O'Connor reports on the results of the INMO's annual internship survey

APPROXIMATELY 1,500 nurses and midwives qualify each year in the Republic of Ireland. Annually, the INMO conducts a survey of fourth-year students during their 36-week internship. The purpose of these surveys is to collect information on the undergraduate experiences of members and to gain an insight into where these groups would seek employment on qualification.

There has been a concerning trend in recent years where nursing and midwifery graduates feel they need to look overseas for greater prospects of employment, higher pay, better working conditions, an enhanced quality of life and enhanced career opportunities.

Considering the pressures on the Irish health service it is vital that we retain our graduates in order to meet present and further healthcare demands. I would like to thank all internship student members who gave their time to complete this year's survey.

HSE as an employer

During the first wave of Covid-19 in April 2020, the INMO secured that the internship rate of pay was changed to the first point of the HCA pay scale – €14 per hour. This arrangement ended at the end of 2020. When interns began their internships in January 2021, case numbers were as high as 8,000 new cases per day yet the government refused to re-introduce the measure.

The overwhelming majority of respondents (93%) said that the way the government and public service handled the matter of internship pay negatively affected their opinion of the HSE as an employer.

In the open question for comments, many interns expressed their frustration at the actions of the HSE. One respondent commented: *"The manner in which the government dealt with the matter of intern pay disgusted me. They spoke to us as if we are stupid when in fact, we were the ones on the ground seeing the reality they clearly were not. I enjoy working in my teaching hospital, but I do not plan to stay due to the working conditions. What is expected of us and what is given in return does not equate."*

Another student said: *"The way the government handled the intern rate of pay during a global pandemic has solidified my decision that I do not want to stay in this country where I feel unappreciated."*

Indeed, the lack of respect and appreciation were a common theme in the respondents' comments: *"My experience of working as a student during Covid was one of complete lack of respect or consideration for the work we were doing during such a difficult time."*

Plans post-qualifying

The majority of 2021 nursing and midwifery graduate respondents (62%) reported that they were considering emigrating when they qualify. While there has been a slight decrease in this number compared to previous surveys, this is likely due to the travel restrictions currently in place because of Covid-19.

Almost one-third (29%) of respondents had been approached by overseas recruiters. Three-quarters (73%) of respondents who plan to leave said they would delay their departure for a year if their employer guaranteed permanent employment.

Some 39% of respondents who plan to leave Ireland to travel said that incentives would entice them to return to work in Ireland, while 59% of respondents say they would likely stay in Ireland if an incentive was given by the employer.

More than half (55%) of respondents reported 'increases in pay' as being the priority incentive to encourage them to stay in the Irish public health service, while 37% said improved staffing levels and working conditions would be the top incentive to encourage them to stay.

It is worth noting that this year 68% of respondents have reported not having adequate staffing levels in the workplace to support a positive learning environment.

Some students gave an indication of other incentives which would entice them with one commenting: *"I would stay in Dublin another year if the hospital gave out incentives such as a starting bonus or rent support"*.

More than half of respondents (55%) reported that they were considering moving to the Irish private sector after qualifying.

Covid-19

The pandemic has presented new challenges for students on their internship. Almost one-fifth (18%) of participants reported having contracted Covid-19. Of these, 39% have persistent problems post-infection. The main symptoms these students continue to experience include lethargy (79%), brain fog (55%), anxiety or other mental health issues (45%), and breathlessness (39%).

Call for student reps

It is essential that each class has an INMO student representative linked in with me. If your group does not yet have an INMO student rep, please discuss this among yourselves and nominate one rep per year, discipline, and placement area if you are spread across multiple sites.

If you are interested in learning more, please do not hesitate to contact me at catherine.oconnor@inmo.ie.

Catherine O'Connor is the INMO's student and new graduate officer. If you have a question for her you can send her an email to: catherine.oconnor@inmo.ie

Kick start your self care

Let's talk about wellbeing resources available to INMO members

THIS summer, kick start your self-care routine with free wellbeing resources available to all INMO members as part of the 'Let's Talk About It' mental health collective.

Many of us have a lot of responsibilities in both life and work that get prioritised ahead of our personal needs. Often the lengthy to-do list makes it hard to fit in 'me time'. Nevertheless, self care is an important aspect of stress management, which is more important than ever in the nursing and midwifery professions. With brighter days and longer evenings, this summer is a great time to dedicate some time just for you.

To help you on your wellbeing journey, Zevo Health, a workplace wellbeing company who are part of the Let's Talk About It collective, has gathered a series of their videos and guides that can help INMO members look after their wellbeing in both work and home life.

These wellbeing resources are available to INMO members for free and can be accessed via the Let's Talk About It digital hub on the Cornmarket website. You can find a number of activities with practical tips and advice about looking after your wellbeing including a series of pre-recorded 'Wellbeing Webinars' on the following topics:

- 12 ways to improve psychological and physical wellness
- Creating a self-care routine
- Self compassion 101
- Dealing with change and uncertainty
- Mental health and resilience
- Food for mood
- Mental health awareness and positive mental health
- Emotional resilience for challenging times
- Positive psychology during troubling times.

What is really great is that this hub is available 24 hours a day, seven days a week so you can watch, listen, read the topics that matter to you at a time that suits you best.

We encourage all INMO members to get online and utilise these positive mental health and wellbeing resources while they are available.

Resources

For more details, visit **cornmarket.ie/lets-talk-about-it/resources/**

Let's Talk About It, a mental health collective for INMO members, is brought to you by INMO and Cornmarket.

Let's Talk About It, a mental health collective for INMO members, is brought you by INMO and Cornmarket.

16636 INMO Mental Health Initiative 06-21

The microbiome and human health

Niamh Kennelly takes a look at the link between breastfeeding and the establishment of an optimal microbiome in babies

THE microbiome has become somewhat of a hot topic in recent years and, like any new specialty area, there is a lot of generalisation and misinformation. This article will attempt to clarify what the microbiome is, how it functions and the factors that can affect it. I will also discuss ways in which we can promote gut health, including the use of probiotics, and explore the role of breastfeeding in the development and function of the microbiome.

Most people associate the microbiome with gut health, however the microbiome actually refers to a population of micro-organisms that exist in and on the entire human body, on whom humans are dependent to keep us alive and healthy. These include fungi, parasites and bacteria.[1] In fact, there are as many microbes in/on the body as there are in human cells.[2] The most critical period for the development of the microbiome occurs over the first three years of infancy and early childhood, during which time any medical interventions can have lifelong consequences for the gut and overall health.[3]

Role of the microbiome

Different microbes dwell in specific areas of our bodies, meaning that there are specific microbiomes present in various areas of the body, including the gut, brain, lungs and skin. The theory is that these microbiomes are connected, and that microbial dysbiosis or disharmony is leading to the rise in many chronic conditions, such as infant overweight and obesity, skin issues, autoimmune conditions such as inflammatory bowel disease, multiple sclerosis, diabetes, allergies, asthma, autism and cancer.[4,5,6] There is also emerging research in the area of mental health, whereby our gut and brain microbiomes are connected. Many of our mood-enhancing hormones, such as serotonin – the 'happy' hormone, are made in the gut, and if our gut is not in harmony, it cannot function optimally.[7,8]

Factors affecting microbiome

Mode of delivery

It has been espoused that the mode of delivery of a baby plays a significant role in the development of a healthy microbiome, and indeed there have been differences found in the early microbial balance of a newborn. According to a systematic review by Rutayisire,[9] babies born via vaginal delivery had a more diverse pattern of gut microbiota during the first three months of life. However, after six months the observed differences disappeared.

Aagaard[10] casts further uncertainty on the debate in suggesting that intrauterine life may have more of a role to play than previously thought and that microbial presence in the maternal uterus, upper reproductive tract and preterm placenta may be just as important as the mode of delivery.

Infant diet

Breastfeeding provides the most consistent early source of probiotic bacteria, which includes staphylococcus (via the mother's skin bacteria), infant saliva bacteria and bacteria produced in the milk glands.[1] Breast milk delivers 800,000 bacteria daily directly to the baby's mouth and GI tract. Babies who are formula fed will receive environmental pathogens and will have higher amounts of gut bacteria, but they are far less diverse and are missing the highly specialised human milk microbiome.[1]

Breastfeeding stage

Breast milk is not a static substance. It changes depending on the time of day, frequency of breast emptying, infant illness or dehydration, maternal illness and so on. However, breast milk also alters in composition as mother and baby move through various ages and stages.[11] When our babies start to leave our family circle to attend crèche or childcare, they start to pick up more bugs and viruses. A mother's more mature immune system makes antibodies for these germs and transmits them to her child through her breast milk. Therefore we are giving our babies significantly more protection by breastfeeding them for longer.

Gestational age

Babies born preterm are far more likely to need neonatal assistance which involves separation from their mothers, and the possible introduction of very necessary medical interventions. This will give those babies a different microbial cocktail, but giving these baby's breast milk is hugely protective of their overall health.[4]

Also, mothers of preterm babies produce breast milk that is higher in immune components and anti-infective properties than mothers of term babies.[12] In fact, the American Academy of Pediatrics recommends that preterm infants should receive human milk as an essential medical intervention, and in the absence of their mother's milk should receive donor human milk.[13]

Medicines

Antibiotics are a well-known cause of microbial imbalance within the body. They work very well by killing bacteria that are harmful to us, but they also kill our resident good bacteria. If the balance of these micro-organisms is compromised, there can be both short and long-term health repercussions.[3,4]

Maternal diet and lifestyle

'You are what you eat' is a well-known phrase that is as true today as it was when it was first coined in 1826 by the French lawyer Anthelme Brillat-Savarin. A diet that is high in sugar, processed foods and low in fibre has a negative impact on gut health.[14] Stress can also play a role in affecting gut health and is a leading cause of irritable bowel syndrome.[7] Chronic stress and anxiety can cause abdominal pain, diarrhoea and lack of appetite. In fact, resilience to stress and immune-related disorders may be dependent on the diversity and complexity of our gastrointestinal microbiota.[15]

Promoting a healthy infant microbiome

Taking into account all of the factors that affect the microbiome, it is not difficult to see ways to promote a healthy infant microbiome. In the antenatal stage it is important to maintain a healthy diet, reduce stress and keep active.

The preferred mode of delivery is a vaginal delivery (if possible). Postnatally, there should be minimal mother-baby separation, uninterrupted skin-to-skin for the first three hours, and unrestricted infant access to the breasts with breastfeeding on demand.[11]

If there is mother-baby separation for any reason, the mother should be assisted to hand express/pump her colostrum/mature milk every two to two and a half hours so that it can be fed to her baby via syringe, cup or tubefeeding. This will also protect the mother's supply until she and her baby are reunited and direct feeding can resume.

When a newborn ingests colostrum, it coats the gut wall in a thick honey-like substance that is packed with probiotics, good bacteria, and proteins that optimise immunity. These proteins are full of immunoglobulins, antibodies and live cells that give the baby an amazing boost to their immune system. The more breast milk a baby drinks and the longer they breastfeed for, the greater the immunity.[11]

Parents should be made aware of the effects of antibiotics, so that they are not used without due consideration for the dangers of using them as well as the benefits. Where antibiotics are used, probiotics should also be encouraged – under medical supervision – in order to promote the rebalancing of the infant gut microbiome.

Parents should be encouraged to breastfeed their babies well into toddlerhood, and as long as both mother and baby are happy to do so. Breastfeeding isn't just for small babies. Breast milk continues to provide immunities and vitamins and is an excellent parenting tool in providing nutrition, comfort, security and reassurance.[16]

Prebiotics and probiotics

Simply put, prebiotics provide the food for bacteria to grow and flourish, while probiotics provide the bacteria. They are promoted as helping with digestive issues such as diarrhoea, constipation, infant reflux and yeast infections.[17] Both are available for over-the-counter use in Ireland, but the Food Safety Authority of Ireland has not recognised them as a 'health benefit' but as a 'health claim'.[18]

Prebiotics

Prebiotics are food components (complex sugars) that may provide a health benefit by helping bacteria to grow in your gut. Foods such as onion, garlic, asparagus, oats and avocado are considered prebiotic foods. Breast milk actually contains its own natural prebiotic: HMOs (human milk oligosaccharides). HMOs are complex sugars that are the third most abundant component of breast milk, but are indigestible to babies. These sugars feed babies' gut microbes so that they can multiply and colonise the microbiome.[19]

Probiotics

Probiotic foods include fermented foods such as kefir and yoghurts – which can only be called 'live' if they contain at least 10 of the main colony forming starter microorganisms such as *Lactobacillus acidophilus* and *Bifidobacterium infantis*.[18]

Probiotic supplements come in pill, powder or liquid form and seem to be everywhere, but are they safe or effective? Firstly, not all probiotics are created equal. Manufacturers use different strains of bacteria or yeast, in different quantities. Therefore there is no 'one size fits all'.[17,20] Probiotics are not recommended for anyone who is immunocompromised or those with open wounds following major surgery.[2]

In general, probiotics are considered safe for use, but should only be used after consulting with a doctor. It is also preferable to choose a reputable, well-known brand that has probiotic strains formulated specifically for various complaints such as digestive issues or candida.

In general, it is considered that if a healthy varied diet is consumed, there should be no need for prebiotics or probiotic supplements. However, in times of illness or antibiotic therapy, probiotics may play a role in recovery. Interestingly, Nami et al envision probiotic therapy as a possible future preventative treatment so that antibiotic use is decreased, but more research is required in this area.[21]

Conclusion

The microbiome plays a significant role in the health of humans. It is considered by many as another organ, such is its extensive impact. However, as it is not visible to the naked eye, like the heart or lungs, it is difficult for us to be mindful of. Processed and heavily engineered foods are all around us and it can be difficult and expensive to make consistently healthy food choices.

When it comes to the health of our babies however, there are clear steps we can take to ensure we give them the very best start in life. Mode of delivery, infant diet, ie. breastfeeding or not, and maternal/infant antibiotic treatment seem to be the most important factors in optimal microbiome development.[22]

Information is key, and knowledge is power. Parents need to be informed about the importance of the microbiome and the ways in which they can promote gut health within themselves and their family.

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Getting ready for retirement

Retirement coaching can be a pathway to empowerment and wellbeing in later life, writes **Denise Hennessey**

COACHING prior to retirement empowers nurses and midwives to play a more active role in their retirement planning and make and sustain positive lifestyle choices.

While coaching is an intervention that is more commonly associated with corporate life, a coaching approach can be applied to retirement planning. It relies on the coachee taking responsibility for their goals and objectives.[1]

It involves a confidential relationship with a coach who will help to see you through this time. The coach asks questions instead of providing answers, supports nurses and midwives instead of judging them, and facilitates their retirement planning instead of dictating what must be done.[2]

The transition from work to retirement is sometimes taken for granted. However, it is one of the major changes or adjustments in our lives.[3] Is attending a short retirement course enough to prepare for what is an entirely new chapter in a person's life or do you need to make a wellbeing plan for what lies ahead?

The following are out some of the questions that need to be addressed in order to satisfy the psychological, social, emotional and relational processes at play before and during retirement.

Your retirement experience

We are often stuck in the here and now, which can be because of busy routines, but also fear of thinking too far ahead. Have you ever pictured what retirement will look like or even feel like? What emotion, if any, does it evoke? More often than not, the financial side of retirement is assessed but not the emotional or psychological side.

Finding a new purpose

We all yearn for a purpose in life and a reason to get out of bed. For most adults prior to retirement, this is work. Work defines our daily routine, whether we like it or not. If that is taken out of the equation, then why is there a need to get out of bed?

Retirement is a period of re-adjustment, re-evaluation and re-purposing. What are my values? What drives me? Who am I? This may involve identity exploration in a coaching session, to overcome that feeling of identity loss.

Choice

Is retirement something you feel is inflicted on you by your workplace? Do I want to retire? Do I have a choice? Often it is too late by the time all these questions pop into a nurse or midwife's mind.

Retirement was once considered an exit from full-time work into full-time leisure. Research indicates however that a growing number of retirees are re-entering the labour force. Coaching helps sound out the intention to work as a nurse/midwife post-retirement, and the factors influencing this.[4]

How coaching helps

Listening is at the core of coaching. Listening to a nurse or midwife's concerns about the transition and facilitating them to formulate new goals is key to retirement success and fulfilment.

A few of the insights that coaching can provide for a nurse or midwife in preparing for retirement include:

- Greater self-insight through a coach's feedback and self reflection
- A more satisfying work-life balance and improved health
- Key motivation identification, which enables nurses and midwives to identify clearly what they want in retirement
- Closure on long term frustration.

Coaching session

It is crucial to remember that in any coaching relationship, it is the coachee who drives the agenda, not the coach. The relationship will consist of weekly, one-hour meetings at a mutually agreed time.

The coachee enters the session having reflected on the previous session and sets the agenda.

The coach will listen and facilitate in the session to ensure the coachee gets the most value out of the session.

Coaching can help nurses and midwives adapt to the challenges retirement brings. It can increase engagement and ensure a positive mindset up to the last day of your working life.

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National hepatitis C treatment registry

Valuable information has been gathered to assess the impact of treatment, write **Aisling O'Leary** and **Caitríona Ní Choitir**

THE National Hepatitis C Registry (NHCR) was established in 2012 by the Irish Hepatitis C Outcomes and Research Network (ICORN) as a tool for assessing clinical effectiveness of new treatment regimens for the treatment of hepatitis C virus (HCV) infection in the real-world Irish setting. It was also proposed to serve as a tool for research on the new regimens in the various treatment hospital sites.[1,2,3,4,5]

In 2015 the ICORN treatment registry transitioned to the National Hepatitis C Disease Registry (NHCDR).[6] It was recommended that the existing treatment registry would be expanded to include information on patients diagnosed with chronic HCV infection awaiting treatment initiation.

Purpose and oversight

The purpose of the registry is to collect and collate data on patients diagnosed with chronic HCV infection awaiting treatment, data on patients treated for HCV infection and their subsequent treatment outcomes.

The key objectives of the registry to support the National Hepatitis C Treatment Programme are to:

- Determine the number of patients attending designated treatment sites and the number of patients commenced on treatment
- Report on rates of HCV treatment among individual participating centres and at a national level
- Support continued HCV treatment planning through various strategies by utilising data collected through the disease/pre-treatment and treatment registry.

Operational procedures

A clinical registry can be described as a system which collects a defined minimum data set from patients undergoing a particular procedure or therapy, diagnosed with a disease, or using a healthcare resource. Registries may be developed to address a specific goal or several objectives including the provision of a real-world view of clinical practice, patient outcomes, safety, and comparative effectiveness.[7]

Pivotal to the registry is pertinent data. Sources of data for the NHCDR are the treatment sites and the staff who are engaged with patient care. Clinical nurse specialists (in HCV infection) based in treatment sites are essential to the provision of data to populate the registry, in addition to GPs, pharmacists and designated data managers.

Data is captured through the completion of registry support paperwork, ie. two specific data collection forms: the Patient Registration Form and the Patient Treatment Registration Form. Following patient registration, the treatment sites submit patient details with the assigned Registry Numbers to the Primary Care Reimbursement Service (PCRS) for verification to commence treatment. Outcome data are collected on an ongoing basis by the registry team through liaison and follow-up with the various treatment sites. Registry staff work closely with sites to minimise the risk of patient duplication in the absence of a unique patient identifier in the Irish setting, to verify submitted data and to ensure quality control of submitted data.

Patients pending treatment for more than a year are checked on an ongoing basis with the treatment sites to determine reasons for treatment delay, and may be reclassified as 'inactive', or 'not for treatment' depending on the information received.

Outcome data for individual treatment episodes are classified as follows:

- Sustained viral response (SVR)
- Early discontinuation (early d/c)
- Treatment failures (virological failure/ relapse)
- Lost to follow-up (LFU) (ie. did not return for SVR bloods)
- Did not return for SVR (DNR for SVR) (ie. patient booked but failed to return).

Outcome data are recorded in the registry and where patients are classified as early d/c or treatment failures, patient details are re-entered into the database as a re-treatment episode will be required. Patients categorised as LFU or DNR for SVR are checked for outcome status on an ongoing basis, as they can present for bloods in other sites, or through GP care. This may require liaison with primary care sites as well as hospital sites, due to the movement of patients between these sectors, and movement between treatment sites.

Treatment sites

The registry commenced with treatment restricted to the hospital setting. A total of eight hospitals have been involved in the provision of care to over 6,000 patients with HCV infection since 2012, four in Dublin and four elsewhere. In three participating hospitals, care is stratified into the disciplines of hepatology and infectious diseases. Hospital sites provide a holistic care pathway in designated out-patient clinics with central involvement of clinicians, CNSs, pharmacists, and other allied healthcare professionals, where prescribing and dispensing of DAA regimens is done on site.

The transition to the simpler, shorter and safer treatment regimens in the last number of years, has reduced the need for patients to attend for multiple hospital visits for on-treatment episodes. However, patients with compensated or decompensated cirrhosis require enhanced vigilance in the hospital outpatient setting. Early initiatives to expand treatments to those outside the hospital setting included prison outreach programmes overseen by CNSs from hospital treatment centres, supported by prison medical, nursing and pharmacy teams. These continue to the current day.

The lack of engagement of certain vulnerable groups with hospital care, particularly those with drug addiction issues, in tandem with successful examples of programmes in other jurisdictions, prompted the need for community-based care to be initiated in the Irish setting.[8,9,10,11] Therefore, a pilot programme of care initiated in 2017 specifically aimed at the recruitment of drug addiction centres in Dublin initially and latterly, cross country, aimed at treating patients on opioid substitution therapy (OST).

This was facilitated by the involvement of key addiction centre stakeholders led by the National Drug Treatment Centre in Pearse St, the Castle St Clinic and St Patrick's Addiction Centre in Dún Laoghaire. This has now been extended to 16 centres that actively treat patients, some of whom have treated all their HCV-positive patients (while still actively screening at risk individuals).

Despite the expansion to patients on opioid substitution therapy, it was recognised that there were still groups of patients with a HCV-positive diagnosis, who were not engaging in care despite the availability of curative therapy. Hence, primary care-based treatment was expanded to GPs in 2020 in an effort to reach these patients.

To date, five practices have registered patients, with additional sites coming on board on a regular basis. There is also a shared care initiative between the Genito-Urinary and Infectious Disease Department in St James's Hospital and Dr Kieran Harkin of the Merchant's Quay Initiative which began in late 2020 and has registered some 25 patients to date.

Medication distribution

The initiation and recruitment of GP practices and community pharmacies would not be possible without the active support and initiation of an innovative method of distributing HCV medication to pharmacies obviating the need for direct payment facilitated by the PCRS. Clinical guidelines also provide in-depth information on patient pathways and clinical guidance.[12]

At the end of 2020, 6,694 patients were registered with the NHCDR, and 5,940 treatment episodes were recorded. Males account for 67% of patients registered and 57% are recorded as Irish born (21% not recorded). Patients with cirrhosis accounted for 19% of all patients registered in 2020 which has fallen from a high of 71% in 2013, when patients with advanced disease were prioritised for early access to treatment. Genotype 1 (GT1) accounts for 62% of all cases registered (GT1a 72% and GT1b 28% respectively) compared to 31% for GT3. The main acquisition risk factor for registered patients overall is illicit drug use (55%), with the rate rising to 68% in 2020. Close to 90% of all those registered have been commenced on treatment, with the highest number commenced on treatment in 2018. The SVR rate is 94% for all patients with a recorded treatment outcome in the NHCDR (excluding those who are classified as 'DNR for SVR'. This includes those treated with both the early protease inhibitors with pegylated interferon and ribavirin regimens and interferon-free regimens.

Community-based treatment

Between January 2017 and April 2021, a total of 491 patients have been registered through the primary care pilot across both drug addiction centres and GP practices. Some 4% of these patients were originally registered in hospital sites and were subsequently re-registered through primary care. This fluidity of movement is also a feature whereby patients registered with primary care sites may re-engage with hospital care, in some cases but not all, driven by clinical status such as compensated or decompensated cirrhosis.

Of those registered in primary care, 396 patients have commenced on treatment. The SVR rate for the pilot is 94% in all patients where an outcome is known – this result again excludes those patients who have been recorded as DNR for SVR bloods, which is currently at 45%. This high rate is attributable to a number of factors encompassing social factors, addiction problems and general lack of engagement.

It is highly likely that HCV PCR tests have been conducted on a number of these patients through GPs, but active and ongoing follow-up by CNSs across the sites will eventually increase the number of treatment outcomes. There is the potential to link data from multiple sources including the National Virus Reference Laboratory to facilitate real-time results from treatment episodes – this scoping exercise is an aim of the NHCTP. Registry data are reported monthly to the NHCTP. An annual report is collated at the end of each year.

Phenotypic and genotypic profiles

Registry data also serves as a source of health intelligence to the NHCTP through the ability to provide information on the phenotypic and HCV genotypic profile of registered patients. This has acted as a support to decision-making in the processes of drug procurement and reimbursement.

It has also helped to optimise the management of patients through enabling a better understanding of the burden of chronic HCV infection and the impact of the use of DAAs on disease characteristics. It has helped to inform the development of national clinical pathways and clinical guidelines.

The registry provides meaningful and robust data-driven intelligence and insights to the NHCTP for future healthcare service planning, as part of the implementation of the multiannual national treatment programme.[6]

Registry data can also be a source of information for treatment sites as it is a collation of information on all patients registered and treated in each site for almost a decade. Each year a number of reports are generated for individual sites including, for example, the provision of patients with a history of cirrhosis for ongoing hepatocellular carcinoma surveillance purposes, or more recently for the purposes of flagging this cohort for Covid-19 vaccination. The follow-up of 'pending' patients in each site is also performed on a regular basis. The registry also provides practical help with data management in individual sites.

The registry data indicates that the uptake for treatment among patients engaged with care is in excess of 90%, and there is a high SVR rate. Hence, ensuring that patients who are diagnosed with HCV infection and notified to the HPSC are linked with care is a key priority in meeting the WHO Global Health Sector Strategy on Viral Hepatitis 2016-2021.[13]

A comparison of the total volume of patients reported to the NHCDR and the HPSC by year of birth indicates that there are a number of patients notified to the HPSC who are not represented in the NHCDR.[14] It is unclear whether these patients were previously treated and have cleared the virus, or the potential for duplicates to be present in the HPSC data. Therefore, an exercise to link the two sources of data to identify and remove patients from the HPSC list who have resolved the infection or achieved SVR, will help identify the remaining untreated patients. This exercise is currently being scoped by the NHCTP and the NHCDR.

Extending care in the community

While the majority of patients in the registry are linked with hospital care, the proportion of patients registering through primary care sites is increasing steadily and it is clear that treatment outcomes are similar. The strategy to extend care of patients with HCV infection in the community setting is feasible and achieves positive effects.

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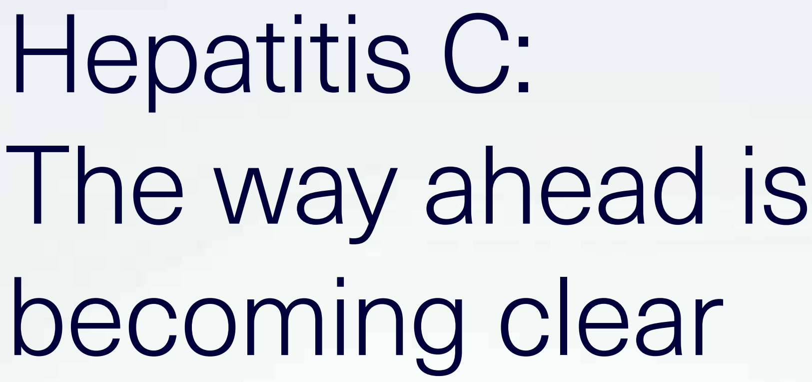
Acknowledgements: The NHCDR wishes to acknowledge the support of the clinical nurse specialists, the pharmacists and data managers and the members of ICORN who were fundamental to the development of the registry.

References available on request by email to nursing@medmedia.ie (Quote: O'Leary WIN 29 (6): 47-48)



GPs registered to prescribe methadone can now be trained to **treat Hepatitis C in the community**[1]

Hepatitis C can be **cured* using oral regimens** over 8-12 weeks[2]

The World Health Organisation established the goal of **eliminating Hepatitis C as a major public health threat by 2030**[3]

AbbVie is committed to eliminating Hepatitis C in Ireland[4]

* Patients who achieve a sustained virologic response (SVR12), defined as undetectable HCV RNA 12 weeks after treatment completion, are considered cured of Hepatitis C.[2]

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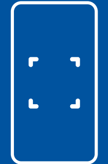

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Urinary incontinence

Women are slow to seek assistance for urinary incontinence and may socially isolate and restrict activities to cope with the problem, writes Susmita Sarma in the first of a two-part series

INCONTINENCE is defined by the International Continence Society (ICS) as any involuntary passage of urine and is broadly separated into stress incontinence, urge incontinence and mixed incontinence.

Stress urinary incontinence (SUI) is defined by the ICS as "the complaint of any involuntary loss of urine on effort or physical exertion (eg. sporting activities), or on sneezing or coughing".

Urgency urinary incontinence (UUI) is the complaint of involuntary leakage of urine accompanied by or immediately preceded by urgency – the latter is defined as "the complaint of a sudden compelling desire to pass urine, which is difficult to defer". Mixed incontinence is a combination of both symptoms, while overactive bladder syndrome (OAB) is defined as urinary urgency, usually with urinary frequency and nocturia, with or without urgency urinary incontinence.[1]

The prevalence urinary incontinence ranges worldwide with millions of women estimated to be affected. Irish data from the Maternal Health and Maternal Morbidity study estimates that up to 34% of young women experience stress incontinence before their first pregnancy.[2] The Irish Longitudinal Study on Ageing (TILDA) showed that in older female patients, 21% describe any urinary incontinence in the preceding 12 months.[3]

Internationally, estimates also vary widely with data from the UK showing that 34% report clinically significant symptoms while figures from Spain and Germany range from 23% to 40% respectively.[4]

In general, stress urinary incontinence is more prevalent in younger women with urge incontinence becoming more common in women over age 50.[5] Despite its prevalence, women are slow to seek assistance for incontinence, whether due to embarrassment or lack of awareness of treatments, and will socially isolate, restrict activities and endure restrictions placed on them because of their condition.

Assessment

The initial clinical assessment is aimed at defining the woman's type of incontinence: stress incontinence, urge incontinence/overactive bladder or mixed symptoms. Once the type of incontinence is known, initial treatment can then be started. A detailed history and examination are required with consideration given to modifiable risk factors that may affect incontinence such as obesity, fluid intake and medication, as well as practical issues such as toilet access and mobility. Examination and history taking will highlight which patients will need referral.

A pelvic exam to rule out pelvic masses and significant pelvic organ prolapse should be followed by a urinalysis to outrule urinary tract infection. Perineal excoriation secondary to frequent contact with urine should be looked for and barrier creams advised if necessary.

Bladder diaries including electronic diaries recorded over a three-day period provide invaluable information regarding the women's fluid intake, urinary frequency, variation between day and night, bladder capacity and incontinence episodes, according to the latest NICE guidelines.[6]

In the absence of concerning features such as haematuria or previous surgery, there is no indication for invasive investigations such as cystoscopy or urodynamics before starting conservative treatments.

If women have a history suggestive of a voiding dysfunction or recurrent urinary tract infections, then they should have a post-void residual assessment. This may be done with bladder scan or ultrasound. There is no other imaging required in the routine assessment of incontinence.

Treatment for urinary incontinence

Treatment for urinary incontinence includes conservative/lifestyle changes, physical therapy, pharmacotherapy and surgical interventions. For many women, exercise, weight loss and smoking cessation can be recommended but there is a lack of evidence for these interventions with minimal randomised trials published. There is an association between obesity and both stress and urgency incontinence with evidence for weight loss and improvement in stress incontinence symptoms in morbidly obese women but less so in moderately obese patients.

Weight loss is recommended for all women with a BMI > 30.6. While there is evidence for the implication of cigarette smoking and constipation in the pathogenesis of incontinence, again the evidence for improvement with intervention is lacking.

In women who have documented excessive or restricted fluid intake, intervention may be required. Too little fluid can predispose to urinary tract infections, constipation and dehydration, too much can result in excessive frequency.

A high fruit intake can also result in excessive urinary frequency. Some women may benefit from a reduction in

caffeinated and carbonated fluids as well as alcohol. Studies are few but do show an association in urge symptoms with caffeine and an association with both stress and urgency incontinence with carbonated drinks.[7,8] Some women may benefit from supportive underwear which gives direct perineal and urethral support.

Physical therapy

Pelvic floor muscle training under the supervision of a physiotherapist has been shown to be effective in reducing stress incontinence in 40-60% of women and has become the mainstay of treatment. The distinction between pelvic floor muscle training with and without a physiotherapist must be emphasised, as 50% of women do not know how to perform a pelvic floor muscle contraction correctly.[9]

There is increasing emphasis of the importance of teaching pelvic floor muscle training during a first pregnancy, and this has been shown to reduce the incidence of postpartum incontinence. Ideally, this should be taught to young women prior to pregnancy as part of a holistic pelvic health topic. Currently, it is incorporated into prenatal education classes in maternity units.

The goal is to improve the strength/timing of a pelvic floor contraction and is recommended as first-line treatment for stress incontinence and mixed incontinence in women.[6]

There is however great variation in pelvic floor programmes which makes comparison difficult. The NICE guidelines recommend a programme of at least eight contractions performed at least three times a day. Other programmes suggest eight to 12 contractions performed three to four times a day. A minimum of three months duration is suggested before an improvement in symptoms may be noted.

Long-term studies have shown a significant risk of relapse of urinary incontinence with two-thirds of women satisfied with their outcomes. Good outcome was associated with those who continued to practise their pelvic floor exercises.

Feedback mechanisms can be used in association with pelvic exercises. This can be simply a digital assessment during a pelvic floor contraction or intravaginal devices which can monitor pressure and electrical activity via vaginal or anal probes. Research has shown significant improvement when biofeedback is used but this may be due to increased contact with health professionals.[10]

Vaginal cones can also be used as a type of feedback. Progressively heavier weighted cones are retained in the vagina by pelvic floor muscle contraction and can be used without supervision or vaginal examination. They may be easier for some women to use and understand compared to pelvic floor muscle training.

Electrostimulation of the pelvic floor is a non-invasive method of getting the pelvic floor muscles to contract. Electrical pulses are delivered to induce a pelvic floor contraction placed on the skin or in the vagina or anus. They are also believed to produce some inhibition of bladder-voiding via a spinal reflex. Evidence for efficacy in studies is inconsistent and the NICE guidelines do not recommend it for routine treatment of urinary incontinence but may be useful for biofeedback.

Bladder training or bladder drill can be a useful tool in the treatment of urgency and mixed incontinence. The aim is to increase the time intervals between voids and reduce incontinence episodes. NICE guidelines recommend a minimum of six weeks training as first-line management of urgency and mixed incontinence as well as in cases of resistant OAB, along with antimuscarinic treatment. Prompted and timed voiding or toileting regimes are recommended for women who are incapable of independent toileting or have impaired cognitive function.

Neurostimulation

Neurostimulation is the alteration of neural pathways by the application of a stimulus (either electrical or chemical) to a targeted site of the body. When it comes to its use in urinary incontinence, there are two pathways: sacral nerve stimulation or posterior nerve stimulation.

Posterior tibial nerve stimulation (PTNS) can be administered through surface electrodes, transcutaneous posterior nerve stimulation (T-PTNS) or by using a fine needle inserted close to the actual nerve (percutaneous posterior nerve stimulation [P-PTNS]). For all of these treatments, small studies have shown only limited improvements in patient satisfaction or clinical outcomes when compared to sham or anticholinergic medication. As such, the NICE guidelines do not recommend either modalities for the treatment of OAB but suggest that P-PTNS can be offered to women who fail conservative and medical management and who may not want surgical treatment of OAB.

Conservative measures aimed at coping with incontinence include absorbent products, catheterisation and intravaginal devices. These are usually aimed at managing urinary incontinence as a temporary coping strategy. However, they may be required if other treatments have failed. An annual review of such use should include an assessment of continence, of skin integrity and any change to symptoms, comorbidities, lifestyle, mobility, medication, BMI and social and environmental factors.[6]

Intermittent catheterisation may by required if women have urinary retention and indwelling urethral or suprapubic catheters are useful where areas of skin injury or irritation are being contaminated by urine. Intravaginal devices can be useful for women who are able to self-care (remove and replace) for activities such as exercise.

Role of urodynamics

Urodynamic testing is an invasive procedure and does not need to be carried out prior to starting treatment for urinary incontinence. It is especially useful for women who have failed multiple medications for OAB/urgency incontinence. It is not considered necessary prior to surgical treatment for stress incontinence but in practice is usually carried out before same.

It can help bring clarity where the type of incontinence is unclear from history and examination and if there are symptoms suggestive of voiding dysfunction. It is also helpful where there has been a history of previous surgery for stress incontinence.[6]

Susmita Sarma is a consultant obstetrician/gynaecologist at University Hospital Galway

Part two of this article will focus on medications to treat OAB

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Prescribing Information: Please read the Summary of Product Characteristics (SPC) before prescribing. **Presentation:** Prolonged-release tablet, containing mirabegron 25mg/50mg. **Indication:** Symptomatic treatment of urgency, increased micturition frequency and/or urgency incontinence as may occur in adult patients with overactive bladder (OAB) syndrome. **Posology and method of administration:** The recommended dose is 50 mg once daily. A lower dose of 25mg is recommended for specific patient populations (renal and hepatic impairment) as well as in specific patient populations in combination with strong CYP3A inhibitors such as itraconazole, ketoconazole, ritonavir and clarithromycin. Renal impairment: *End stage renal disease* (GFR < 15 mL/min/1.73 m2 or patients requiring haemodialysis): Not recommended. *Severe renal impairment* (GFR 15 to 29 mL/min/1.73 m2): Reduce dose to 25 mg. *Severe renal impairment and concomitant strong CYP3A inhibitors:* Not recommended. *Moderate renal impairment* (GFR 30 to 59 mL/min/1.73 m2): 50 mg. *Moderate renal impairment and concomitant strong CYP3A inhibitors:* Reduce dose to 25 mg. *Mild renal impairment* (GFR 60 to 89 mL/min/1.73 m2): 50 mg. *Mild renal impairment and concomitant strong CYP3A inhibitors:* Reduce dose to 25 mg. Hepatic impairment: *Severe hepatic impairment* (Child-Pugh Class C): Not recommended. *Moderate hepatic impairment* (Child-Pugh B): Reduce dose to 25 mg. *Moderate hepatic impairment and concomitant strong CYP3A inhibitors:* Not recommended. *Mild hepatic impairment* (Child-Pugh A): 50 mg. *Mild hepatic impairment and concomitant strong CYP3A inhibitors:* Reduce dose to 25 mg. The tablet is to be taken once daily, with liquids, swallowed whole and is not to be chewed, divided, or crushed. It may be taken with or without food **Contraindications:** Hypersensitivity to the active substance or to any of the excipients (see the SPC for a list of excipients). Severe uncontrolled hypertension defined as systolic blood pressure ≥180 mm Hg and/or diastolic blood pressure ≥110 mm Hg. **Special warnings and precautions for use:** Renal impairment: Betmiga has not been studied in patients with end stage renal disease (GFR < 15 mL/min/1.73 m2 or patients requiring haemodialysis) and, therefore, it is not recommended for use in this patient population. Data are limited in patients with severe renal impairment (GFR 15 to 29 mL/min/1.73 m2); based on a pharmacokinetic study a dose reduction to 25 mg is recommended in this population. This medicinal product is not recommended for use in patients with severe renal impairment (GFR 15 to 29 mL/min/1.73 m2) concomitantly receiving strong CYP3A inhibitors. Hepatic impairment: Betmiga has not been studied in patients with severe hepatic impairment (Child-Pugh Class C) and, therefore, it is not recommended for use in this patient population. This medicinal product is not recommended for use in patients with moderate hepatic impairment (Child-Pugh B) concomitantly receiving strong CYP3A inhibitors. Hypertension: Mirabegron can increase blood pressure. Blood pressure should be measured at baseline and periodically during treatment with mirabegron, especially in hypertensive patients. Data are limited in patients with stage 2 hypertension (systolic blood pressure ≥ 160 mm Hg or diastolic blood pressure ≥ 100 mm Hg). Patients with congenital or acquired QT prolongation: Betmiga, at therapeutic doses, has not demonstrated clinically relevant QT prolongation in clinical studies. However, since patients with a known history of QT prolongation or patients who are taking medicinal products known to prolong the QT interval were not included in these studies, the effects of mirabegron in these patients is unknown. Caution should be exercised when administering mirabegron in these patients. Patients with bladder outlet obstruction and patients taking antimuscarinic medicinal products for OAB: Urinary retention in patients with bladder outlet obstruction (BOO) and in patients taking antimuscarinic medicinal products for the treatment of OAB has been reported in postmarketing experience in patients taking mirabegron. A controlled clinical safety study in patients with BOO did not demonstrate increased urinary retention in patients treated with Betmiga; however, Betmiga should be administered with caution to patients with clinically significant BOO. Betmiga should also be administered with caution to patients taking antimuscarinic medicinal products for the treatment of OAB. **Interactions:** *Pharmacokinetic interactions:* Mirabegron is a substrate for CYP3A4, CYP2D6, butyrylcholinesterase, uridine diphospho-glucuronosyltransferases (UGT), the efflux transporter P-glycoprotein (P-gp) and the influx organic cation transporters (OCT) OCT1, OCT2, and OCT3. *Pharmacokinetic interactions involving the potential for other medicinal products to affect mirabegron exposures:* Increases in mirabegron exposure due to drug-drug interactions may be associated with increases in pulse rate. *Strong CYP3A inhibitors* See Posology and administration above for dose adjustments recommended during concomitant use of strong CYP3A inhibitors in patients with renal or hepatic impairment. Mirabegron exposure (AUC) was increased 1.8-fold in the presence of the strong inhibitor of CYP3A/P-gp ketoconazole. *CYP2D6 inhibitors:* No dose adjustment is needed for mirabegron when administered with CYP2D6 inhibitors (or in patients who are CYP2D6 poor metabolisers). Inducers: Inducers of CYP3A (such as rifampicin) or P-gp may decrease the plasma concentrations of mirabegron. No dose adjustment of mirabegron is required as this effect is not expected to be clinically relevant. *Pharmacokinetic interactions involving the potential for mirabegron to affect exposures to other medicinal products: Inhibition of CYP2D6:* Moderate and time dependent inhibition of CYP2D6 by mirabegron may result in clinically relevant drug interactions. CYP2D6 activity recovers within 15 days after discontinuation of mirabegron. Caution is advised if mirabegron is co-administered with medicinal products metabolized by CYP2D6 with a narrow therapeutic index such as thioridazine, Type 1C antiarrhythmics (e.g.flecainide, propafenone) and tricyclic antidepressants (e.g., imipramine, desipramine). Caution is also advised if mirabegron is co-administered with CYP2D6 substrates that are individually dose titrated. *Inhibition of P-gp:* Mirabegron is a weak inhibitor of P-gp. For patients who are initiating a combination of Betmiga and digoxin, the lowest dose for digoxin should be prescribed initially. Serum digoxin concentrations should be monitored and used for titration of the digoxin dose to obtain the desired clinical effect. The potential for inhibition of P-gp by mirabegron should be considered when Betmiga is combined with sensitive P-gp substrates e.g. dabigatran. **Fertility, pregnancy and lactation:** The effect of mirabegron on human fertility has not been established. Betmiga is not recommended during pregnancy and in women of child-bearing potential not using contraception. Mirabegron should not be administered during breast feeding. Refer to SPC for full guidance. **Driving and use of machines:** Betmiga has no or negligible influence on the ability to drive and use machines. **Undesirable effects:** Summary of the Safety Profile: the safety of Betmiga was evaluated in 8433 patients with OAB, of which 5648 received at least one dose of mirabegron in the phase 2/3 clinical program, and 622 patients received Betmiga for at least 1 year (365 days). In the three 12-week phase 3 double blind, placebo controlled studies, 88% of the patients completed treatment with this medicinal product, and 4% of the patients discontinued due to adverse events. Most adverse reactions were mild to moderate in severity. The most common adverse reactions reported for patients treated with Betmiga 50 mg during the three 12-week phase 3 double blind, placebo controlled studies are tachycardia and urinary tract infections. The frequency of tachycardia was 1.2% in patients receiving Betmiga 50 mg. Tachycardia led to discontinuation in 0.1% patients receiving Betmiga 50 mg. The frequency of urinary tract infections was 2.9% in patients receiving Betmiga 50 mg. Urinary tract infections led to discontinuation in none of the patients receiving Betmiga 50 mg. Serious adverse reactions included atrial fibrillation (0.2%). Adverse reactions observed during the 1-year (long term) active controlled (muscarinic antagonist) study were similar in type and severity to those observed in the three 12-week phase 3 double blind, placebo controlled studies. The following adverse reactions were observed with mirabegron in the three 12-week phase 3 double blind, placebo controlled studies. The frequency of adverse reactions is defined as follows: very common (≥1/10); common (≥1/100 to <1/10); uncommon (≥1/1,000 to <1/100); rare (≥1/10,000 to <1/1,000); very rare (<1/10,000); not known (cannot be established from the available data) Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. The adverse events are grouped by MedDRA system organ class. Infections and infestations: *Common:* urinary tract infection *Uncommon:* vaginal infection, cystitis Psychiatric disorders: *Not known:* Insomnia*, confusional state* Nervous system disorders: *Common:* headache* dizziness* Eye disorders: *Rare:* eyelid oedema Cardiac disorders: *Common:* tachycardia *Uncommon:* palpitation, atrial fibrillation Vascular disorders: *Very rare:* Hypertensive crisis* Gastrointestinal disorders: *Common:* nausea*, constipation*, diarrhoea* *Uncommon:* dyspepsia, gastritis *Rare:* lip oedema Skin and subcutaneous tissue disorders: *Uncommon:* urticaria, rash, rash macular, rash papular, pruritus *Rare:* leukocytoclastic vasculitis, purpura, angioedema* Musculoskeletal and connective tissue disorders: *Uncommon:* joint swelling Renal and urinary disorders: *Rare:* urinary retention* Reproductive system and breast disorders: *Uncommon:* vulvovaginal pruritus Investigations *Uncommon:* blood pressure increased, GGT increased, AST increased, ALT increased *(*observed during post-marketing experience)*. **Reporting of suspected adverse reactions:** see below. **Legal category:** POM (S1B) **Marketing Authorisation number: EU/1/12/809/003** - 25mg **EU/1/12/809/010** - 50mg. **Marketing Authorisation holder:** Astellas Pharma Europe B.V. Sylviusweg 62, 2333 BE Leiden, The Netherlands. **Further information is available from:** Astellas Pharma Co., Ltd, 5 Waterside, Citywest Business Campus, Dublin 24. Phone: +3531 467 1555. Summary of Product Characteristics with full prescribing information available upon request. **Job number:** BET_2019_0002_IE **Date of preparation of API:** 27 May 2019.

Reporting of suspected adverse reactions:

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via:

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E-mail: medsafety@hpra.ie.	

Date of preparation: June 2019

References: 1. Freeman R, et al. Current Medical Research and Opinion 2017. https://doi.org/10.1080/03007995.2017.1419170.

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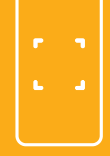

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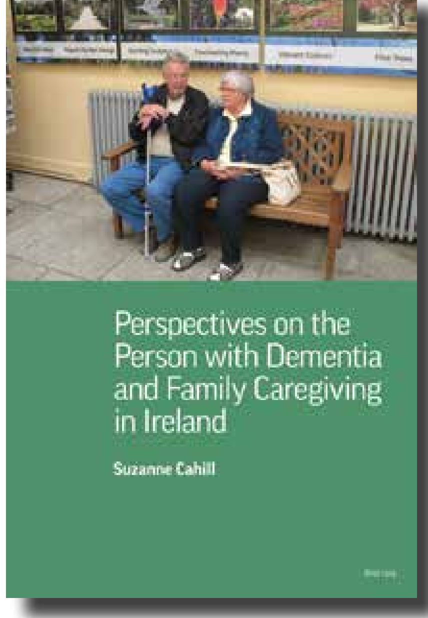
New perspectives on dementia

Perspectives on the Person with Dementia and Family Caregiving in Ireland provides a fresh and useful framework in which to set our understanding of dementia, tracing the individual's journey through the illness from diagnosis and its disclosure (where a first person account is provided in one of the chapters) to accessing home care services to moving from home into long term residential care.

The book is an introductory Irish guide that brings together local and international research to help dispel some of the myths and stigma surrounding dementia. It challenges the biomedical model by making the case for the importance of analysing dementia from several different perspectives, including public health, human rights and disability.



Many topics and questions are explored in the book, including the difference between dementia and normal age-related memory loss, what can be done to help us avoid getting dementia as we age, what interventions – both medical and non-medical – are currently available in Ireland to treat a person with dementia and the meaning of autonomy and supported decision-making in the context of dementia?

Author Suzanne Cahill is an adjunct professor of social work and social policy at Trinity College Dublin and an honorary professor in dementia care at the Centre for Economic and Social Research on Dementia in NUI Galway. Prof Cahill was the lead author on the research review which has underpinned Ireland's first National Dementia Strategy.

The book provides the reader with a wealth of information including research evidence, comparative international data, best practice guidelines and a first person account of an individual's own unique experience of young onset dementia. It shows us what good dementia care can look like, provides a cautionary note about rising prevalence rates of dementia, and makes a case for the importance of strong public and private investment in dementia care services.

The book is timely and unique as it brings together in one volume the wealth of knowledge about dementia that has been gathered in Ireland over several decades, which is discussed against the backdrop of international research. The direct experience of stakeholders is reflected in the book and its content is rooted in a rights-based social model of care.

Perspectives on the Person with Dementia and Family Caregiving in Ireland by Suzanne Cahill is available at: www.peterlang.com ISBN:978-1-80079-117-6 RRP €23.95

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Across
1 & 15a Part of the digestive system upset a tyrannical male (10,5)
6 Uterus (4)
10 A native of New Zealand (5)
11 Unscathed, not harmed (9)
12 Singing in a pub to a background instrumental music track (7)
15 See 1 across
17 Den finishes off the eclair (4)
18 Right, help with the attack (4)
19 Obvious (5)
21 Hairstyle developed with Con nigh perhaps (7)
23 Beethoven's Choral symphony (5)
24 Eye infection (4)
25 Seaport city in Yemen (4)
26 Holy song about lamps (5)
28 Drinking-vessel (7)
33 Dessert provided by Granny Smith - the floozy! (5,4)
34 Oriental city located in part of Oskaloosa, Kansas (5)
35 The 'three' in a deck of cards tells readers 'Eat your starters!' (4)
36 Cop-on, equine style! (5,5)

Down
1 Charity (4)
2 Enforced seclusion from others, to avoid contagion perhaps (9)
3 Musical based on the life of Eva Peron (5)
4 Luggage for an elephant? (5)
5 Roach-like fish (4)
7 & 16d Operation in which a keyboard instrument is relocated? (5,10)
8 The sot belched out cot coverings! (10)
9 Moronic kind of Greek letter (7)
13 A sound of pain coming finally from a grouch (4)
14 Tastefully fine (7)
16 See 7 down
20 Amuse (9)
21 Room (7)
22 One would love to prohibit this Scottish town! (4)
27 More than enough (5)
29 Section of the choir involved in a sensational Tosca performance (5)
30 In which to quantify one's speed at sea (5)
31 Starch used to make a dessert (4)
32 Person from Copenhagen, perhaps (4)

June crossword solution

Across: 1 Map 3 Frivolously 8 Trojan 9 Laburnum 10 Angst 11 Eclat 13 Canal 15 Abdomen 16 Bicycle 20 Minus 21 E-mail 23 Joker 24 Beheaded 25 Minted 26 Works to rule 27 One

Down: 1 Mitral valve 2 Ploughed 3 Feast 4 Volcano 5 Ovule 6 Single cream 7 Yam 12 Tower Bridge 14 Lairs 17 Cockatoo 18 Invader 19 Father 22 Leads 23 Juice 24 Bow

The winner of the June crossword is: Liliana Marclean, Finglas, Dublin

You can now email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included.
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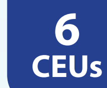
Friday, 16 July 10.00am –12.30pm	**What is Mindfulness?** There is more right with us than wrong
Friday, 23 July 10.00am – 2.30pm	**Perception and creative responding:** How we perceive the world and ourselves
Friday, 30 July 10.00am – 12.30pm	**Mindfulness of the Breath and the Body in Movement:** There is both pleasure and power in being present
Friday, 6 August 10.00am – 12.30pm	**Learning about our Patterns of Stress Reactivity:** Wherever you go, there you are
Friday, 13 August 10.00am – 12.30pm	**Working with Stress:** Mindful Responding instead of Reacting
Friday, 20 August 10.00am – 12.30pm	**Stressful Communications** - Interpersonal Mindfulness
Monday, 23 August 10.00am – 4.00pm	**Full day Retreat**
Friday, 27 August 10.00am – 12.30pm	**Lifestyle Choices**
Friday, 3 September 10.00am – 12.30pm	**A Mindful Life - Keeping your Mindfulness Alive**

Introduction to Positive Behaviour Support Webinar



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Online from 9.15am - 4.45pm
€65 INMO members, €130 non members

Positive Behaviour Support is an internationally recognised evidence based approach to supporting individuals that can present with behaviours that challenge. This workshop introduces participants to the model of Positive Behaviour Support and outlines the benefits and considerations in its utilisation from a practical and applied standpoint. This programme is designed specifically for management and frontline staff that work in situations where there is potential for exposure to what may be termed "behaviours that challenge".

Programme Outline:

- Understanding behaviours that challenge
- Positive Behaviour Support Model
- Managing behaviours that challenge
- Developing a Behaviour Support Plan

BOOKING YOUR PLACE IS ESSENTIAL

Tel: 01 6640641/18 or go to www.inmoprofessional.ie

Failure to report allergy symptoms can heighten asthma risk

Survey finds 30% of asthma sufferers do not seek advice on allergies

THE findings of a recent Asthma Society of Ireland survey are cause for concern for people with asthma, according to the society's medical director Marcus Butler, who said that just 30% of the 655 respondents reported seeking medical advice for allergy management.

Dr Butler, who is a respiratory consultant at St Vincent's University Hospital, said that more than 300,000 people in Ireland suffer from both asthma and hayfever, and that the two conditions in combination can have a significant negative impact on overall health and quality of life.

Pollen (63%) and house dust mites (56%) were the most commonly reported allergies by respondents with allergy diagnoses, while more than one-third of respondents reported a diagnosis of allergy to pet or animal hair. Just over one-fifth had confirmed allergies to certain foods.

Dr Butler said: "The findings are concerning for the asthma population in Ireland as while all of those surveyed reported experiencing asthma symptoms, 30% had not sought advice from their healthcare practitioner in managing their symptoms. While the symptoms are frustrating for many, unmanaged hayfever or allergies can cause asthma symptoms to heighten and escalate into an asthma attack. An asthma attack is a respiratory emergency that should be taken seriously by patients and carers. Allergies and hayfever with asthma can be fatal. At least one person dies every week as a result of asthma.

"Our research showed that 50% of those surveyed have had an asthma attack in the past year; 14% had experienced an attack in the past four weeks alone, 19% in the past six months and a further 16% in the past 12 months. Good hayfever management is crucial in preventing an asthma emergency."

Nursing perspective

Sneezing, stuffy nose and runny nose were commonly experienced among respondents. Of the symptoms most frequently experienced, 92% cited the urge to sneeze or sneezing fits, 91% reported runny nose/rhinitis, 88% experienced stuffy or itchy nose, while 74% reported itchy, burning eyes.

Ruth Morrow, respiratory nurse specialist with the Asthma Society, said that these are all symptoms of hayfever which, if left unaddressed, can lead to more serious problems, especially in those with asthma.

"Usual hayfever symptoms include runny nose with clear or pale-coloured mucus, sneezing, red, watery eyes, and itching around the nose, mouth or eyes," Ms Morrow said.

"Left untreated, this can lead to nasal congestion, postnasal drip, coughing, lower respiratory problems, sore throat, headache, decreased sense of smell, ear or sinus infection, puffiness or dark circles under the eyes, and fatigue," she added.

"Spring and summer are the peak times for people with hayfever, with 51% reporting increased symptoms at this high pollen time. That can really impact on quality of life and asthma management. Lying in bed at night and being close to meadows, fields or trees can further aggravate symptoms."

Green-fingered Waterford midwives 'Get Ireland Growing'

The midwifery team at University Hospital Waterford (UHW) has joined the 'Get Ireland Growing' challenge and is encouraging others to join the initiative, which aims to allow people to enjoy the benefits of growing their own food. Led by Maria Murtagh, the UHW midwifery unit's 'green team' said the activity has been a welcome release in a difficult period. Ms Murtagh said: "We have 45 in our group now, from nurses to neonatal team members to consultants, who are all hugely competitive about 'outgrowing' each other. It's only just at the beginning stage this year because we're all busy, but it's also a great release for us all." Midwife Helen Patmore said: "It's really therapeutic. You wouldn't think it is, but when you go out it's absolutely wonderful. Even if you don't have a garden you can just grow in a few pots or planters." Though the day itself took place on June 19, the event's organisers Grow it Yourself (GIY) are encouraging people of all experience levels to get involved during the growing season. Challenges include sowing a seed, filling a takeaway coffee cup with soil to turn it into a makeshift pot, making bug hotels that support biodiversity and turning nettles into plant food. See ***www.getirelandgrowing.ie*** *for more information.* ***Pictured left are midwives (l-r) Maria Murtagh, Helen Patmore and Victoria Ben, all from UHW***

'Broad alignment on Covid response between North and Republic' – study

Study shows potential for all-island co-operation on public health policy

RESEARCHERS from Trinity College Dublin (TCD) have found that public health commitments contained within the Good Friday Agreement have allowed for "broad alignment" in public health policy during the pandemic.

The study, which was published in the journal *Irish Studies in International Affairs*, concluded that this co-operation provides a framework for future all-island co-ordination of public health policy.

The study's authors said that despite historical and constitutional obstacles to an all-Ireland Covid-19 response, there was evidence of "significant public health policy alignment brought about through ongoing dialogue and co-operation" between the health administrations north and south of the border during the first wave of the pandemic in 2020.

The researchers analysed the inter-jurisdictional Covid-19 policy measures using the Oxford Covid-19 Government Response Tracker. They found that:

- There was broad alignment in public health and containment policy responses to Covid-19 in the Republic of Ireland and Northern Ireland and in the pace of their introduction
- While the historical and constitutional politics of the island of Ireland coupled with Brexit were significant obstacles to an all-island response to Covid-19, the framework provided by the Good Friday Agreement enabled public health policy alignment
- Parliamentary debates and minutes of meetings revealed regular dialogue between the Public Health Agency in Northern Ireland and NPHET in the Republic of Ireland, as well as weekly conversations between the chief medical officers on cross-border matters relating to Covid-19
- Interjurisdictional alignment was evident in the joint cancellation of St Patrick's Day parades, lockdown policies and movement restrictions, public transport, social distancing measures and the mandatory wearing of face masks. Policy for testing generally defied interjurisdictional comparison and while workplace closures occurred in both jurisdictions in the space of one week in early-March 2020, school closures revealed a more cautious and conservative tendency in the Republic.

The study's lead author, Dr Ann Nolan, assistant professor in global health at TCD, said: "I came to this study, like everyone else at the time, believing that there was little or no interjurisdictional co-ordination of the response to Covid-19 on the island of Ireland and I'm very happy to find that I was wrong.

"While an all-island response to the pandemic might have been the most desirable approach from the perspective of public health, the historical and constitutional politics of the island of Ireland coupled with the coincidental timing of Brexit made that impossible.

"At a time of some political instability in Northern Ireland, encouragingly, the Good Friday Agreement has enabled public health policy alignment through ongoing dialogue and co-operation between the health administrations in each jurisdiction," Dr Nolan added.

For further information on the study, see: **https://bit.ly/3yVZ71b**

'Respect the rights of nurses': ICN demands end to violence against healthcare workers in Myanmar

THE International Council of Nurses (ICN) has called on the government of Myanmar to respect the rights of nurses and other healthcare workers. The council has also sent messages of support to the nurses of Myanmar along with its 130-plus national nursing associations.

In a recent statement, the ICN expressed its deep concern regarding the targeted and deliberate violence against healthcare workers and the devastating consequences of these disruptions to public health.

The ICN said it strongly condemns any violence towards nurses and healthcare staff and advised that UN Resolution 2286, which strongly condemned attacks against medical facilities and personnel in conflict situations, should be fully implemented and embraced to protect the delivery of healthcare services.

The ICN also urged the Myanmar government, whichever form it takes, to adhere to its international obligations regarding the health and wellbeing of its healthcare staff.

"It is difficult to imagine the stress and fear that Myanmar's nurses are under when performing their professional duties at this time, and our hearts go out to them, to their healthcare colleagues and to the patients they serve," the ICN said in a statement.

"The ICN strongly condemns all forms of violence against healthcare organisations and their staff as they endanger the health and human rights of the people of Myanmar and are a violation of the Geneva Convention. Health is a universal human right which creates legal obligations on governments that must be adhered to, even in situations of instability and conflict," the statement continued.

"In addition, nurses are bound by ethical rules, including ICN's own Code of Ethics for Nurses, which states that they have four fundamental responsibilities: to promote health; to prevent illness; to restore health and to alleviate suffering.

"The ICN Code states that the need for nursing is universal, and therefore it is offered to everyone, irrespective of their age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status. It goes without saying that this also applies to the delivery of impartial healthcare services to the entire population of Myanmar."

INMO launches position statement on period poverty

TO MARK World Menstrual Hygiene Day on May 28, 2021, the student and new graduate members who worked on the INMO's position statement on period poverty marked its launch by hosting a webinar on menstrual health.

Opened by INMO president Karen McGowan, the webinar featured a varied lineup of speakers. One such speaker was lecturer, media commentator and sex educator Dr Caroline West, who presented on the period positivity movement as well as common myths regarding menstruation and menstrual health.

Founder and general manager of Homeless Period Ireland Claire Hunt spoke about the work of this volunteer initiative, which was founded to provide free period poverty products to those in need. Ms Hunt also outlined the nature of her work with Lidl Ireland, the first major retailer in the world to offer free period products.

Ellie Loftus, CEO of Nixxworld – an Irish company that was set up to design and manufacture sustainable, absorbent and leak-proof period and bladder leak underwear – presented recent Irish research of young people's experiences and attitudes towards menstruation and period poverty.

Labour Party Senator Annie Hoey gave a brief outline of the Period Products (Free Provisions) Bill, which was introduced earlier this year.

Melissa Plunkett, who holds the student seat on the INMO Executive Council, provided a rationale for the position statement, which INMO student and new graduate members worked on over a number of months. This statement can be viewed at **www.inmo.ie/8192**

The calls for actions outlined in the statement include:

- The provision of access to free menstrual supplies with appropriate disposal facilities in all public toilets (regardless of gender) in clinical areas, public and governmental buildings, schools and higher education institutions
- To continue to ensure that tampons and sanitary towels are not subject to VAT in Ireland
- To extend the zero-rate treatment to include all menstrual sanitary products
- To work towards changing attitudes towards periods through education and advertising campaigns to normalise discussions and decrease stigma.

A questions and answers session was held following the presentations, as well as well as a raffle.

Congratulations to the three prizewinners: Julie Ann Daly-Dorrian, Samantha Stackpoole and Laura Tully.

A recording of the webinar is available to watch back at **www.inmoprofessional.ie/Home/OnlineResources**

RCN members vote to re-join ICN

THE UK's Royal College of Nursing (RCN) has voted to re-join the International Council of Nurses (ICN). This has been welcomed by ICN chief executive Howard Catton, who said: "We warmly welcome the news that the RCN's membership has voted to re-join ICN and we are extremely grateful for the open and transparent conversation we have had with the RCN leadership and its members about the importance of global nursing, in the lead up to the vote.

"The pandemic has shown that no nation can tackle global health issues alone, and that we must work together to create sustainable health systems for all, where no-one is left behind," Mr Catton added.

"We wish to put on record our sincere and heartfelt thanks to those who have taken part in the discussions about the importance of RCN re-joining ICN. UK nurses and the RCN have played an integral role in the development and the history of ICN for more than a century, and I am absolutely certain that this news will be hugely well received by nurses and our associations around the world."

Clontarf Hospital celebrates Pride 2021

*Clontarf Hospital was delighted to mark Pride month for the first time in June. The hospital partnered with LGBT Ireland, Dublin Pride, An Garda Síochana and Dublin Fire Brigade with the aim of educating staff and breaking down barriers to enhance the care of LGBTQ+ patients and colleagues. Staff wore Pride colours to work, the hospital menu carried a Pride theme and an information stand was hosted by Dublin Pride chief executive Jed Dowling. A 'lunch and learn' session was hosted by James O'Hagan, LGBT Champions programme manager, while Sean, a patient at the hospital, discussed his first-hand experience and his journey through the health system. Emergency services visited in a Pride-themed car and the day ended with staff unveiling the Dublin Pride flag in the hospital's garden (pictured above). **Also pictured at the Clontarf Hospital Pride celebrations were: MIchelle Fanning, CEO and Bernie Connolly, quality improvement officer (top left) and Gillian McKeown, catering manager (top right), all with Clontarf Hospital***

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

July

Monday 26
National Children's Nurses Section meeting. 11am via Zoom

September

Saturday 4
School Nurses Section training on over-the-counter medication protocols. 10am

Saturday 11
Public Health Nurses Section meeting. 11am via Zoom

Saturday 11
Midwives Section meeting. 11am via Zoom

Wednesday 15
Operating Department Nurses Section meeting. 7pm via Zoom

Monday 20
Telephone Triage Section webinar

Thursday 23
Retired Section meeting. 11am via Zoom

Thursday 23
Assistant Directors Section meeting. 2pm via Zoom

Saturday 25
SEN Section meeting. 10am via Zoom

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

Thursday 30
Directors Section and Assistant Directors Section webinar

October

Thursday 14
Student Allocation Liaison Officers Networking Group meeting. 12pm via Microsoft Teams

Saturday 16
Public Health Nurses Section webinar

Tuesday 19
Care of the Older Person Section webinar. 2pm via Zoom

Monday 25
National Children's Nurses Section meeting. 11am via Zoom

Condolences

❖ It is with great sadness that we learned of the sudden death of Melissa Pyne, senior staff nurse, Daughters of Charity Services, Lisnagry. The thoughts and prayers of the INMO Limerick Branch are with Ms Pyne's family, friends and colleagues in Lisnagry and the wider Daughters of Charity Services during these very difficult times. May she rest in peace.

❖ The INMO Limerick Branch extends its deepest sympathies to the family and former colleagues of retired nurse Ken Doheny, Daughters of Charity Services, on his recent sudden death. Mr Doheny worked on both the Kilkenny and Lisnagry campuses of the Daughters of Charity Services. May he rest in peace.

❖ The INMO North Tipperary Branch extends its deepest sympathy to Mairead King, clinical nurse manager, Nenagh Hospital, on the sad passing of her mother Kathleen Byrne. May she rest in peace.

❖ The INMO was saddened to learn of the death of Kirsten Stallknecht, former International Council of Nurses (ICN) president. Ms Stallknecht became president of the Danish Nurses Organisation aged just 29. She set up the Danish Institute for Health and Nursing Research in 1980, which was linked to the WHO's work in developing nursing, and set up the Danish Museum of Nursing History in 1999. For four years from 1991 she was president of the European Federation of Nurses Associations and in 1997 she was elected as ICN president. We extend our deepest sympathies to all who knew this formidable woman, nurse and trade union official.

❖ Our dear friend and colleague Regina Durcan passed away recently surrounded by her loving family. Ms Durcan was INMO industrial relations officer for the Western Region from 2008 to 2016. We will miss her beautiful smile, infectious laugh and practical, common-sense approach. We extend our deepest sympathies to her husband Tom and daughters Gina and Catherine. May she rest in peace.

INMO Professional Library Opening Hours

July/August

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

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

INMO Membership Fees 2021

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

Retirements

❖ Everyone at the INMO would like to wish Margaret Frahill the very best in her retirement. Ms Frahill was active with the INMO for 30 years and sat on Executive Council for four years, serving as second-vice president, as well as being chair of her local branch. Her activism and commitment have been constant and her input will be greatly missed.

❖ The Castlebar Branch would like to wish Patricia Barrett O'Boyle and Jacinta Flynn the very best on their recent retirements. Both women have been active INMO reps since the early 1990s and have been a voice for their peers, fighting to break through the glass ceiling of rights and entitlements. Their humour and dedication helped their colleagues through many tough times and they have made lifelong friendships.

Nurse required

Home Instead Tipperary is looking to recruit a nurse for part-time or bank shift basis to support an established team. This is an excellent opportunity to gain knowledge and experience in caring for an adult client at home with complex needs, assisting with activities of daily living and to enable them to live to maximum potential. Work within an established team with clinical lead support. All necessary training provided. Call 083 829 7416 for more information.

MSc Loss & Bereavement
and
MSc Loss & Bereavement (Clinical Practice)

Starting in September 2021, these Royal College of Surgeons in Ireland (RCSI) postgraduate programmes, in association with Irish Hospice Foundation (IHF), are designed to impact on health, social and community systems and ultimately to enhance quality of life. They are rooted in contemporary bereavement scientific research and are designed against a policy and professional regulation backdrop.

For **MSc Loss & Bereavement**, applications are invited from a wide range of professional disciplines who wish to develop a deeper understanding of loss and grief at individual and societal level or whose work/volunteering roles involve the organisation of bereavement support in community, health or other areas of general bereavement care.

For **MSc Loss & Bereavement (Clinical Practice)**, applications are invited from mental health professionals such as counsellors, psychotherapists, psychologists, social worker bereavement coordinators and others who design and implement clinical bereavement interventions as part of their practice.

For further information please go to the Irish Hospice Foundation website **www.irishhospicefoundation.ie** Education and Training

Application is online only through the RCSI website (**www.rcsi.com**) For more information, email **jennifer.leech@hospicefoundation.ie**

Irish Cancer Society Nurses

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

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

Irish Nurses Rest Association

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

Please send applications to:
Ms Margaret Philbin, Rotunda Hospital, Dublin 1.
email: mphilbin@rotunda.ie

WIN

Don't forget to mention *WIN* when replying to advertisements

• **Next issue:** September 2021 • **Ad booking deadline:** Monday, August 23
• **Tel:** 01 271 0218 • **Email:** leon.ellison@medmedia.ie

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Milford Care Centre, Limerick

Serving the people of the Mid-West

Milford Care Centre, Limerick is currently inviting applications for the following positions:

CNM3 (SPECIALIST PALLIATIVE CARE COMMUNITY SERVICES)

Fixed-term contract for 1 year – 2 posts

The CNM3 Team will work with the ADON-Community Services in the overall management, co-ordination and supervision of patient care within a multidisciplinary setting, ensuring a high quality of patient care in a safe and caring environment. They manage the day-to-day activities of the Nursing Team in SPCCS and will be responsible for the co-ordination and management of activities and resources in a cost-effective manner. They will provide leadership and supervision of patient care and caseload management, ensuring high-quality and timely care in a safe and caring environment.

ESSENTIAL QUALIFICATIONS

Candidates must::

- Be registered on the General Register of Nurses as maintained by NMBI
- Have CNM2 level/CNS level or its equivalent
- Have a Post Graduate Qualification in Palliative Care
- Have 5 years' experience in palliative nursing
- Have the clinical, managerial and administrative experience to fulfil the role
- Demonstrate evidence of continuing professional development at the appropriate level

Informal enquiries on CNM3 to Jacqueline Holmes, ADON Community Services at Tel: 061 201773

DESIRABLE QUALIFICATIONS

Candidates must::

- Have a recordable post-registration course in management or be willing to undertake training as required
- Have an Information System and Technology skills or be willing to undertake training as required

REGISTERED GENERAL NURSES – PALLIATIVE CARE (INPATIENT UNIT)

(Creation of a panel)

It is essential that the successful candidate possess the following:

- Two Years' Postgraduate experience with an interest in Palliative care
- Postgraduate Qualification in Palliative Care (Or in the process of completing)

Informal enquiries on RGN to Sinead O'Sullivan, ADON Inpatient Services at Tel: 061-485855

Email your CV and cover letter by 12pm on July 16, 2021 to Declan Deegan, Head of HR, Milford Care Centre (**recruitment@milfordcarecentre.ie**)

HEALTH SERVICE EXECUTIVE – SAOLTA UNIVERSITY HEALTHCARE GROUP

Opportunities for Staff Midwives

Saolta University Health Care Group provides a comprehensive range of medical, surgical, paediatrics and obstetrics, and gynaecology services to emergency and elective patients on an inpatient, outpatient and day care basis across the West and North West of Ireland.

Portiuncula University Hospital has the following opportunity:

Staff Midwives

The successful candidate will join the maternity team in Portiuncula and provide day-to-day care in the maternity inpatient and outpatient services, neonatal and gynaecology service.

Informal enquiries are welcome: Deirdre Naughton and Ciara Brady. **Tel: +353 9096 246 88**. Website: **puhmaternity.ie**
Email: **deirdrep.naughton@hse.ie** Portiuncula University Hospital, Ballinasloe, Co Galway, Ireland.

Full details on this post and requirements available on **www.saolta.ie/jobs** or **www.hse.ie/jobs** or **www.puhmaternity.ie/work-with-us** and the Saolta LinkedIn page. Please forward your CV to **personnel.portiuncula@hse.ie**

"We are proud and honoured to offer maternity care to the women of the region at such an important time in their lives. In Portiuncula Maternity Unit, the values of care, compassion and commitment underpin our practice."

– Ms. Deirdre Naughton, Director of Midwifery, Portiuncula University Hospital

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mmatthysen@interhealthcanada.com

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