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WIN

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

World of Irish Nursing & Midwifery

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Gender pay gap must be closed

LATE last month the government issued its summer economic statement flagging its intentions for the October budget. In the budget lead up, nurses and midwives will be interested in whether the budget will include provisions to address low pay, improve job security, increase employment and correct the gender pay gap. How many times have you posed the question: is it because nursing and midwifery are predominantly female professions that their pay is the lowest of professional grades in the public service? I believe, based on all available research and evidence, that the answer is simply, yes.

The gender pay gap refers to the relative difference in average gross hourly earnings of women and men. The gender pay gap, which is 14.4% in Ireland (**www.genderpaygap.eu**), relates to several factors and needs to be understood in the context of economic, social and legal factors so that account is taken of the position of women in society.

Research shows that women are likely to work in jobs that undervalue their skills and training. It is a feature of nursing and midwifery that they are predominantly female professions. Occupational segregation like this can result in undervaluing of the occupation. Traditionally, caring responsibilities were, and in many instances remain, undervalued. When the level of education and skill in these professions improves, the occupational segregation, if ingrained in the relevant pay setting mechanisms, tends to remain. In a submission to the Gender Equality Division, the Chartered Institute of Personnel and Development Ireland called for the work of professionals (nurses) to be better valued and paid.

It is also a fact that women are the main providers of unpaid care. Women do more unpaid work than men and also take more career breaks, which reflects their disproportionate share of caring responsibilities and has consequences in the latter part of a woman's life. There is a lack of economic value placed on unpaid care across the system relating to raising children and caring for older parents or relatives. The high cost of childcare for nurses and midwives, coupled with the non-availability of childcare particularly for mandatory shift patterns/rosters (24 hours per day/365 days per year), influences the decision of nurses and midwives to work part time for significant periods of their working lives.

The gender pay gap also follows women into retirement, with women, on average retiring with half the superannuation of men. The gender pension gap in Ireland is a staggering 37% and the current state pension system punishes thousands of pensioners, mostly women, for having left the workforce to care for their families.

The 2015 European Institute for Gender Equality report states the EU pension gap average is 38% for the EU27. This is the gap between female and male pensioners aged between 65 and 79. The shortfall leaves women two and a half times more likely to retire in poverty than men and increasingly vulnerable to homelessness. Unfortunately, we know that most Irish female nurses/midwives retire without reaching full occupational pension benefit.

The gender pay gap is alive and well in Ireland. Equality legislation provides remedies based on individual rights: however, it has proven ineffectual in dealing with group claims. Therefore, collective bargaining mechanisms must be capable of correcting this embedded discrimination. The current Public Service Stability Agreement allows for such an opportunity, with robust protection against what have been termed 'knock-on claims'. This historical structural problem requires interventions designed to correct differences in real earnings over the career span to ensure the nursing and midwifery professions remain attractive so that well educated professionals can be recruited and retained in the health service to care for the growing needs of our population. This issue must be prioritised, and the state must lead the way.

Phil Ní Sheaghdha
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

Busy times

RECENT weeks have borne witness to mixed emotions: national exam season for over 120,000 students; the tragic deaths of several young Irish people; the result of the referendum marking historical change for women's choice in this country; the adoption scandal; the CervicalCheck controversy; and world leaders falling out, all against a backdrop of balmy summer weather. It has also been a busy time for the INMO and a snapshot of some recent events follows.

ICN Triad meeting in Geneva

I ATTENDED this meeting alongside Phil Ní Sheaghdha, INMO general secretary. The theme of the meeting was pay, recruitment and retention, working environments and student and novice nurses. Phil participated in a panel discussion regarding the issues of pay and nursing shortages. This presentation was received positively. James Buchan from the University of Technology in Sydney referenced OECD nursing figures which in Ireland are derived from the quarterly household survey. Phil set the record straight on the misleading nature of the OECD's nursing numbers in Ireland. The meeting was held over three days. Day one opened with a joint plenary session of the Triad – the ICN, the ICM and the WHO – which focused on building nursing and midwifery capacity in order to achieve the UNs sustainable development goals. Day two saw separately chaired sessions with the national nursing associations and the regulation and credentialing forums. INMO representatives attended the national nursing associations forum, which was moderated by Howard Catton, ICN nursing and health policy director. The Forum was opened by ICN president Annette Kennedy and ICN interim CEO, Thomas Kearns who gave an update on ICN work incorporating ICN strategic plans, programmes, events and policy work. On the third day, Lord Crisp of the Nursing now! campaign gave an overview of the programme's focus to raising the profile of nursing. He said that visibility is key to ensure investment in nursing and that the role of nursing and midwifery globally must be elevated and incorporated and included on national and international Health Policy Agendas. The key message was that collaboration and partnerships are the only way to strengthen nursing and midwifery. Ireland will now begin the process of endorsing and participating in the Nursing Now! campaign. This will require collaboration between the INMO and the Department of Health's chief nursing officer Siobhan O'Halloran. We will need local involvement of all members in this programme and hope to launch it in November 2018.

A very moving video was shown by the Korean Nurses Association which acknowledged two Austrian nurses, Marianne Stoeger and Margaritha Pissarek, who dedicated their lives to care for Leprosy patients and their families on the isolated Korean Island of Sorokdo. The Korean Nurses Association is seeking one million signatures on a petition nominating them for the Nobel Peace Prize. I urge all of you to watch the video and to sign the petition. To sign the petition visit: **http://mm.kna.or.kr/**

ICTU Women's Conference

THE ICTU Women's Conference was held in Enniskillen last month and was attended by a delegation of 11 INMO members. This was my second time to attend as president and it was Phil Ní Sheaghdha's first attendance as general secretary and her appointment was acknowledged in the closing remarks by Anne Speed, head of bargaining and representation of Northern Irish union UNISON. 'Better Work and Better Lives for Women Workers' was the agreed campaign for women in both the Republic of Ireland and Northern Ireland. The three themes of the campaign will be: the elimination of low pay; the promotion of decent work; and investment in work and infrastructure. The world of work holds particular challenges for women and these were debated across 21 motions, spanning the themes of pay, leave, inequalities, reproductive rights, violence, sexual harassment, automation, childcare, housing and pensions. I proposed and spoke on the INMO's motion on violence against women. All 21 motions debated were passed. For further information visit: **www.ictu.ie**

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

Quote of the month

"This union and its National Executive are on a journey, we will travel it well together. Have no regrets and make it count for the future generations of nurses and midwives"
- Martina Harkin-Kelly

Report from the Executive Council

FIRSTLY, I would like to thank the outgoing Executive 2016/18 for its hard work and commitment. The incoming Executive was in HQ for orientation on June 11 and 12 to ensure good governance and a smooth transition. The meeting was soon overtaken by the Public Service Stability Agreement. The recruitment and retention difficulties of the health service were prioritised for examination by the Public Service Pay Commission, which had committed to issue its findings in June. Within four weeks of this the Department of Public Expenditure and Reform was to conclude negotiations on the outcome of those deliberations. The Executive is now concerned that the Commission will not finalise its first module until July and emphasis seems to have shifted from heath service recruitment and retention to other public service pay agendas, which were not due to be dealt with within the lifetime of the agreement. The Executive released a statement, re-emphasising the strong message delivered by delegates at ADC – pay is the only game in town. Members have had enough. Therefore, the summer period will be busy with a July meeting and an additional meeting called in August to consider balloting members for industrial action unless the Commission confirms the link between pay and recruitment and retention and the government finally addresses the pay deficiencies for nurses and midwives. Last month we saw a clear demonstration of how financial settlements, like that awarded to consultants for unjust cuts, are the only remedy for recruitment and retention issues.

Get in touch

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INMO warns of 'winter of discontent'

Executive Council will consider action at extraordinary August meeting

THE newly elected INMO Executive Council is to convene an extraordinary Council meeting in August 2018, to consider progress on the Organisation's staffing and pay claims at that point.

Under the Public Service Stability Agreement (PSSA), the recruitment and retention difficulties of the health service were prioritised for examination by the Public Service Pay Commission. In a series of clarification letters, the INMO had been given commitments that the Pay Commission would issue its findings in June and that the Department of Public Expenditure and Reform would then, within four weeks, conclude negotiations on the outcome of those deliberations.

However, at its oral submission to the Pay Commission on May 15, the INMO was informed that the Commission's report on nursing/midwifery recruitment and retention difficulties would issue in July – a month later than originally indicated.

At its next meeting following this, the INMO Executive Council expressed concern that the Commission's first module would not be finalised until July, a month later than expected, and that the political system seems to have shifted emphasis from the problems of the health service to other pay agendas in the public service.

The frustration of the newly elected Executive Council was compounded by the fact that the health service failed to meet its targeted staffing number under the Funded Workforce Plan, agreed with the Organisation, for the year 2017 and, in spite of direct commitments from the Minister for Health, that the Department and the HSE, have failed to produce a Funded Workforce Plan for the year 2018 and only produced a first draft on May 31, 2018.

Additionally, in the draft shown to the INMO, the Department and the HSE have changed the method of counting student nurses, thereby giving the effect of double counting the students and creating the impression that recruitment was way ahead of what it actually is.

Phil Ní Sheaghdha: *"Members have had enough and this is the last chance for procedure to work"*

INMO general secretary Phil Ní Sheaghdha said: "The Public Service Stability Agreement is quite specific in giving priority to the urgent need to tackle the recruitment and retention issues facing the health services, and nurses and midwives are a priority in that regard. Hospitals are struggling to provide full services, with beds closed due to staff shortages, agency costs are spiralling out of control, and nurses are leaving because of the impact of over-work and poor work environments, which is causing burnout on a large scale across experienced nurses and midwives.

"Our Council is re-emphasising the strong message delivered by delegates to our recent conference through an emergency motion. It is patently obvious that you cannot treat these professions as second class citizens by leaving them as the lowest paid professional grade in the health service and working the longest hours among their peer group.

"This is the itch that successive governments have failed to scratch and our members are telling their Executive Council they have had enough and that this is the last chance for procedure to work. If the agreed procedures fail nursing and midwifery on this occasion, then our health service is certainly facing a winter of discontent".

It is expected that, when the Executive Council meets in August, it will consider balloting members for industrial action unless the Public Service Pay Commission confirms the link between pay and the difficulties of recruitment and retention, and government engages in addressing these pay deficiencies.

Consultants settlement a welcome indication of pay as remedy for recruitment issues

THE INMO welcomes the Consultant Settlement, reached recently as a clear demonstration that financial settlements are remedies for unjust cuts resulting in recruitment and retention difficulties.

The INMO, in its engagement with the Public Service Pay Commission, has made comprehensive written and oral submissions emphasising the urgent need to correct nursing and midwifery pay in order to stem the difficulties in retention and recruitment within the professions. The terms of reference of the Public Service Pay Commission requires it to conduct a comprehensive examination and analysis, taking into account the full range of causal factors underlying difficulties in recruitment and retention in nursing and midwifery. The Commission is also required to generate options for resolving the issues identified.

INMO general secretary Phil Ní Sheaghdha said: "The settlement with hospital consultants will undoubtedly and correctly improve the ability to recruit to this grade. This proactive approach must now be taken in respect of the anomaly in the pay of nurses and midwives which is affecting the ability to recruit and retain to these professional grades. Nurses and midwives are the lowest paid professional grade in the public service with a starting salary of €28,768.

"This settlement sets the tone for the dialogue which is required as part of the Public Service Stability Agreement, which prioritised medical and nursing/midwifery grades for consideration. These discussions are required to take place within four weeks of the Public Service Pay Commission issuing its report (now due in July) and the INMO looks forward to the discussions being approached in an equally positive way by government in the context of the consultants' settlement."

Serious concern at lack of funding for bed capacity and workforce plans

THE INMO met with Department of Health and HSE officials in early June in relation to the planned numbers of funded posts allocated for recruitment in the calendar year 2018 for the grades of nursing/midwifery.

These figures were due to be presented to the health service unions in November 2017, however at the meeting the HSE and the department were unable to comprehensively or with clarity set out the basis of the figures presented.

The unions sought a full and detailed account of the Funded Workforce Plan within 24 hours of the meeting and confirmation from the Department of Health that the practice of double counting student nurses since January 2018 would cease immediately. In addition, agreements in relation to growing the nursing/midwifery workforce brokered with the assistance of the Workplace Relations Commission in 2017 are not being honoured. The INMO also sought an emergency meeting with the Oireachtas Health Committee in relation to the lack of planning for workforce and capacity growth in the public health service.

INMO general secretary, Phil Ní Sheaghdha said: "The Funded Workforce Plan has been delayed by six months and is still incomplete, and our hospitals were more overcrowded in May 2018 than the same period in previous years. The Department of Health and the HSE have confirmed that they cannot commence negotiations on increasing bed numbers as set out in the capacity report by the government.

"While they accept additional nursing staff will be required to facilitate the opening of these beds, the draft plan presented had no allocation of funding for these posts. This poses real concern that a significant funding deficit exists and will negatively affect frontline services which could lead to a restriction of services rather than the required expansion to assist hospital overcrowding and reduce waiting lists."

INMO defends its record on safe staffing and skill mix

FOLLOWING "erroneous contentions" in an article by Susan Mitchell in the *Sunday Business Post* on June 10, 2018, the INMO wrote to the newspaper to set the record straight.

In response to an article entitled 'How self-interest kills off health reform', INMO general secretary Phil Ní Sheaghdha said: "To ignore the facts and research relating to nursing and midwifery staffing will have a considerable negative effect on Ireland's ability to expand the public health service as we now seek to increase capacity and expand services.

"The facts are that, during the financial crisis, the government cut the number of nurses and midwives working within the Irish healthcare system by 5,000. At the same time, from March 2009 to February 2018 the number of healthcare assistants (HCAs), care assistants and attendants working within the health service increased from 13,389 to 16,103"

Ms Ní Sheaghdha pointed out that in April 2018, the Minister launched the Safe Staffing Taskforce Report, which is a scientific and systematic exercise, led by Prof Jonathan Drennan in UCC. "This report demonstrates that if you stabilise the workforce, put in place an appropriate skill mix of 80% registered nurses and 20% healthcare assistants, you can reduce reliance on agency staff, improve patient care, improve staff satisfaction and significantly reduce adverse outcomes for patients, including reducing mortality.

"Misinformed opinion, peddling a line that lack of skill mix is the problem, ignores the evidence that skill mix has been a feature of the Irish public health service for decades. Nurses and HCAs work together as teams daily. Each has an important but different role within that team and work towards the same aim. It is a proven fact that patient outcomes are influenced positively by a skill mix determined by a recognised and proven scientific method such as that used in the nursing taskforce study. This results in better outcomes for patients; who could argue against that?

"There is no denying that there is a shortage of nurses and midwives in Ireland. This fact has been accepted by all political parties and by the Minister for Health and is confirmed by research. The issue is that recruitment and retention is a problem, as nursing and midwifery are the lowest paid health professions in Ireland."

She said the use of OECD figures to measure available nursing/midwifery staff is not reliable and, in fact, "masks the reality of a chronic shortage of nursing staff in our health services". The OECD records for Ireland are taken from samples obtained from the Quarterly National Household Survey (QNHS), which records any person with a nursing qualification, who may not be professionally active. On its figures, the OECD states: *"Nurses are defined as all 'practising' nurses providing direct health services to patients, including self-employed nurses. However, for some countries (France, Ireland, Italy, the Netherlands, Portugal, Slovakia, Turkey and the US), due to lack of comparable data, the figures correspond to 'professionally-active' nurses including nurses working in the health sector as managers, educators, researchers etc. For Austria and Greece, the data include only nurses working in hospitals. Midwives and nursing aides (who are not recognised as nurses) are normally excluded".*

The INMO understands that when the calculation in Ireland is undertaken the figures for midwifery are included. This means two professional grades are being compared to one across the European comparative states. The INMO has raised these concerns with the Department of Health and understands that dialogue with the OECD has commenced.

Ms Ní Sheaghdha concluded the letter to the *Sunday Business Post* by stating that: "Nurses and midwives continuously advocate for safe patient care, this includes correct skill mix. These concerns have been publicly raised and indeed many times resulted in industrial action seeking to secure safe staffing levels. If this is the vested interest we are accused of, then we wear that title with pride."

May trolley numbers at record high

Proactive planning essential to correct year-round overcrowding

RECORD levels of hospital overcrowding continued into the summer this year, confirming that overcrowding is an increasing problem year on year and a feature of patient care throughout the year.

INMO trolley/ward watch figures for May recorded the highest figure ever for this month, with 9,091 patients awaiting an inpatient bed *(see Table)*. The hospitals with the most trolleys recorded were University Hospital Limerick with 858, and Cork University Hospital with 826. During May, 92 children were also on trolleys waiting for a bed in the three Dublin children's hospitals.

The figures show an overall increase of 12% on the same period last year, May 2017 when there were 8,154 admitted patients awaiting a bed and 116% increase from May 2006 when there were 4,214 patients on trolleys. The figures confirm that Irish hospitals are constantly overcrowded, working above the safe occupancy level and that demand for emergency admissions, even in summer, continues to grow.

INMO general secretary Phil Ní Sheaghdha said: "The INMO is seeking a total re-look at the national planning process and particularly the Winter Initiative, as solutions to this constant and worsening crisis cannot wait for a funding injection in late November or January when the escalating problems are out of control.

"We live in a society which expects a long wait, and a lack of privacy and dignity when attending EDs. This is not acceptable! It is a basic human right that a person deemed as requiring hospital admission is admitted to a suitable bed which is appropriately staffed.

"Complacency must be replaced with proactive planning, aimed at correcting, not simply reducing, the numbers to make it look somewhat better. In line with the HIQA recommendations of 2012, the aim must be: patients never have to experience care on corridors and inappropriate spaces in EDs. These HIQA recommendations are like a fairy-tale, considering the worsening problems with overcrowding since its report".

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

Hospital	May 2006	May 2007	May 2008	May 2009	May 2010	May 2011	May 2012	May 2013	May 2014	May 2015	May 2016	May 2017	May 2018
Beaumont Hospital	324	559	733	601	638	622	722	453	341	782	535	269	373
Connolly Hospital, Blanchardstown	189	126	161	201	214	398	416	568	499	382	215	223	338
Mater Hospital	366	507	467	270	483	345	449	323	223	497	371	533	445
Naas General Hospital	218	113	75	358	215	524	116	152	218	138	218	288	329
St Colmcille's Hospital	59	96	22	179	226	115	189	139	n/a	n/a	n/a	n/a	n/a
St James's Hospital	53	79	110	139	35	151	121	190	83	258	92	176	150
St Vincent's University Hospital	314	552	504	340	538	599	354	462	116	427	194	188	361
Tallaght Hospital	293	323	352	591	527	566	223	489	363	325	337	476	532
Eastern total	**1,816**	**2,355**	**2,424**	**2,679**	**2,876**	**3,320**	**2,590**	**2,776**	**1,843**	**2,809**	**1,962**	**2,153**	**2,528**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	4	10	93	101
Cavan General Hospital	174	199	156	71	165	446	318	126	68	38	48	46	56
Cork University Hospital	434	393	341	212	629	653	444	353	400	454	397	401	826
Letterkenny General Hospital	204	26	33	15	22	38	56	59	334	93	38	507	310
Louth County Hospital	10	0	0	6	2	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo University Hospital	192	36	111	77	123	65	90	128	191	64	211	109	50
Mercy University Hospital, Cork	129	65	145	40	93	138	160	183	140	253	175	326	210
Mid Western Regional Hospital, Ennis	33	61	12	113	54	1	6	30	n/a	3	7	15	5
Midland Regional Hospital, Mullingar	10	7	8	23	134	171	242	389	309	435	445	341	390
Midland Regional Hospital, Portlaoise	35	21	31	9	11	178	33	56	212	167	307	287	284
Midland Regional Hospital, Tullamore	0	14	2	2	65	220	95	130	426	116	448	420	598
Monaghan General Hospital	25	35	16	7	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nenagh General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	0	9	3	3
Our Lady of Lourdes Hospital, Drogheda	297	270	196	160	172	649	683	272	375	718	451	219	138
Our Lady's Hospital, Navan	17	50	9	118	17	137	25	109	23	42	50	139	127
Portiuncula Hospital	42	8	27	0	97	66	40	58	23	101	19	87	31
Roscommon County Hospital	9	66	46	58	48	84	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sligo University Hospital	47	76	40	0	152	54	237	101	162	245	180	132	377
South Tipperary General Hospital	40	27	45	55	75	27	184	321	161	223	448	397	472
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	n/a	34	23	159	77	297	159	404	356
University Hospital Galway	154	209	218	186	378	510	493	282	410	524	349	671	637
University Hospital Kerry	102	20	33	11	38	56	26	42	77	169	85	234	272
University Hospital Limerick	112	98	80	181	233	193	263	755	502	538	592	627	858
University Hospital Waterford	n/a	n/a	40	13	147	129	124	221	83	357	195	412	329
Wexford General Hospital	332	15	151	194	212	222	56	137	75	63	42	131	133
Country total	**2,398**	**1,696**	**1,740**	**1,551**	**2,867**	**4,071**	**3,598**	**3,911**	**4,048**	**4,904**	**4,665**	**6,001**	**6,563**
NATIONAL TOTAL	**4,214**	**4,051**	**4,164**	**4,230**	**5,743**	**7,391**	**6,188**	**6,687**	**5,891**	**7,713**	**6,627**	**8,154**	**9,091**

Comparison with total figure only:

Increase between 2017 and 2018: 12%
Increase between 2016 and 2018: 37%
Increase between 2015 and 2018: 18%
Increase between 2014 and 2018: 54%

Increase between 2013 and 2018: 36%
Increase between 2012 and 2018: 47%
Increase between 2011 and 2018: 23%
Increase between 2010 and 2018: 58%

Increase between 2009 and 2018: 115%
Increase between 2008 and 2018: 118%
Increase between 2007 and 2018: 124%
Increase between 2006 and 2018: 116%

Tony Fitzpatrick reports on issues discussed at the latest National Joint Council forum

The National Joint Council (NJC) is the primary forum for the management of industrial relations in the health service. The NJC meets every two months when the staff panel and senior managers within the HSE and Section 38 organisations address national matters and local issues that require national input.

The INMO plays a pivotal part on the NJC staff panel, which also includes SIPTU, FORSA, IMO, MLSA, Connect and Unite. The purpose of the staff panel is to use the collective might of all the unions involved to work as one on behalf of all our members within the health sector. The most recent meeting of the National Joint Council took place on May 22, 2018. I have written to NJC chair seeking to progress a number of matters raised in that forum. I highlighted the INMO's dissatisfaction with the failure of management to follow up matters agreed for action at the NJC. In order to progress matters quickly, the chair has set out actions on which the HSE must follow up, which are outlined below.

Over payment and use of annual leave

A meeting to discuss over payment and use of annual leave arranged for June 19, 2018 was postponed by management and is to be rearranged.

Pension matters

At a meeting on outstanding pension matters on May 21, 2018, management committed to reverting within a week with several clarifications, particularly in relation to pensionable allowances.

Fixed travel and subsistence

Management committed to providing an updated proposal document around the issue of fixed travel/subsistence within one week, this remains outstanding. A further meeting date is arranged for early July however, we still await the updated proposal document.

Joint declaration on lifelong learning

The working group set up to implement the Joint Declaration on lifelong learning/CPD was due to meet, under the chairmanship of Ray McGee, former chair of the Labour Court, on June 20. However, the staff panel is concerned at the delay to date, considering the HSE signed up to the Joint Declaration in November 2016.

Compassionate leave

Talks on the claim for application to the health service of the civil service circular issued in January 2017, which substantially increased the level of compassionate leave available to civil servants, was due to go back to the WRC on June 26, 2018. An update will follow in the next issue of *WIN*.

Ballincollig CNU

A meeting on insourcing/outsourcing at Ballincollig CNU took place locally, chaired by Anna Perry of the HSOB and chair of the NJC. Management is required to provide detailed documentation to the union side. Further local engagement is to take place once this outstanding documentation is received. The INMO has corresponded locally with management and outlined its disappointment that the agreed documentation has not been forthcoming as yet.

S38 on-call in ID

A meeting has taken place involving CERS, Section 38 Organisations, INMO, SIPTU and FORSA on on-call in intellectual disability services, as per Labour Court recommendation 21437. A further meeting took place on June 13.

Cath labs

At a meeting on several issues of concern to Cath labs on June 15, the HSE distributed a spreadsheet which was incomplete and inaccurate. The INMO has sought standardisation of terms and conditions for out of hours services and a review of staffing. This matter is to be referred to the WRC.

SATU nurses

The INMO indicated that it was referring matters of concern to nurses working in sexual assault treatment units to the WRC. However, further to a request from the Department of Health and the HSE, the INMO agreed to a further meeting to continue discussions, which will take place on July 11, 2018

South Tipperary

The Labour Court recommendation on the staffing framework at South Tipperary General Hospital is over one year in existence and the INMO awaits a meeting, involving management. Requesting an urgent date for the meeting, the INMO indicated that the delay is unacceptable.

Injury allowance

An individual adjudication case has been resolved on the non-application of the injury allowance at St Michael's House. However, the principle of the application of the injury allowance to staff working within Section 38 organisations who have been injured in the course of their work, but not by an assault, remains outstanding. A meeting took place on June 13, however matters remain unresolved. While the Section 38 organisations are currently doing a costing exercise for the Department of Health, the unions intend to refer the matter to the WRC.

SAP

Management was to issue clarification on non-consultation on SAP and that clarification is still awaited by the staff panel, since March. The INMO has requested immediate receipt of this.

Policy and procedure protocol

Discussion took place involving CERS and the staff panel. The staff panel are dissatisfied with one paragraph still contained within the protocol. A new draft is to issue from CERS regarding same.

Staff mobility

Management highlighted at the last NJC that due to the IBEC official being on sick leave, there was a delay on the inclusion of voluntary organisations in the staff mobility/transfer panel. Management is due to clarify the situation.

National ambulance service

Management was to convene a direct meeting with SIPTU.

Beaumont

Management is to follow up on Beaumont adjudication and revert to the INMO.

Outsourcing

CERS is to follow up outsourcing at Cavan laundry and Mater Hospital CSSD and revert to SIPTU directly with regards to convening separate meetings.

Storm Ophelia/Emma

HSE circular 017/2018 was issued on June 6, 2018, which outlined the agreement reached on Storm Ophelia and Storm Emma. A further meeting is to be organised with regards to a protocol for future weather alert events.

– Tony Fitzpatrick, interim director of industrial relations

INMO presses for HSE to comply with ED Agreement

FURTHER to the continuing intolerable working conditions in emergency departments around the country, INMO officials attended negotiations chaired by the Workplace Relations Commission on June 8, 2018.

The INMO team highlighted the significant difficulties within EDs, and indeed across the acute and continuing care system, with regards to the management of patient flow within hospitals. The INMO also highlighted the significant components of the WRC agreement that HSE management is not complying with. Issues raised included:

- Non-filling of ED vacancies
- Non-recruitment of additional staff to care for admitted patients
- Requirement to recruit additional CNM2s to care for admitted patients
- Ensuring job descriptions for the CNM2 for admitted patients and the ADON for patient flow were complied with for those deployed to these roles
- The manipulation of figures by the HSE so as to return a trolley count that is lower than the actual count
- Non-compliance with agreed escalation policy.

ED agreement oversight meeting: *At the WRC conciliation conference on the ED Agreement were (l-r): Joe Hoolan, IRO; Tony Fitzpatrick, interim director of industrial relations; and Philip McAnenly, IRO*

The INMO also pointed out that the HSE/Department of Health representation at the WRC meeting was inadequate to address the Organisation's many concerns. It was therefore agreed the parties would reconvene at the WRC for conciliation within three weeks (due to take place on June 27).

The INMO also highlighted to the HSE and the Department of Health that currently ED staff are somewhat frustrated and that members in some departments are seeking permission to ballot due to management non-compliance with the WRC Agreement of January 2016. The INMO expects the HSE and the Department of Health to present appropriate solutions to these ongoing difficulties at conciliation on June 27. The INMO is also awaiting the calculations on the recalibration of figures that indicate the number of staff required to care for admitted patients.

The INMO highlighted that in particular hospitals, the level of acquiescence and even fatalism in the face of overcrowding continues to put the health, safety and wellbeing of nursing staff in EDs at risk and that significant risks continue to exist for patients.

–Tony Fitzpatrick, director of industrial relations

ICTU motion on violence against women

AN INMO delegation attended the ICTU Women's Conference in Enniskillen on June 13-14, at which the INMO motion on violence against women was passed. Proposing the motion, INMO president Martina Harkin-Kelly said: "Ending violence against women is a necessary precursor to achieving the full participation of women within our society, and to ensure the achievement of equality for women."

Recognising that women are disproportionately burdened by violence in this country, she called on the ICTU to continue its important advocacy work to ensure governmental support for the adoption of an ILO Convention on 'Violence and harassment against women and men in the world of work'.

Pictured at the ICTU Women's Conference were (l-r): Kay Garvey, Mary Rose Carroll, Martina Harkin-Kelly, INMO president; Phil Ní Sheaghdha, INMO general secretary; Karen Eccles (seated);Helen Butler; Eileen Lawrence; Marian Spelman; Josephine Ubas and Emma Morake

The motion called for appropriate workplace policies to ensure zero tolerance of violence, while ensuring no losses are suffered by those injured through violence in the workplace.

World news

Nurses and midwives in action around the world

Australia

- New mums under pressure with significant midwife shortage in hospitals
- Spat on, choked and threatened with razor blades: Shocking footage shows how Australia's nurses are being treated 'like punching bags' by violent patients

Canada

- Hiring of nurses isn't keeping pace with Quebec's greying demographic

India

- Kerala nurses to be taken back

Panama

- Lack of doctors and nurses is aggravated in regions of Panama

Philippine

- Nurses group seeks salary hike

Portugal

- Hospitals only replace half of the nurses that leave
- Union of Portuguese Nurses protest outside Guarda Hospital emergency room

Slovenia

- Nurses demand immediate action in face of lack of staff

UK

- Patient experience tool highlights nurse staffing as factor
- The UK health tax hurting foreign nurses
- New NHS safety body 'must avoid blaming individual nurses'
- NHS Tayside 'very worrying' as more staff leaving than joining

US

- Fight for mandated nurse-to-patient ratios heats up
- California nurses move closer to strike

Young workers forego food for rent

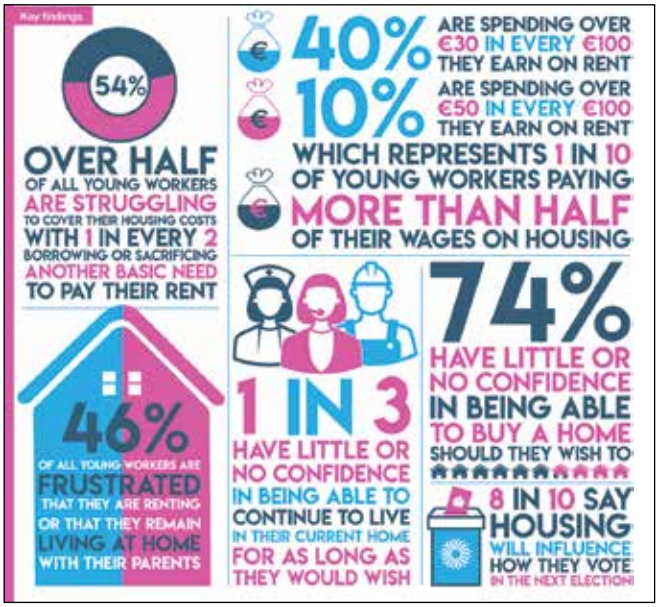
ONE in two young workers are struggling to cover their housing costs and are going without meals and other essentials to pay their rent, according to a new survey from the Irish Congress of Trade Unions.

The national opinion poll of 1,500 trade union members under the age of 34 on their housing costs was conducted online from June 1-14, 2018. The survey was carried out by Congress ahead of the Labour Employer Economic Forum (LEEF) discussions between government, union and employer representatives on housing.

Congress recognises the significant and unacceptable impact of our broken housing system on vulnerable individuals and families with young children experiencing homelessness and is continuing to lobby TDs to commit to adopting the Congress Charter for Housing Rights, which sets out key principles on the creation of a secure and sustainable housing system, including: declaring a housing emergency, establishing a legal right to housing, guaranteeing tenants' rights, preventing evictions into homelessness, and developing a national land use policy.

"This particular piece of research focused on the impact of the housing crisis on a generation of people who are sandwiched between high housing costs and low wages, to allow us take a detailed look behind snappy terms such as 'generation rent' and 'delayed adulthood'," said Congress social policy officer Dr Laura Bambrick.

Congress general secretary Patricia King said: "The findings are worse than feared. Lives are being damaged and destroyed and a whole generation of young workers are now feeling alarming levels of frustration, insecurity and despondency with their housing situation. We are badly failing our young people.



"Congress will use these stark findings to continue to put pressure on government to take action through our ongoing housing campaign and in the upcoming social dialogue with ministers and employers".

Dave Hughes warns members against tolerating unsafe, stressful and problematic workplaces

Workplace safety and health should be top of employers' agenda

SUCCESSFUL management of workplace safety and health is good for workers, business and society as a whole. With the pressures and demands on the modern workplace, particularly in our health services, it is often easy to lose sight of the importance of occupational safety and health and dismiss it as a burden or impediment to getting the work done.

However, the European 2020 Strategy points out, a safe and healthy working environment is crucial to enhancing the potential and commitment of the workforce in delivery of services. The INMO in recent agreements on emergency departments and then in respect of recruitment and retention insisted that nurses be given the right to actively engage in making workplaces more safe and healthy through elected representatives being given the time and facilities to highlight and enforce basic safety, health and welfare legislation.

Mary Leahy, former INMO first vice president, is the Organisation's national safety, health and welfare at work elected representative. She has commenced the mammoth task of trying to ensure that each workplace – that means each ward and each emergency department – has an elected safety rep who is given required rights under the national Safety, Health and Welfare legislation.

Why is safety, health and welfare such an important issue? The two most common causes of absence for workers generally, and nurses and midwives specifically, are musculoskeletal injuries and stress arising from psychosocial risks. Studies reported in the European publication *Healthy Workplaces* suggest that 50-60% of all lost working days can be attributed to work-related stress and psychosocial risks. It rates as the second most frequently reported work-related health problem in Europe, the first being musculoskeletal disorders.

Research indicates that psychological risks and work-related stress give rise to significant costs for organisations and national economies alike. In general, workers are likely to take a significant amount of time off work when suffering from work-related stress and other psychosocial problems.

It is also common for workers to turn up for work when they are not able to function at full capacity. This is known as presenteeism. The total cost of mental health disorders in Europe, both work and non-work related, is estimated to be €240 billion per year. There is, therefore, reason for the European Union to promote healthy workplaces and at a European level both the HSE and the INMO, have agreed to work together promoting safety, health and welfare in our Irish health system.

But for all the research and all the good policies and practices which are emanating in Europe they matter little unless they are delivered at the local level in our wards, our EDs and our community services. Evidence shows that the workplaces most radically changed by the introduction of safety health and welfare legislation are those where the workers themselves have actively promoted their right to safe work places.

The evidence of this can be seen in the transport sector, the construction sector, telecommunications and electricity supply industries, where practices and procedure have changed beyond all recognition following active involvement of employees in those sectors in the promotion of their own safety, health and welfare at work.

There is a general lack of consciousness and awareness among workers across many sectors about their rights and entitlements to a safe workplace. Elected safety, health and welfare representatives have rights in legislation but they do not carry responsibility in respect of a safe workplace any more than any other employee whom they represent. Their role is to promote safety, health and welfare in the workplace and their employer is obliged to facilitate the necessary time and appropriate response to the concerns they raise.

Safety, health and welfare reps can, for example, carry out workplace audits and raise the findings with the relevant managers. This places an obligation on the manager to put in place mitigating measures to reduce the highlighted risks. Failure to do so is, in fact, a breach of law.

It is essential that the INMO branches and sections elect safety, health and welfare representatives now. Many of the problems highlighted by nurses and midwives in respect of staffing, in fact have implications for the safety, health and welfare of the nurses and midwives in those very services. The focus needs to shift and if it does, by focusing on a safe workplace for the nurses and midwives, patient care itself will improve.

Arguably tolerance is the enemy to safe workplaces. We must, therefore, become less tolerant to unacceptable, stressful and problematic workplaces and we must treat the personal safety, health and welfare of our nurses and midwives as a priority.

Safe Practice Workshop: *INMO members at a Safe Practice Workshop at the National Rehabilitation Hospital, Dun Laoghaire, with INMO IRO Philip McAnenly (front left)*

Update

- **Expansion of UHL dialysis services:** The INMO has written to management at the University Hospital Limerick requesting early engagement on the proposed expansion of dialysis services. A longstanding claim for loss of earnings following removal of night duty and Sunday premium hours in the unit was due to be heard at the WRC on June 19, as management reneged on the clause under the Public Service Agreements to compensate for loss of earnings.
- **Bon Secours, Limerick:** The INMO made repeated requests without any response in May to local management at Bon Secours Hospital Limerick for a meeting to review the financial situation of the company following an agreement brokered last year to realign the pay scales of all staff there with that of the overall Bon Secours Group. Additionally the INMO requires agreement with the company on the terms within the employee handbook and alignment of same to the group, including agreement on sick pay and maternity pay. Following formal correspondence citing a referral to the Workplace Relations Commission, management recently confirmed that a local meeting will take place.

– Mary Fogarty, INMO IRO

Tipperary dispute on hold

98% vote in favour of action for more nursing staff

FOLLOWING confirmation from the HSE that it will proceed to a local recruitment campaign for nurses, the INMO has withheld serving notice of industrial action in St Patrick's Hospital, Cashel and St Anthony's Unit, Clonmel. In tandem with this commitment management will fill current sick leave vacancies via agency nurses when available.

The INMO has in return agreed to enter local discussions on a review and alignment of rosters to the required nurse staffing levels which is expected to be completed by the end of July. The HSE has given assurances that any deficits identified as a result of the review will be progressed in favour of permanent nurse positions, clerical cover and supervisory time for all CNMs.

Mary Fogarty, INMO IRO: *"INMO members were forced into this dispute to protect the frail and elderly patient population"*

This followed a vote by 98% of members working in the two facilities in favour of industrial action, up to and including a full withdrawal of nurses unless HSE management in CHO Area 5 took the nurse vacancies seriously and put an actionable plan in place to alleviate risks for all the residents.

As previously reported, the INMO had attended meetings in recent months where nurses detailed to management their inability to provide acceptable standards of care to vulnerable patients and pleaded for additional nurses.

INMO IRO Mary Fogarty said: "INMO members were forced into this dispute, which is not for themselves but for their patient population who are elderly, frail and vulnerable. Nurses have a duty to advocate to the HSE on their behalf. The current nurse staffing levels are inadequate across all shifts."

Need for improved health promotion for people with intellectual disability

At a meeting with fourth year intellectual disability nursing student interns and clinical placement coordinators at Moore Abbey, Monasterevin, Co Kildare, the group had a constructive discussion on the specialist role of the RNID.

Stating that the INMO is committed to supporting RNIDs in promoting and developing their profession, INMO student/new graduate officer, Neal Donohue said: "Taking account of the health risks and the need for improved health promotion for people with an intellectual disability, RNIDs must remain in central co-ordinating roles and specialist roles with clearer professional boundaries to ensure that care provided is safe and equitable."

Pictured with Neal Donohue (back, left) are: Lisa Scully, Gaby Joyce, Aoife Clare, Orla Mahon, Michael Flynn, Rebecca Copeland, Emma Rachel Carragy, David Magee, Aislinn Keane, and clinical placement co-ordinators, Sharon Phelan and Kate Meredith

INMO ensuring contract continuity as Mater Private changes ownership

FOLLOWING the recent announcement that the Mater Private Hospital Group is likely to be sold to a French company, the INMO is seeking a meeting with the employer to ensure that all matters relating to contracts of employment, pensions and working conditions will remain unaffected by this change of ownership.

It is expected that, subject to the approval of the Competition Authority, the sale of the Mater Private Hospital will be concluded by the end of August 2018.

Albert Murphy, INMO IRO

Ongoing disputes with hospital management

Meanwhile the INMO is in dispute with the hospital in relation to the non-implementation of the HSE Circular regarding the 'Storm Emma' extreme weather event.

The hospital has a clear link with HSE terms and conditions and this is provided in the analogous Haddington Road Agreement between the Mater Private and the trade unions.

In addition, the INMO is in dispute with the hospital regarding premium payments in relation to the cathlab at the hospital.

The two issues were due to be heard at the Workplace Relations Commission in late June.

– Albert Murphy, INMO IRO

INMO reps the key to a dynamic union

In order to build a dynamic and lively union, the INMO depends on its members in all settings to become more active. The Organisation strongly urges members who have an interest in becoming a rep to avail of the basic and advanced rep training courses on offer regularly around the country. Further training courses will take place on September 11-12 in the INMO Cork office. If you are interested in attending any of the INMO training courses please contact Martina Dunne at email: martina.dunne@inmo.ie or Tel: 01-6640624. According to Albert Murphy, INMO organiser: "The interest in becoming a rep at local level is growing and will lead to active engagement at workplace level."

A group of 12 new workplace reps attended the INMO rep training course in Cork last month. Pictured are: (back row, l-r) Liam Conway, IRO; Elaine Watkins; Patricia King; Bernadette Meade; Helen Norton; Kate O'Brien; Roslyn Garde; and Dave Hughes, INMO deputy general secretary; (front row) Michelle O'Donovan; Una Cott; Louise McHugh; Jennifer Rea; and Rebecca Amosu

Agreement on physical assault scheme

THE INMO has reached agreement with the HSE with regard to a member based in the north east, who had applied for payment under the Serious Physical Assault Scheme.

The member was assaulted at work and sustained a serious injury as a result. Originally, the member was only being paid under the scheme for core hours worked as part of the substantive reduced-hours contract.

However, the member had worked an additional number of hours regularly to accommodate the service, and it was these hours for which the agreement was reached.

INMO IRO Noel Treanor said: "This is a commonsense agreement, as the member regularly worked these hours, with the full knowledge and at the request of the employer, the HSE. It would have been unreasonable for the member to be financially penalised as a result of an injury sustained, following an assault in the workplace."

The agreement is being backdated to the date of commencement of application of the scheme.

Nurse shot dead in Gaza while aiding injured

RAZAN al-Najjar, a 21-year-old nurse, was killed in Gaza during protests last month. She was trying to help an injured protester near the border fence when witnesses say she was shot by Israeli soldiers.

UN officials and agencies expressed their outrage at the murder of Ms al-Najjar, who was carrying out her humanitarian duties as a first responder when she was shot.

"Healthcare workers must be allowed to perform their duties without fear of death or injury. The killing of a clearly-identified medical staffer by security forces during a demonstration is particularly reprehensible," said UN humanitarian co-ordinator Jamie McGoldrick.

As a volunteer emergency medical worker, Ms al-Najjar wanted to prove that women had a role to play in the conservative Palestinian society of Gaza.

General secretary Phil Ní Sheaghdha has written to colleague associations to offer condolences on behalf of the INMO.

Mental health focus for TT Section

Pictured(l-r) at the recent telephone triage section meeting in Limerick: Mairead Murphy, clinical nurse specialist, CAMHS; Carmel Murphy, chairperson, INMO Telephone Triage Section; and Stephanie Quinn, psychiatric nurse, CAMHS

Also pictured with Carmel, Mairead and Stephanie were: Hazel James, vice chairperson Telephone Triage Section; and Geraldine Byrne, secretary Telephone Triage Section

THE Telephone Triage Section recently held a three-hour educational morning on the subject of mental health. We met in the South Court hotel in Limerick where we had four speakers from the psychiatric speciality of nursing.

This educational component was an add-on to our Section meeting which is held three times a year. There were 25 nurses in attendance, firstly at the Section meeting and, following this, for the presentations on mental health

Mairead Murphy CNS and Stephanie Quinn RPN discussed the role of the Child and Adolescent Mental Health Services (CAMHS) in the children and adolescent mental health area. They advised us on the services available and how these services are accessed, especially in the out of hours setting, which is relevant to the telephone triage area. It was a very comprehensive and informative talk.

Pauline Walsh CNS in crisis intervention gave two presentations – the first was the triaging and assessing of the mental health patient. It was exceptionally accurate and relevant to the nurses in the Telephone Triage Section, very few speakers fully understand the workings of telephone triage and Pauline had it down to a tee.

Pauline also gave a presentation on postnatal depression in which she has a particular interest and knowledge. It remains a subject that many are reluctant to discuss and we, as triage nurses, felt was a very useful talk on this subject. We feel there are symptoms that we may be more alert to in the future following the presentation.

Mark Johnston is a CNS in the Co Clare area and an authorised officer, gave us a talk on the assessment and treatment of crisis patients who may require involuntary admissions. He outlined the objectives and criteria for assisted admission and the forms used etc. It was a very informative and interesting presentation.

Many thanks to all the speakers and to John Lyons in the psychiatric services who organised the speakers for us.

We finished off with lunch and an active discussion between the nurses from the various services who were in attendance from around the country.

Our next meeting is our annual day of health presentations which are geared towards the Telephone Triage Section and the triaging of patients over the phone in the out-of-hours setting. The subjects this year include ophthalmics, ambulance and the role of GPs, sepsis, system review, continuity and consistency of care and Lyme disease.

We are still finalising the programme which will be featured in a future issue of *WIN*, but the meeting will take place in the new Richmond building on October 3, all are welcome.

Carmel Murphy is chairperson of the Telephone Triage Section and a telephone triage nurse in Shannondoc in Limerick

Successful meeting for Third Level Student Health Section

The INMO Third Level Student Health nurses section held a very successful and well attended meeting last month in INMO HQ. A number of guest speakers attended the day and the topics covered included: epilepsy with Sinead Murphy CNS from Beaumont; GPDP with Aisling Malone; and finally a relaxing session on mindfulness with Carmel Sheridan which finished off the educational sessions.

The Section also held a meeting, with an update from ADC and a catch up on official business. The next meeting of the Section is planned for November 16, in INMO HQ.

See Diary *page 58* for details on upcoming section meetings and conferences

Dublin set to host FOHNEU board meeting in November

FOHNEU will host its 48th board meeting later this year in INMO HQ in Dublin on November 14-16.

FOHNEU is a non-profit making organisation representing the largest single group of professionals in the field of occupational health.

Margaret Morrissey, INMO Occupational Health Nurses Section member and FOHNEU treasurer, and Una Feeney, Irish board member of FOHNEU will be in attendance alongside the national representatives from the other member states within the EU.

FOHNEU's aims include:

- To contribute to the total health, safety and wellbeing of the EU working population
- To raise the profile of occupational health nursing within the EU
- To promote training, education and standards of professional qualifications
- To encourage research into areas of occupational health practice, education and management with publication of the results
- To maintain an open dialogue with the EU organisations responsible for health and safety, public health and EU nursing authorities.

Preparing for a full FTP hearing

Edward Mathews continues his series of articles focusing on the fitness to practise process, this month discussing a full inquiry

THIS article continues our consideration of the fitness to practise (FTP) process for nurses and midwives. In the last instalment, we examined the procedures and process associated with the Preliminary Proceedings Committee (PPC), and now we turn to consider what happens where a full inquiry into your fitness to practise takes place.

If the PPC forms a view that the complaint should be subject to a full investigation, or if the Board directs an inquiry, then a referral to the FTP committee will be made under section 61 of the Nurses and Midwives Act 2011. The basis for this complaint can be the subject matter of the original complaint, or can contain other grounds that have come to the attention of the Committee during the course of considering the original complaint.

Preparing the case

The Board must inform the registrant within 30 days of the complaint being referred to the FTP committee that such referral has been made, that the registrant will be afforded an opportunity to attend and defend themselves, and notice that the registrant may make an application for all or part of the hearing not to take place in public.

At this stage the CEO of the NMBI takes over the process, and will, through her legal representatives, commence preparation of the case against the registrant. This includes drawing up a notice of inquiry, gathering documentary evidence and gathering witness statements. At some stage following onward referral of the complaint, the CEO's team will generally try to agree dates for a hearing with the parties. It is impossible to foresee the timeframe between a complaint being referred to inquiry by the PPC and the date of the inquiry. The best we can say is that it is likely to take a minimum of a year, and in some cases there have been delays of three to four years, though it is hoped that these types of delays will no longer occur.

The CEO's team will prepare a notice of inquiry and a book of evidence that will make up the case against the registrant. The notice of inquiry is a legal document that sets out the specific allegations against the registrant, and formally notifies them of the place, date and time of the inquiry and finally advises which witnesses the CEO intends to call.

The allegations may be the same as the original complaint but can be worded differently, often containing additional allegations which may be supported by evidence uncovered by the CEO's legal team while preparing the case.

The CEO's team will also procure documentary evidence relating to the complaint which often includes: patient files; disciplinary files; workplace statements which have been made; documents prepared by managers; any internal reports into matters being considered; documents relating to criminal prosecutions; training records; and any other materials they consider relevant.

These will be sought from your employer – or others who hold the records – and if they fail to comply with a request for the production of the documents then the CEO will apply to the FTP committee pursuant to section 64 of the Act for an Order compelling production of the documents. Failure to comply with such an order is an offence punishable by a fine up to €5,000. In addition, the CEO will seek permission from you to obtain a copy of your HR file, and, if relevant to the allegations against you, also a copy of your GP or other medical/counselling records. The CEO requires your consent for these records, however, if your consent is not provided the CEO can seek an order from the FTP committee and is likely to obtain them in any event.

The last step in preparing the case will involve taking witness statements from the witnesses the CEO intends to call to give evidence.

The procedures of the FTP committee state that the CEO will seek to send the notice of inquiry and a book of documents comprising all the material they have gathered in preparing the case to the registrant six weeks before the hearing date. At that stage we should know all the evidence that the CEO intends to rely on in attempting to prove the allegations set out in the notice of inquiry, so my office then meets with you to start preparing your defence.

Defence

In preparing your defence we consider first the notice of inquiry and, in relation to each allegation, we first consider whether you accept the facts of the allegation, ie. that they are true and, if so, if it is an allegation of professional misconduct or poor professional performance, whether you accept that the conduct rose to the threshold for these two types of violation. Having considered those points, we have a better sense of your position in relation to the case. We also consider in detail the evidence that is to be presented by the CEO, what evidence we accept or contest, what your position is in relation to the evidence, what points we will make to the witnesses for the CEO and, finally, what your evidence will be.

The hearing

This should lead us up to the day of the hearing, however, as the preparation of the case is ongoing, there will be opportunities for us to make and respond to preliminary applications in relation to the case. The main application we will consider making

is an application that the hearing, or part of it, take place otherwise than in public. In the next article we will consider how applications for privacy are dealt with in more detail but for the moment I will note that section 63(3) provides that all hearings shall be in public, except where the Committee decides otherwise.

On the day of the hearing you will meet with me and our team approximately an hour before the hearing, which generally takes place in the NMBI building. During that time, we will discuss any last minute matters relating to the hearing and show you the room where the hearing will take place. In general, the hearing takes place in a boardroom type setting.

The panel

The panel will consist of five members of the fitness to practise committee, at least one of whom will be a nurse or midwife, and they will be assisted by a legal assessor. The legal assessor is a practising lawyer, generally a Barrister, who sits with the committee and provides legal advice to them when requested to do so. Of their own initiative, they may provide advice on a matter that has arisen which they believe the committee should receive advice on.

The assessor may also advise the committee during its private deliberations, however, any such advice is disclosed to both parties who can make submissions in relation to the advice. At the conclusion of the hearing, the assessor generally advises the committee in relation to its duties, however, they do not participate in the deliberations on the outcome of the case. The committee is free at any stage to disregard the advice of the assessor. A stenographer will take a detailed note of proceedings that will be available to those present at the hearing at a later date.

The committee and the assessor sit at a table at the top of the room and in front of them, to either side, sit the CEO's representative who presents the case against the registrant. The registrant and their representative are opposite. In the middle, in front of the committee there is a table where witnesses sit while they are being questioned. Off to the side there is a public gallery where members of the media and public may sit. Unless the hearing is being heard in private, which is the exception rather than the rule, then the public and media are entitled to attend. I accompany registrants at all times coming into and out of the hearing. At no time are registrants subject to questions or interactions with the public or media during the hearing or breaks.

Media

Unfortunately, the media can wait outside,however we do everything in our power to ensure an orderly exit from the building and we support you every step of the way.

Formal proceedings

The hearing opens with an opening statement from the CEO's representative setting out the nature of the allegations and a summary of the proposed evidence, which in general is followed by a brief statement by the registrant's representative outlining the case of the nurse or midwife. After this the witnesses for the CEO are called.

As the FTP Committee operates with the powers and privileges of the High Court, the proceedings are quite formal and reminiscent of a court case. Each witness must swear an oath or affirmation and they will first be questioned by the CEO's representative and then will be cross examined by the representative of the registrant. The questions that we put on your behalf to the CEO's witnesses are based on the discussions we have in preparing the case and very importantly must be based, in the main, on the evidence you will give later in the hearing.

Daunting as it may be there is no substitute in a legal forum such as this for your evidence and we build our case and our questions on your evidence. Often the CEO will call an expert witness who will speak about your conduct; this is quite normal, and we will most probably also have called a witness on your behalf. Once the CEO's witnesses have finished giving their evidence we then call witnesses. The most important witness will be you; we will lead you through your evidence in a controlled and robust fashion, and then the CEO's representative will cross examine you.

There is no doubt that this is daunting, but in reality there is little room for *Perry Mason* or *Law and Orde*r style behaviour, and telling the truth is all that is required. We may also have evidence from medical or professional witnesses, and we may also have witnesses in relation to your character or previous performance in work. After the witnesses have concluded their evidence both sides make closing submissions relating to the law and the facts.

In general, we will make a longer submission which will address not only the law but the facts of the case, and how we are asking the committee to proceed.

Findings

After this the committee retire, and while the committee may deliberate for a short time and deliver its findings on the same day, it is more likely that they will deliver the findings on a later date.

If the hearing took place in public, the committee will either sit in public to announce the findings on the same day, at a later date, or notify the public by way of notice on their website.

The findings of the committee will explain whether they accept, beyond all reasonable doubt, that the facts of an allegation have been proven. Also, they will then indicate whether they accept, beyond all reasonable doubt, that these facts amount to professional misconduct, poor professional performance, or non-compliance with the Code.

In cases of relevant medical disability they will make a finding as to whether, beyond all reasonable doubt, they accept that such a disability exists. They, in addition, will generally make recommendations in relation to the sanctions to be imposed, if any, and the rationale underpinning these recommendations.

Sanctions

Thereafter, the matter of what sanction to impose, if any, falls to be considered on a later date by the overall Board of the NMBI. The recommendations as to sanction will not be made public ahead of being considered by the overall Board.

As you can see this is a complex and inherently legalistic procedure. Not only does it require navigation of the legal rules ahead of and during the hearing, but also an astute appreciation of the profession and proceedings when preparing for the process and selecting experts to give evidence on your behalf. This is a service which is inherent to your membership of the INMO.

In future articles, we will consider what the Board does when it is faced with what it believes to be an urgent case that may require suspension from the register pending any investigation of a complaint, what is the legal standard that must be met for a hearing, or part thereof, to take place in private, the sanctions that may be imposed by the Board, the procedure for considering which sanction to impose, and the aftermath of a hearing for the registrant.

Edward Mathews is INMO director of regulation and social policy

Q and A Bulletin Board

With INMO interim director of industrial relations Tony Fitzpatrick

Query from member

I am looking to take carer's leave for a period of 12 weeks during the summer months but my employer has refused my request, stating that due to high levels of annual leave being taken by staff during these months, it is not possible to grant me this time. I thought employees were entitled to carer's leave if the person being cared for has been deemed in need of full-time care and attention. Please advise.

Reply

Under the Carer's Leave Act 2001 your employer has the right to refuse to grant carer's leave for any period that is less than 13 weeks on 'reasonable grounds'. Your employer must specify in writing the grounds for refusal and if you are not happy with the reason you can appeal same. Please contact the INMO if you require further assistance.

Query from member

I have lodged a complaint with my line manager in regard to the granting of leave over three weeks ago. To date I have not had a response. When a complaint is lodged, what is the expected timeframe for the complaint to be dealt with?

Reply

Your matter should be dealt with under the grievance and disciplinary procedures of the health service. A grievance and a complaint should be dealt with in compliance with the grievance procedure. It must be stated that most grievances can be addressed locally and on an informal basis. However, if you have formally lodged a complaint there is a requirement on the manager to arrange a meeting to discuss the matter no later than seven working days following receipt of the complaint. You have the right to be accompanied to that meeting by a work colleague or a union representative. The meeting should allow you to express your grievance clearly and, following the meeting, a decision should be conveyed to you in writing within seven working days. Therefore, in summary, once your complaint is lodged, you should be accommodated with a meeting within seven days and you should have an outcome from that meeting within a further seven days. If you are unhappy with the decision you can escalate the matter to the next stage of the grievance procedure under the HSE grievance and disciplinary procedures.

Query from member

I am applying to take the 16 weeks of additional maternity leave. Will I accrue annual leave during this period while I am not getting paid?

Reply

Under the Maternity Protection Act 1994-2004, while on maternity leave and additional unpaid maternity leave you are regarded as being in employment and therefore retain all rights such as annual leave, public holidays and increments.

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

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

Why we need RNIDs

INMO student and new graduate officer, **Neal Donohue**, discusses the vital role played by intellectual disability nurses

IN RECENT years there have been significant changes in the delivery of services to people with intellectual disabilities (ID). Currently, there is a greater focus on social care and primary care and since the introduction of HIQA there has been a constant focus on improving standards. The roles of the person in charge and the unregulated role of the social care worker have created confusion for the registered nurse in intellectual disability (RNID), where professional boundaries are often blurred. With services moving away from traditional models of care and preferring to hire social care workers and healthcare assistants the RNID has struggled to maintain its professional identity, although they continue to promote their professional relevance.

Students undertaking the BSc in intellectual disability nursing can very clearly articulate the necessity of their role, however, they are acutely aware of the difficulties they face in gaining professional recognition. The students explain that the truest form of person-centred and holistic nursing care is embedded in the mantle of the RNID. They adopt nursing theory, social and biological sciences combined with a philosophy of inclusion and empowerment to support people with complex needs in achieving best possible health, independence, and self-actualisation. They are experts in communication and observation and are the only professionals with the necessary extensive knowledge and skillset to support people with ID in all aspects of their lives promoting physical, psychological, sociological, spiritual and emotional wellbeing.

The problem exists where unregulated personnel are permitted to carry out the same tasks and functions as the RNID, though they lack the ability to effectively and critically evaluate care. This may provide a cheaper service, but it is the person with ID who pays the price.

How can this be permitted since the WHO constitution[1] clearly states that the highest attainable standard of health is a fundamental right of every human being? People with intellectual disabilities are entitled to the same access to timely, acceptable and affordable healthcare of appropriate quality as other citizens but they often require additional supports to ensure equity in access to care. The RNID is best placed to support these individuals in achieving the highest attainable standard of health.

Many employers will say people with intellectual disabilities are not always sick, so why should they need a nurse? That very question highlights part of the problem. Service providers must understand the role of the nurse is not only to care for those that are ill. That is an archaic and inaccurate view of the profession that may hinder many services abilities to effectively manage their human resources.

People with ID often have difficulties in communicating their needs, and difficulties in recognising that they have a health problem. According to the National Disability Authority[2] "People with intellectual disabilities have more health issues than the rest of the population and have significant difficulties in accessing appropriate health care". It has also been stated that "people with intellectual disability are at increased risk of exposure to psychotropic drugs and polypharmacy because of the higher prevalence of mental health conditions present and more controversially, the use of these agents to treat challenging behaviours".[3]

Special precautions are required in reviewing and monitoring service users being treated with psychotropic medications, especially where combinations of psychotropic medications are used. The monitoring of side effects, toxic effects, idiosyncratic effects, and the effects of polypharmacy is essential. Training in pharmacology is necessary to provide this level of assessment and can only be co-ordinated by the RNID.

It is not acceptable that unregulated assistive personnel are given the responsibility of medication management in ID services where they only receive minimal training on medications. Taking account of the health risks and the need for improved health promotion for people with ID the RNID must remain in central co-ordinating roles and specialist roles with clearer professional boundaries to ensure that care provided is safe and equitable.

Research into the enhanced service the RNID provides is necessary to highlight the high standards of care and education associated with their profession. Further research should also focus on the cost effectiveness associated with hiring such professionals with an abundance of knowledge, expertise and abilities on all aspects of care including managing behaviours that challenge.

Further development of CNS roles and ANP roles will enhance the provision of care and provide clear career progression to encourage RNIDs to remain within the field. The development of RNID positions in education, primary care, and in frontline services is essential to support people with ID of all ages in accessing health and social care.

The RNID is dynamic, versatile and specialised but there is a growing need for access to post graduate education and nursing research if the profession is to continue to evolve. The current students must be supported in attaining contracts of employment in their chosen field, with access to funded post graduate education opportunities to ensure that the highest possible standards of care are achieved for all of our most vulnerable citizens.

References on request by email to nursing@medmedia.ie (quote: Donohue N. WIN 26 (6): 27)

Treating fungal infection of the scalp

In the latest clinical update **Catherine Lewis, Stephanie Laidlaw** and **Gerry Morrow** examine tinea capitis or 'scalp ringworm'

FUNGAL infection of the scalp (also known as 'tinea capitis' or 'scalp ringworm') is an infection of scalp hair follicles and the surrounding skin caused by dermatophytes. Infection in cities is usually caused by the anthropophilic (spread from human to human) dermatophyte *Trichophyton tonsurans*. Transmission is usually from contact with an infected child, either directly or via fomites – objects or materials which carry infection. Fungal spores or infected hairs are transferred by contact or airborne dissemination on to the epidermis between hair follicles. The spores germinate, producing chains of cells or hyphae, which grow down into the hair shaft and penetrate the hair. In more rural areas, infection can also be caused by the zoophilic (spread from animals to humans) dermatophyte *Microsporum canis*, which usually affects household pets.[1,2]

Fungal scalp infection mainly affects prepubertal children aged six months to 12 years. It occurs most commonly in Afro-Caribbean children living in urban areas. The reported prevalence is Europe is about 1.5% of the population. The incidence in adults is generally low, but infection may be seen in people who are immunosuppressed.[1,2,3,4]

Complications of fungal scalp infection may include:

- Secondary bacterial infection such as cellulitis or impetigo
- Scarring alopecia (hair loss)
- Skin pigmentation changes
- Erythema nodosum.

A dermatophytid (id) reaction is a reactive phenomenon to the dermatophyte causing a disseminated itchy, popular or vesicular eruption commonly affecting around the helix of the ear, which may also affect the trunk or the limbs. This may accompany the start of oral antifungal treatment and may be misinterpreted as a widespread fungal infection.[1,23,4]

Hair usually regrows fully after effective oral antifungal treatment for *Trichophyton tonsurans* infection, and scarring of the scalp is rare.[2]

Diagnosis

The clinical features of fungal scalp infection vary depending on the causal organism, type of hair invasion and degree of inflammatory response present. Non-inflammatory involvement is characterised by scaling and itch of the scalp, which may be generalised and diffuse. Single or multiple circular patches of alopecia (hair loss) which is usually asymmetrical may be present, this may be associated with a 'black dot' appearance on the scalp caused by broken-off, swollen hair stubs within the follicles.[1,2,3,4]

An inflammatory involvement may present with additional features such as erythema, scattered pustules and crusting. Painful, pustular boggy masses which have a thick crust (kerion) may be present. Alopecia may present with scarring of the hair follicles indicating hair loss may be permanent. Be aware that infection may present atypically in people who are immunosuppressed.[1,2,3,4]

If fungal scalp infection is suspected ask the patient about:

- The nature and duration of any symptoms, such as an itchy or painful scalp
- Any previous treatments, including over-the-counter preparations
- Any family or close contacts affected
- Any household pets affected or contact with animals
- Any co-morbidities such as an underlying cause of immunosuppression.[1,2,3,4]

Examine the person to assess:

- The severity of infection, including the presence of any kerion – if a kerion is suspected, arrange an urgent referral to a dermatology specialist
- Whether eyebrows and eyelashes are also affected
- Any associated fungal infection at other sites, such as the upper trunk and limbs, which may also need treatment.[1,2,3,4]

Arrange skin and hair sampling for fungal microscopy and culture, to confirm the diagnosis and identify the underlying cause.[2,3]

When taking skin and hair samples for fungal microscopy and culture, wipe off any creams from the scalp before sampling. Scrape the affected areas with a blunt scalpel blade to collect affected hairs and/or broken-off hair stubs, and scalp scale (sampling the edge of lesions may provide a higher yield of dermatophyte). At least 5cm^2 of skin flakes and hair should be collected into a folded dark paper square, secured with a paper clip (alternatively, packs are available commercially).

Ensure samples are labelled clearly and stored at room temperature. Samples should not be refrigerated as dermatophytes are inhibited at low temperatures. Ensure clinical details provided on the microscopy request form include any treatment used, and likely

animal contacts and exposure to overseas travel.[2,3]

If sampling is not possible or tolerated, or the person is a suspected carrier, the scalp should be brushed with an unused, soft toothbrush or cytobrush (normally used to take cervical smears), passing the brush through the hair several times in the abnormal skin area. If the person is a suspected carrier, pass the brush through different areas of the scalp to obtain a good sample. Send the brush for culture as microscopy is not possible on brush samples.[2,3]

Differential diagnosis

Other conditions that may present similarly to fungal scalp infection include:

- Seborrheic dermatitis – typically causes greasy scaling of the scalp without significant hair loss
- Atopic eczema – causes a scaling and itchy scalp and hair loss is less likely
- Alopecia areata – usually presents with sudden-onset of discrete patchy hair loss of the scalp with little or no scaling or inflammation
- Traction alopecia – hair loss secondary to pulling on the roots, typically caused by hair styling techniques
- Trichotillomania – a psychiatric condition where people pull their own hair out, hair loss is typically incomplete and asymmetrical
- Psoriasis – scalp involvement is usually a variant of chronic plaque psoriasis
- Discoid lupus erythematosus – causes persistent, scaly plaques on the scalp face and ears
- Lichen planus – causes a very itchy scalp mainly affecting the vertex, with redness and scaling around the base of the hair follicles
- Folliculitis – superficial infection of the hair follicles which develop into small inflammatory papules or pustules
- Scalp abscess – presents as a swollen, painful collection of pus on the scalp.[1,2]

Management

The management of fungal scalp infection depends on the site and severity of scalp and hair involvement, the causative organism, the person's symptoms, and any co-morbidities. If the person has a suspected kerion, urgent referral to a dermatology specialist should be made.[1,2,3,4] Provide advice on self-care management strategies such as softening any surface crusts (for example, by applying moistened dressings to the affected areas), and then gently teasing them away.

Objects that can transmit fungal spores, such as hats, scarves, hairbrushes, pillows and scissors, should be discarded or disinfected. Towels should not be shared and should be washed frequently. Parents of carriers should inspect the scalps of other children and household contacts regularly for clinical signs of infection and manage appropriately.

If it is suspected that a household pet is the source of infection, it should be assessed and treated by a vet.[1,2,3,4]

In adults, an oral antifungal treatment should be offered if there is a positive skin or hair sample microscopy or culture result. A negative mycology result is not a reason to delay oral antifungal treatment, if clinical features are very suggestive of infection; in this scenario a repeat skin and hair sample should be taken and oral antifungal treatment started.

Oral antifungal treatment can be started before mycology results are back, if there is a strong clinical suspicion of fungal scalp infection.[1,2]

In children, consider offering treatment with an oral antifungal in primary care, if the diagnosis is certain. If this is not the case, advice should be sought from a paediatric dermatologist before starting treatment. Advise the parent or carers that once appropriate treatment is started, their child should attend school or nursery as normal.[1,2]

If oral antifungal treatment is offered in primary care prescribe either oral griseofulvin (licensed) if the person lives in a rural area, for four to eight weeks or oral terbinafine (off-label) if the person lives in an urban area, for four weeks. When the culture results are available, if the infective organism is *Trichophyton tonsurans*, continue terbinafine (if taking already), or switch to treatment with terbinafine. If the infective organism is a *Microsporum* species, continue griseofulvin (if taking already), or switch to treatment with griseofulvin. Consider the use of itraconazole (off-label indication) for four weeks if griseofulvin is not tolerated or is contradicted.[1,2]

To reduce the risk of transmission to other people, consider co-prescribing a topical antifungal agent during the initial oral antifungal treatment. Options include selenium sulphide or ketoconazole shampoo to be used at least twice weekly for two to four weeks, or an imidazole cream (in children less than five years of age) to be used daily for one week.[1,2,3,4]

Assess and manage any possible complications, such as secondary infection; be aware that pustule formation may represent an inflammatory response to the dermatophyte itself rather than a secondary bacterial infection. If there is a suspected id reaction, advise the person to continue oral antifungal treatment as prescribed and consider prescribing a topical corticosteroid for symptom relief, if needed.[2,4]

A review should be arranged four to eight weeks after completing the course of oral antifungal treatment to assess the response to treatment. Assessment should include looking for signs of normal hair regrowth, suggesting clearance of infection or for signs of treatment failure. If normal hair growth does not occur and there are signs of persistent infection, consider, and if possible, manage any underlying cause of treatment failure, for example, non-adherence to self-care advice or treatment regimen. Arrange for repeat skin and hair sampling for fungal microscopy and culture.[1,2,4]

Referral should be made to a dermatology specialist, the urgency depending on clinical judgement if:

- The person has a suspected kerion – urgent referral should be arranged
- Oral antifungal treatment is being considered for a child
- The diagnosis is uncertain
- Treatment in primary care is unsuccessful
- There is severe or recurrent infection
- There is a suspected severe id reaction which is not responding to treatment
- The person is immunocompromised.[1,2,4]

Catherine Lewis is clinical author at Clarity Informatics, Stephanie Laidlaw is information specialist at Clarity Informatics and Dr Gerry Morrow is editor and medical director at Clarity Informatics. Clarity Informatics is contracted by the National Institute for Health and Care Excellence (NICE) to provide clinical content for the Clinical Knowledge Summaries service available through the Clarity Informatics Prodigy website at: https://prodigy-knowledge.clarity.co.uk/

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4. Bennassar A and Grimalt R. Management of tinea capitis in childhood. Clinical, Cosmetic and Investigational Dermatology 2010; 14(3): 89-98

A full reference list available from the Prodigy fungal skin infection - scalp topic. **https://prodigy-knowledge.clarity.co.uk/**

CPD Quiz

There may be more than one correct answer to the multiple choice questions listed here. The correct answers *(given below in the inverted text)* are those deemed most appropriate by the authors in the context of this CPD article.

1. Fungal scalp infection is most common in:

A) Immunocompromised people
B) Men
C) Pregnant women
D) Prepubertal children

2. Symptoms of fungal scalp infection include:

A) Bleeding scalp
B) Fever
C) Itchy scalp
D) Circular patches of hair loss

3. Skin and hair samples taken for fungal microscopy and culture should:

A) Be kept refrigerated
B) Be kept at room temperature
C) Be taken from the edge of lesions
D) Be secured in dark paper squares

4. The prevalence of fungal scalp infection is:

A) Approximately 15%
B) Approximately 1.5%
C) Higher in Afro-Caribbean children
D) Low in adults

After reading this article you may wish to reflect on what you have learned, how this might be applied to your own work and to make a note of this in your portfolio.

Clarity informatics

For further information and resources: **www.clarity.co.uk**

Answers: Question 1 = a, d, Question 2 = c, d, Question 3 = b, c, d, Question 4 = b, c, d

Quality & Safety

A column by Maureen Flynn

Introducing NOCA's Major Trauma Audit

IN THIS month's column we continue the series focusing on the work of the National Office of Clinical Audit and how it informs nursing and midwifery practice. The National Office of Clinical Audit (NOCA) established a Major Trauma Audit (MTA) in 2013. Major trauma is defined as 'an accident resulting in life threatening or life changing injuries'.

Major Trauma Audit

This national audit focuses on the care of the more severely injured trauma patients in our healthcare system. The Trauma Audit and Research Network (TARN) provides the methodological approach for the MTA in Ireland and all 26 eligible hospitals now submit data to the MTA. In 2016, the MTA became the first national clinical audit endorsed by the National Clinical Effectiveness Committee (NCEC) and mandated by the Minister for Health.

MTA measures the quality of care provided to patients sustaining major trauma in Ireland. This audit is one of the key sources of data for the HSE and national clinical programmes to monitor changes in processes and outcomes associated with the development of major trauma networks. The valuable data entered by nurses and administrative staff in the 26 hospitals is key to the success of this audit.

Messages for nursing practice

In the recently published second report, a focus was put on age as a factor in major trauma due to the high numbers (40%) of older major trauma patients identified in the first report. The face of major trauma has changed over the past two decades from being typically young males with high mechanism injuries, eg. road traffic accidents, to now an older age group with low mechanism injures, eg. falls. This shift directly correlates with the road safety campaign in recent years and an increase in our ageing population and has changed the way we need to think as nurses about major trauma patients and their care needs *(see figure below)*. A key message for nursing practice is recognising that older people with falls from less than two metres can be severely injured and a high level of suspicion of major trauma should be applied until proven otherwise.

Get involved

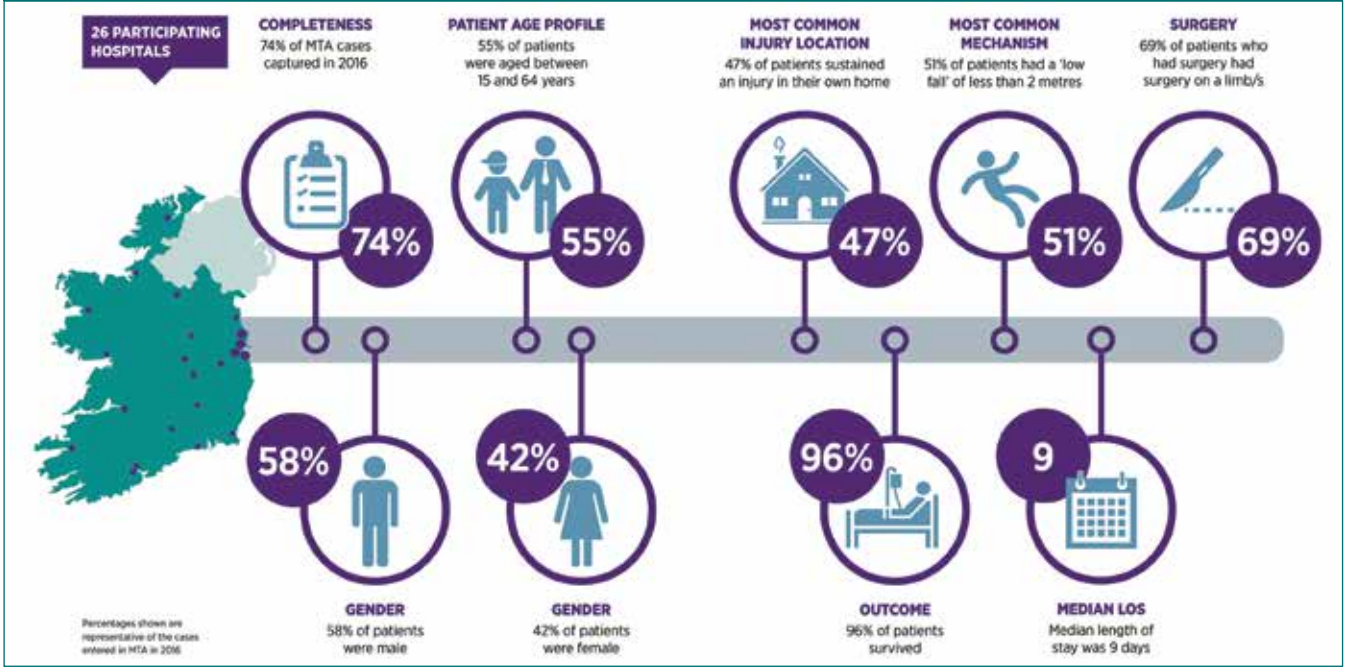
At your next team, ward or unit meeting you might like to consider how the findings from MTA inform the development of your practice. In preparation you might ask your manager who to contact in your hospital for the MTA findings specific to your service.

If you have any queries about the MTA please contact the national co-ordinator, Louise Brent by email to: louisebrent@noca.ie. The full report is available for download from **www.noca.ie**

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

Acknowledgement: Thank you to Louise Brent and the NOCA team for assistance in preparing this column. Dr Conor Deasy, MTA clinical lead, along with the MTA governance committee and NOCA wish to extend thanks and gratitude to the local clinical leads and data coordinators entering data locally. These efforts are continuing to ensure better, safer care for major trauma patients in Ireland

Figure: 2016 Major Trauma Audit report highlights



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
Quality Improvement Division

About the HSE Quality Improvement Division (QID): the division led by Dr Philip Crowley was established in January 2015. The mission of the QID team is to provide leadership by working with patients, families and all who work in the health system to innovate and improve quality and safety of care by championing, educating, partnering and demonstrating quality improvement. Our vision is *working in partnership to create safe quality care*.

Tús Áite do Shábháilteacht Othar
Patient Safety First

Breaking bad news: The best approach

We can't make bad news good, but we can make a huge difference to patients by the way we communicate that news, writes **Terry Hanan**

DURING the public consultation process for the development of the 2017-2026 National Cancer Strategy, it became apparent that communication on the diagnosis and prognosis of cancer was an issue for patients, families and healthcare professionals.

The need for enhanced communication was raised by patients and healthcare personnel, who stressed the importance of good communication and in particular 'getting the message right and delivering it properly'. Many patients said that they will always remember how their diagnosis was delivered to them. Some healthcare professionals said that they struggled in delivering bad news to patients and felt formal training in this area would further enhance their ability to communicate more effectively.

In response, the National Cancer Control Programme (NCCP) in collaboration with the Office for Nursing and Midwifery Services Directorate secured funding to deliver a 'train the trainer' programme for HCPs who deliver a cancer diagnosis or manage patients and their families around the time of receiving a cancer diagnosis.

The main aim of the initiative is to build capacity in acute hospitals and in primary care to enhance communication for cancer patients and their families. A programme of education has been procured after a tendering process and the Irish Hospice Foundation was awarded the contract. The programme commenced in May 2017 and will be rolled out over two years.

The training is suitable for healthcare personnel who, during the course of their work, may have to deliver bad news to patients, or support patients and families diagnosed with cancer. Participants need to be committed to enhancing their communication skills and to training their colleagues following completion of the training.

What is involved?

- A two-day 'train the trainers' workshop held in the National Cancer Control Programme office in Dublin
- Once trained as a trainer, a commitment to run a number of half-day 'delivering bad news well' workshops to colleagues
- A comprehensive facilitators' guide and full details of delivering the training is provided
- A follow-up support workshop, (half-day) for trainers is provided.

Following the two-day train the trainer programme, health professionals acquire the skills to be able to give a half-day 'delivering bad news' well programme to their colleagues. The programme supports staff in developing their communication skills, including having the confidence and competence when dealing with patients and their families following their cancer diagnosis.

A variety of delivery methods is used in the workshops including; group work, discussion, scenarios and role play, as well as custom-designed facilitator presentations and a video. There is an emphasis on role-play and reflection, and participants are constantly encouraged to think about ways to implement the training in their respective work situations.

Areas covered in the delivering bad news well workshop include:

- Five-step approach for effectively delivering bad news
- Communication skills
- What do patients and families hear?
- How can I answer difficult questions?
- What is the best way to respond to patient family distress?

The benefits of this training include:

- The development of skills for good communication
- A better understanding what bad news is and how it can impact on people
- Increased confidence and competence as a healthcare professional in communicating a difficult diagnosis
- Developing a better communication culture at time of a cancer diagnosis and greater understanding by healthcare personnel of patient needs and issues.

Case scenario for using the workshop

According to Buckman in 1992 "If we do it badly, the patients or family members may never forgive us; if we do it well, they may never forget us".[1]

Ingrid, a 45-year-old woman with two children, was referred to the breast clinic by her GP for investigation of a lump she discovered in her left breast. Following completion of a number of investigations she returned to see her consultant at the breast clinic where she was informed that her tests confirmed she had stage two breast cancer.

Breaking the news to Ingrid that she has breast cancer is not easy, but her consultant is acutely aware that the way she is told will have a profound effect on how she will cope. If it is done well, in a sensitive and sympathetic way, Ingrid will always remember the human compassion shown to her.

In preparing for delivering the news to Ingrid, her consultant applied the five-step

approach to delivering bad news which involves:

- Preparing yourself (having a quiet private and relaxed space with a nurse present)
- Making a good connection with the patient (building on what Ingrid already knows)
- Giving a warning shot (telling her gently and slowly in manageable chunks)
- Acknowledging the shock (giving her an opportunity to react to the news or raise concerns)
- Planning the next steps (explaining what happens next).

Ingrid left the clinic after receiving the news of her cancer diagnosis. She mentioned to her consultant that she would make an appointment to see her GP the following day as she would need and value his advice and support.

Workshops attendances

Eight workshops have been held to date with 53 attendees including doctors, nurses and social workers. Feedback from participants has been really positive. A sample of the comments from participants are listed below:

"I found the course very valuable and very enjoyable. I have learned that I do not have to have all the answers to everything or be able to fix everything. My confidence as a facilitator has gone from zero to hero."

"A very comprehensive course looking at the relevant topics and delivered very professionally."

"Really practical informative session, answered all my questions, increased my competence dramatically. Role playing was particularly beneficial."

"Very informative and positive. Role play was excellent, facilitator was engaging, very interactive workshop."

"Fantastic programme, delivered very well… providing confidence to those hoping to facilitate the programme."

Delivering bad news well

As health professionals we sometimes need to deliver bad news to patients. We also offer information and advice to patients and families to cope when a cancer is diagnosed and we strive to support them along their journey. Many healthcare professionals have never had formal training in how to deliver bad news well.

Though these are anxious times for patients, they will hopefully have a better experience if we can really help them to understand their diagnosis and if we can communicate well with them from when they receive their cancer diagnosis and at different points of their journey.

Bad news is difficult to convey and difficult to hear. Despite the best efforts of healthcare professionals to impart the bad news well, when asked afterwards 'What did the doctor say?' often the patient cannot recall much of the conversation. The NCCP Delivering Bad News Well initiative offers healthcare professionals an opportunity to make a vital difference in this most challenging of situations.

We can never make bad news good, but we can make a huge difference by the way that we communicate that news. Delivering bad news with compassion and competence can make all the difference to a patient like Ingrid, for whom it may feel like life has come to a crashing halt. Patients will turn to health professionals who they know and are comfortable with in times of crisis. Training takes place in NCCP offices in Dublin.

If you are interested in booking a place or want to enquire about the next available training date please contact us by email to: marie.byrne2@cancercontrol.ie

The programme runs to the end of 2018.

Terry Hanan is a nursing projects manager with the National Cancer Control Programme

Reference

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Intestinal failure:
update on management in Ireland

Claire Donohue outlines the need for a more centralised approach to the management of the complex health needs of people with intestinal failure

INTESTINAL failure (IF) is defined as the inability to tolerate 80% of nutritional requirements delivered enterally for a minimum of 48 hours.[1] Nutritional deficiencies include protein-energy requirements, fluid and electrolytes and micronutrients.

Intestinal failure is divided into three types according to its duration:

- Type I representing short duration reversible IF (< 28 days), often occurring associated with acute illness or surgery
- Type II occurs if IF persists for more than 28 days from onset
- Type III represents a chronic, irreversible state of IF.

In patients with type II IF, 40% undergo full intestinal rehabilitation and resolution, 10% require long-term enteral nutrition supplementation and 50% long-term parenteral nutrition.

Causes of intestinal failure

Intestinal failure arises from gastrointestinal or systemic benign diseases, resulting in decreased intestinal absorptive capacity, often associated with multiple intestinal resections (such as Crohn's disease, radiation enteritis, vascular insufficiency), as well as congenital digestive diseases or end-stage intra-peritoneal cancer or metastases. Intestinal fistulae, extensive small bowel mucosal disease or mechanical obstruction or dysmotility may result in failure to maintain health using enteral nutrition and require parenteral nutrition replacement.

Prevalence

The five year survival rate of patients with intestinal failure is reduced compared to population controls – approximately 80% in adults and 90% in children.[2] Most of the excess mortality rate is attributable to complications of treatment rather than the underlying disease process per se.

Management

Patients with type II or III intestinal failure often require parenteral nutrition delivered intravenously to maintain their nutrition. During the initial one to two month period, patients are often metabolically unstable and require careful titration of fluids and electrolytes. They then undergo a process of adaptation whereby the ability to absorb macronutrients increases as absorptive capacity increases and GI motility decreases.

Intestinal rehabilitation requires nutritional, pharmacological and surgical input to facilitate the process of adaptation.[3] Select patients who remain dependent on

Table 1: Classification of intestinal failure and indication for home parenteral nutrition[9]

IF type	Features	Indication for home parenteral nutrition (HPN)/ referral to specialist IF centre?
Type I	– Less than 28 days duration – Usually occurs post operatively or due to obstruction – May require short term parenteral nutrition (PN)	No
Type II	– Greater than 28 days duration - Usually occurs in severely ill patients, mostly after bowel resection with complications such as intestinal fistulae, sepsis and metabolic disturbance - May require prolonged nutritional/metabolic support pending surgical treatment or spontaneous resolution	- Not generally an indication for HPN but should be managed in specialist centre
Type III	– Generally irreversible and occurs as consequence of massive small bowel resection, leading to short bowel syndrome (SBS), or malignant obstruction, or severe motility problems - A small number of patients will become suitable for either small bowel or combined small bowel and liver transplantation	- HPN may be indicated - Specialist centre depending on whether the result of malignant/non-malignant disease

long-term parenteral nutrition after this process of rehabilitation may be candidates for intestinal transplant.[4] After one to two years, due to the process of intestinal adaptation, 20-50% of patients can be successfully weaned from parenteral nutrition.[5,6] After this time period, fewer than 6% are successfully weaned.

What are the consequences of IF?

Aside from the complexity of initial management of patients in transitioning onto parenteral nutrition and determining a tolerable enteral nutrition intake, there are several long-term consequences of being dependent on parenteral nutrition. Metabolic bone disease, micronutrient and electrolyte management, and liver function all require careful surveillance.[7] Patients are prone to developing small bowel bacterial overgrowth.[8] The requirement for a long-term indwelling central venous access catheter results in persistent risk of central line associated bloodstream infections, venous thrombosis and hepatic steatosis and cholestasis, which can result in cirrhosis.[3]

IF management in the Irish context

There is currently no centralisation in the care of Irish patients with intestinal failure despite their complex health needs. The prevalence of IF in audits of Irish practice seem to demonstrate fewer patients are on home parenteral nutrition than a comparable population in Northern Ireland.[9,10] This may reflect fewer patients surviving their initial critical illness or an under utilisation of supplementary parenteral nutrition due to lack of access to this resource.

A recent study of Irish IF patients reveals disparate care spread over a number of centres, with only two-thirds of patients with IF on prolonged parenteral nutrition being managed in the home setting.[10] Most Irish treatment centres manage only one or two IF patients per year, preventing expertise acquisition. There was a higher than acceptable rate of re-admission to hospital (2.86 admissions per patient per year) and one-third of patients had experienced a catheter-associated bloodstream infection in the prior year, far in excess of international norms. Half of patients studied had at least one treatment-associated complication. Only one in five patients were subject to recommended long-term surveillance for chronic associated conditions.[7]

Thus the standard of care received by Irish IF patients is sub-optimal and reflects a clear indication for a more organised networked approach to improve care.

Claire Donohoe, specialist registrar in general surgery, Irish Society for Parenteral and Enteral Nutrition (IrSPEN), now fellow in minimally invasive surgery, Oregon Health and Sciences University (OHSU), Portland, Oregon, US

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Crumlin guidelines light the way

Fionnuala O'Neill discusses the rationale for publishing nursing practice guidelines on the OLCHC website

NURSING sick children is a specialised role and has become much more complex in recent years. Nurses are required to develop increasing levels of expertise and skill to care for sick children with complex needs in hospital, the community and at home.

Much of this skill is learned through experience in the clinical area with the education as well as training, such as that provided in Our Lady's Children's Hospital, Crumlin (OLCHC). In conjunction with this formal education, a qualified nurse must also maintain their professional competence by keeping their knowledge and skills up-to-date by taking part in relevant continuing professional development.

Children's nurses are working in an environment that is heavily influenced by evidence based practice, legislation, standards and health policy with a demographic that is ever changing. Sicker children are nursed in clinical areas that would previously have been cared for in the paediatric intensive care units.

OLCHC is a worldclass multispecialty hospital. It is the largest children's hospital in Ireland and currently has 227 beds and cots in use. It provides evidence-based quaternary, tertiary and secondary quality care to children and adolescents in a child and family focused safe environment. OLCHC is the national centre for some of these specialities such as children's childhood cancers and blood disorders, orthopaedics, cardiac diseases, major burns, cystic fibrosis, dermatology and rheumatology.

The Nurse Practice Committee in OLCHC has been in existence since the 1980s. This committee is chaired by the nursing practice development co-ordinator with responsibility for nursing document development, review and issue. The Nursing Practice Development Unit (NPDU) critically reviews nursing practice in OLCHC and can identify how practice can be improved by facilitating the education and training required to manage any knowledge-practice gaps. This ensures the guidelines and processes that support nursing are underpinned by quality and safe care. This committee works across all specialities in OLCHC facilitating the creation and review of nursing guidelines and other associated documentation.

The membership of this committee is from all grades of nursing staff, pharmacy and the library. The work of this committee supports the nursing care delivered to infants, children and adolescents by providing evidence-based nursing guidelines, algorithms and parent education plans/ parent information leaflets which assist with the standardisation and evidence-based support of the nursing care infants and children receive both in hospital and when they are discharged home.

Decision

In 2015 nursing guidelines, standard operating procedures and parent information leaflets were placed on the hospital website. A decision which was supported by the director of nursing and the corporate management team. The rationale for this action was to facilitate access to children, parents, guardians and healthcare professional's to nursing care guidelines and other information they require in a timely manner.

Response

The reaction to this launch was positive from parents and staff both inside and outside of OLCHC. In accordance with HIQA guidelines, the presence of these documents facilitates the creation of local and national children's care guidance streamlining processes of care which is person centred. This facility and the availability of specialist information for the healthcare professional with a complex or care need query or a parent who has an infant or child discharged home and is unsure of what care is required is an invaluable resource when phone and email is not available to them out of hours.

Outcome

OLCHC currently has circa 439 documents on the hospital website with many more in development.

Feedback from users using audits on the website is positive and used to make changes as appropriate.

Google analytics show 350-700 hits on the guidelines and parent information leaflet pages per week. The geographical spread of these hits, as shown by Google analytics, is now worldwide with hits from the UK, US, India, Arab Emirates, Canada, Australia, France, Spain, Portugal, Philippines, North and South Korea, Haiti, Egypt, Oman, Japan, India, Vietnam, African countries and Romania.

There is evidence that OLCHC nursing practice guidelines, careplans and parent information leaflets are used in local and regional centres in Ireland as an information resource. The library tracks citations of our nursing practice guidelines in recent publications and has identified numerous citations in international publications from nurse practice committee guidelines and careplans.

Conclusion

Caring for a sick child as close to home as possible is the ideal for child and family, an ideal supported by the model of care for paediatrics and neonatology. Supporting the parents/guardians and staff to manage children with care needs in the home is now aided with the ability to access evidence-based nursing care guidelines, careplans and parent information leaflets electronically.

Fionnuala O' Neill is an assistant director of nursing and the nurse practice development co-ordinator in Our Lady's Children's Hospital, Crumlin

Time to reflect

Niamh Beatty and Bróna Mooney discuss the importance of professional resilience in nursing

NURSING is a physically and intellectually demanding career and the altruistic nature of nursing can be particularly draining and can lead to personal and professional burnout. Irish nurses are expected to deliver high quality patient care in work environments that are currently short staffed and lacking in resources. Professional resilience is a skill that can be developed and fostered to overcome adverse and challenging events in the workplace. This can be facilitated through a positive environment of peer support, mentoring and reflection and can assist nurses to cope with the many demands of their profession.[1,2]

The importance of resilience in nursing is evident, nurses witness trauma, suffering and human tragedy on a daily basis, and often experience stress associated with supporting patients in the face of such adversity. Resilient individuals possess a number of common attributes including adaptability, empathy, self-belief and positivity and adopt a problem-solving approach to life. These traits enable them to cope effectively with workplace adversity.[3]

Working conditions

Stressful working conditions may elicit the 'fight or flight' response. This innate protective mechanism arises when the sympathetic nervous system and endocrine system induce a response to a threatening stimulus. Although this adaptive response is essential, it can be damaging if elicited too frequently. Prolonged stress can disrupt emotional and physiological balance, and may put nurses at risk of illness and burnout.[4] Healthcare professionals are known to experience increased incidences of heart disease, substance abuse, affective and stress related disorders and suicide as a result of prolonged stress exposure to traumatic events and difficult working conditions.[5]

Requirements to work overtime and take on excessive workloads can, in addition, be damaging to nurses' personal lives, making healthy work-life balance difficult to achieve. Consultant Dr Gerry Lane compared EDs across the country to 'battle zones'. He recounted details of his nursing colleagues coming to work early and staying late, in a 'superhuman effort' to deal with increased patient loads. The signs of burnout among staff were clearly evident and a contributing factor to the increased attrition of nurses as a result of impossible working conditions identified in his interview.[6] This account highlights the need for employer's to consider how they can support nurses to cope with the challenges they face in their professional roles.

Sociocultural variables have an impact on how professional resilience is fostered. Working in a bureaucratic and demanding workplace, nurses encounter the unfavourable effects of hierarchy, autocratic, top-down decision-making and hostility both within nursing and from other professionals, often resulting in lack of job satisfaction, autonomy, respect, validation and feelings of disillusionment. Sociocultural supports are essential in promoting resilience, platforms such as peer support groups provides nurses with the opportunity to seek advice, guidance and support. Mentoring relationships within the workplace can be particularly beneficial for promoting professional resilience.[7,8]

Training

Training programmes such as psycho-educational sessions that focus on turning stress into resilience, taking responsibility, promoting empowerment and the importance of social connections have proven to be beneficial and result in increased resilience among nurses, and has shown to enable nurses to be more empathetic and attentive to patients. In addition, stress relieving techniques like mindfulness and meditation may also offer protection against the physiological response to stress.[9,10]

From a personal perspective, resilience can also be enhanced by various psychological factors including having a sense of purpose, positive attitude, being goal-orientated and a sense of spirituality. Not only has positivity been proven to act as a buffer against adversity, but also assists nurses in recovering from negative emotions.[11] A positive outlook helps nurses to be more open-minded and creative in respect to problem solving in the workplace, and is associated with improved coping strategies and increased mental and physical health.

Reflective practice

Professional resilience can be developed through a process of self-reflection. Reflection allows individuals to develop insights and new understanding of various experiences and solutions for the future.[9] Reflection can be conducted in a number of ways and allows nurses to take an active role through journalling, attending support groups or self-discussion and examination. Self-reflection facilitates the identification of one's own strengths and weaknesses and allows for personal and professional development.

Recently, we have seen the introduction of 'Schwartz Rounds' in clinical practice. This medium was devised to facilitate multidisciplinary reflection in the clinical setting in which various healthcare professionals are afforded the opportunity to present a challenging case they encountered and offer their reflections on it. Other colleagues are also challenged to consider how they would deal with a similar situation, resulting in learning and a new understanding for all. By employing previous experiences as a catalyst for learning and growth, reflection provides nurses a chance to develop their professional capabilities and in doing so, improve the care they provide to patients.

The importance of building professional resilience in nursing staff has never been more relevant. A need exists to implement initiatives to assist nurses in maintaining personal and professional wellbeing, which will undoubtedly benefit all stakeholders, increase job satisfaction and create work environments in which nurses feel supported and valued.

Niamh Beatty, is a general nurse working at Galway University Hospital and Bróna Mooney is a lecturer in nursing studies at the NUI, Galway

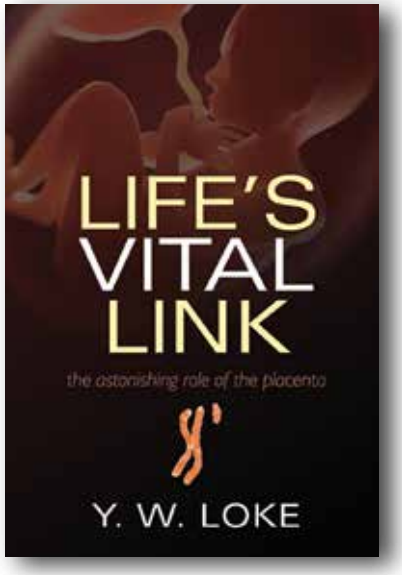
References on request from nursing@medmedia.ie
(Quote Beatty N. WIN 2018; 26 (6): 50)

Popularising the placenta

LIFE'S Vital Link: the astonishing role of the placenta is an intriguing book title. Written by an academic scientist, YW Loke (so academic he doesn't publish his first name), this is his first attempt "to cross the divide from scientific literature to popular science".

The book poses the question: "How is it possible that a partly foreign body can invade your tissues, avoiding attack by your immune system, establish access to your bloodstream, and even influence your brain?"

Given the subject matter raised in the title, images of Margaret Atwood's Gilead spring to mind. But yet, the book proclaims, "every one of us has benefited from just such a parasite, and every mother has experienced it. Because that 'parasite' is the placenta."



Loke tells us that the placenta is one of the most ingenious adaptations and is the result of 300 million years of evolution. "Its cunning ways of growing – cancer like, yet controlled – and camouflaging itself against the defence systems of the host are only just being worked out."

Without the placenta, we would still be laying eggs instead of giving birth to live offspring. It represents the critical link between the foetus and the mother, but its character is extraordinary. Loke explores the nature of the placenta and what it can tell us about evolution, development and genetics. He explores how such an organ evolved, how it is managed and controlled, and why it is tolerated by the mother.

With this book, Loke has successfully crossed into popular science. His language is indeed for the every(wo)man. Before birth, the foetus "has to 'borrow' whatever it needs from the mother, using the placenta via the umbilical cord like a jump lead to plug into the mother's battery while its own is flat. The placenta brings oxygen and food from the mother and, at the same time, excretes waste products back to the mother for her to dispose of."

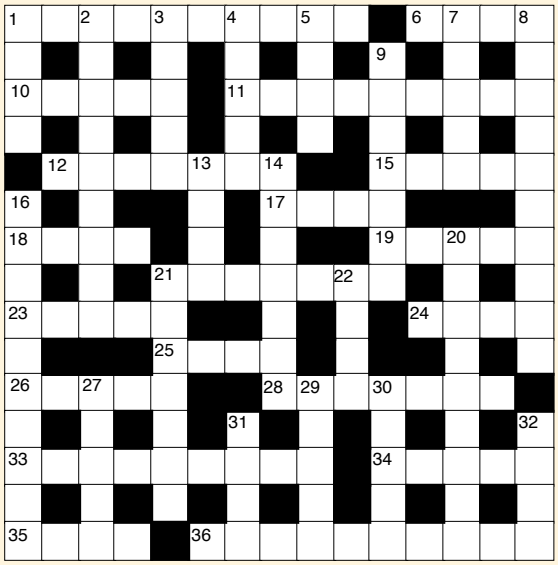
Yoke believes the usual description of the placenta as a 'barrier' does not do it justice as it conjures up the image of a passive inert structure barring all that comes its way. He sees the placenta as much more sophisticated, proposing 'gateway' as a more appropriate term. Rest assured that plenty of scientific detail can be gleaned between the layers of simple language – from the syncytiotrophoblast (the placenta's outer layer in direct contact with maternal blood) to the underlying cytotrophoblast layer, which thins as pregnancy progresses.

Yoke laments that "in spite of being star of the show, the placenta has never quite managed to gain the attention it deserves". However, with *Life's Vital Link,* he rectifies this, telling the story of this astonishing and unique organ, which allows us to grow towards individuality, but also ensures that we are never completely separate – we all carry a tiny bit of our mother within us.

Life's Vital Link: the astonishing role of the placenta' is published by Oxford University Press, May 2018, £10.99, ISBN 9780199694525

Crossword Competition

WIN A €30 BOOK TOKEN



Across
1 Would you fight bacteria with this variety of tibia tonic? (10)
6 Greatest of the Viking gods (4)
10 Nickname of the animal whose name means 'River Horse' (5)
11 Descriptive of a creature that is more active by night (9)
12 A source of venison - for communists? (3,4)
15 Shindig (5)
17 A world's fair in the former post office (4)
18 Plant with edible pods, also called lady's-finger or gumbo (4)
19 Character played in several movies by Sylvester Stallone (5)
21 A courtier and worker appear together in a costume drama (7)
23 Item of cloth repair work (5)
24 Impertinent youngster (4)
25 A bark of pain (4)
26 Steal off to find stories (5)
28 Mathematical proposition, needs to be proved (7)
33 Birdwatchers (9)
34 Ring-shaped coral island (5)
35 Travel on horseback (4)
36 Soil a bird and shoot it for sport (4,6)

Down
1 Pain (4)
2 Is it most important not to tell what keeps the toy spinning? (3,6)
3 & 7a Altruistic type sought by Dracula? (5,5)
4 Imperial weight measure (5)
5 Historic Peruvian native (4)
7 See 3 down
8 Medical instruction written when it's scoreless near the estuary? (3,2,5)
9 Drink fortified wine to give back-up (7)
13 Napoleon was imprisoned here (4)
14 Proof of purchase (7)
16 Rival (10)
20 Thus, one dashes with Dot's method of communicating (5,4)
21 One branch of science (7)
22 Greek goddess of victory (4)
27 Scottish landowner, one found in fat surroundings (5)
29 Precipitous, rash (5)
30 Perhaps Naomi is coming from the country of Muscat (5)
31 Give out cards (4)
32 Stratagem (4)

Name:

Address

The prize will go to the first correct entry opened
Closing date: Friday, August 10, 2018
Post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin

June crossword solution

Across: 1 Win 3 Nonsensical 8 Rapper 9 Underlay 10 Dolly 11,13 Round dozen 15 Minerva 16 Samurai 20 Deems 21 Smart 23 Climb 24,25 Placenta previa 26 Permanently 27 Dud

Down: 1 World-famous 2 Napoleon 3 Needy 4 Squeeze 5 Sheer 6 Colour 7 Loy 12 Diving board 13 David 14 Nears 17 Relieved 18 Refrain 19 Bazaar 22 Theta 23 Curry 24 Pip

The winner of the June crossword is: Catherine Lalor Muinebheag Co Carlow

MONEY MATTERS

Inheritance planning

Thinking about the future now can save you money, writes **Ivan Ahern**

IRELAND has one of the highest rates of gift and inheritance tax in the world. This will affect you if you are likely to be the recipient of an inheritance, or if you plan to leave an inheritance to your family, in the future. However, it's important to know that there are steps that can be taken to reduce the amount of tax that is owed.

Inheritance tax

Inheritance tax, also referred to as capital acquisitions tax, is a tax that can arise where a beneficiary receives an inheritance as a result of someone dying. The beneficiary is responsible for paying the tax.

The tax bill faced by beneficiaries (those receiving the sum) can be substantial, depending on three main factors:

- The relationship between the deceased and the beneficiary
- The net/taxable value of the inheritance
- Any previous gifts or inheritance received.

Payments due

Inheritance can be received free from capital acquisitions tax up to a certain figure. The tax-free amount varies depending on your relationship to the person giving the inheritance. Each group can receive a certain amount tax free. Everything over this amount is subject to 33% capital acquisitions tax (2018 level).

Example

Someone leaves their son €400,000. He can receive €310,000 tax free, but will pay 33% capital acquisitions tax on the remaining €90,000. So having received €400,000, the son would owe €29,700 in tax.

Reducing the amount payable

A 'Section 72' Life Assurance Policy

This policy will help you to protect your family against having to pay capital acquisitions tax. It will provide a cash payment when you die, which your family can use to pay any tax bill that might arise at that stage.

The proceeds of this life insurance policy are exempt from inheritance tax once it is used to pay the inheritance tax bills that arise at that time.

Table: Tax free inheritance limits

Beneficiary	Tax-free amount*
Son or daughter	€310,000
A parent, brother, sister, niece or nephew	€32,500
Anyone outside of the two groups mentioned above	€16,250

**The tax-free amount includes all inheritances the individual has received since December 5,1991, in that particular group*

Annual gifts

You can gift up to €3,000 a year to an individual without owing capital acquisitions tax. This is known as the 'small gift exemption'. This is useful if you can afford to drip-feed their inheritance while you are still alive.

For example, parents can each give of their children €3,000 each year without the child incurring capital acquisitions tax. The child can potentially receive up to €6,000 annually from their parents tax free (€3,000 from each). These gifts will not count towards the child's tax-free limit. Grandparents, aunts, uncles and godparents can make similar gifts, without the child incurring capital acquisitions tax.

Giving the family home to a child

To avoid paying inheritance tax on property, the beneficiary must have lived in the property with you as their only residence for a period of three years immediately preceding the date of the inheritance. This is known as the 'dwelling house exemption'. They must not have any interest in any other sort of property at the time of inheritance (including a holiday home). They must continue to live in the property for six years after inheriting it. They can sell the property after receiving it but must reinvest the full amount in a replacement home. Any difference would be counted against their tax-free threshold.

If you intend to avail of this relief, please be aware that there are certain terms and conditions associated with it.

For more details on inheritance planning, contact Cornmarket at Tel: 01 4206794.

Ivan Ahern is a director of Cornmarket Group Financial Services Ltd

Nurse-led clinics result in 21% drop in moderate to severe pain

THE 'mypainfeelslike…' campaign recently announces results from a nurse-led pain management programme run across Leinster in 2017, which aimed to improve quality of life for people with persistent pain. The results showed a 21% reduction in the proportion of patients experiencing moderate to severe pain, a 6% drop in the proportion of patients who missed work days in the last week due to pain, and a 60% decrease in the proportion of patients waking three to four times a night as a result of pain.[1]

The 'mypainfeelslike…' campaign was created by Grünenthal Pharma Ltd, which also provided funding and support for the nurse-led pain management programme.

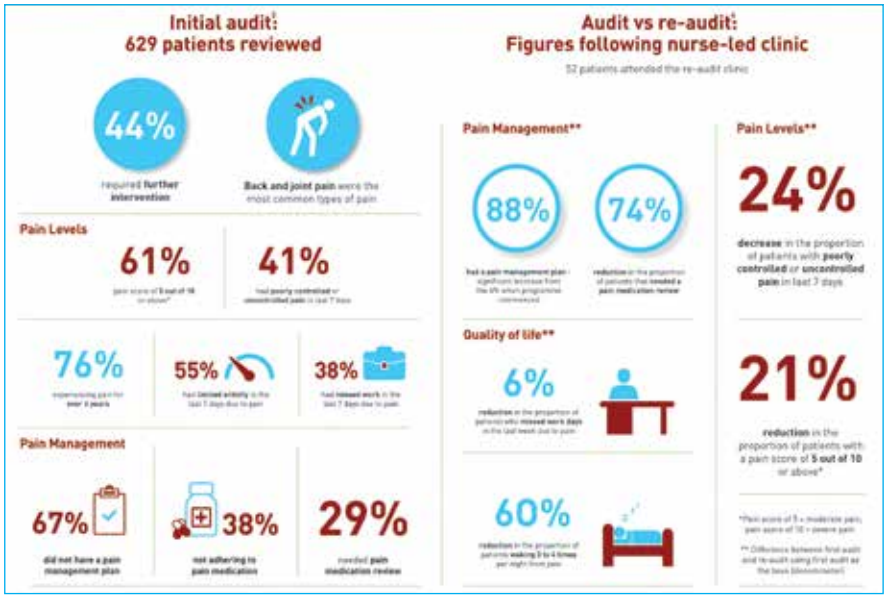
The pain clinics, run over two stages – assessment and re-assessment – were developed to support general practitioners and practice nurses with the management of people diagnosed with persistent pain – that's pain lasting three months or more.[2]

For the initial clinic, 629 patients were assessed and 52 patients attended the re-assessment clinics. In the initial assessment, 67% of patients attending the clinic did not have a pain management plan,[3] whereas, 88% of those who attended the second clinic had a pain management plan in place[1] – showing the benefits of the programme.

Patients identified during an audit process, conducted with the GP, were invited to attend a 30-minutes face-to-face pain management review clinic or assessment with a registered nurse. The nurse provided support and education to achieve better patient outcomes and more effective pain control. Results from the initial clinic showed that 44% required further intervention, 41% had poorly controlled or uncontrolled pain in the last seven days, and 38% were not adhering to their pain medication.[3]

The practice nurse assessed the patient using an audit tool and determined if the patient required a follow up with their GP by assessing the following:

- Stage 1 – pain levels/description of the pain
- Stage 2 – review of current treatment medication plan
- Stage 3 – quality of life
- Stage 4 – new treatment plan and advice.



A reassessment was conducted within six weeks of the initial assessment to measure if the patient's pain control was being better managed following their review. Patients who were still experiencing uncontrolled pain were referred back to their GP.

The inclusion criteria were as follows:

- Patients who had been prescribed a World Health Organization pain ladder step 2 or 3 pain medication for 12 weeks or more
- Patients diagnosed as having persistent pain

"These clinics show how effective pain management can be achieved through nurse-led assessments with support from the GPs", said Joanne O'Brien, registered advanced nurse practitioner (RANP) in pain management. "Providing pain education and support, improving sleep and access to a pain management plan are crucial to helping patients move out of the persistent pain cycle. Practice nurses could take on this task and liaise with the GP as needed to better manage these patients and ensure they adhere to a pain management plan set out for them".

The 'mypainfeelslike…' campaign has developed an information leaflet which gives a brief overview of the nurse-led pain clinic, outlines the stages and the results of the programme. The leaflet available to download at **mypainfeelslike.ie** as also is a video, where Dr Rukshan Goonewardena, GP principal at Ballyjamesduff Family Practice, Cavan, and Caitriona Pollard, the registered nurse who ran the programme, discuss the clinics in more detail – the steps taken, the challenges and the benefits to patients.

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Patient comfort is in the 'squirrel bag'

'Comfort packs' aim to alleviate stress of unexpected hospital stays

SQUIRREL Bag is a new Irish company founded by Maeve Kinsella, a nurse, and her brother Maurice that is hoping to offer some comfort to hospital patients who find themselves in unfamiliar, intimidating and hectic surroundings, often unexpectedly.

Try as nursing professionals might, creating a comfortable and welcoming environment is a challenging task. Patients are cast adrift from familiar surroundings and home comforts, often compounding the physical and emotional discomfort they may already be experiencing.

The goal of Squirrel Bag is to meet the comfort needs of patients in busy hospital departments. The 'Overnight Essentials Pouch' contains a range of items designed to meet the safety, comfort and hygiene needs that patients regularly experience in hospital. Included inside these reusable PVC pouches are non-slip socks, an eye mask, earplugs, toothbrush, toothpaste and a pack of refreshing wipes.

Squirrel Bag's Overnight Essentials Pouch was used in a research project by St Vincent's University Hospital. This project aimed to identify and reduce discomfort within the emergency department by providing patients with comfort packs. The project at St Vincent's subsequently won the An Dhuas Mór overall

award at the Irish Healthcare Awards.

The inspiration for the concept came from working as a nurse where Maeve observed that people would frequently arrive into hospital and be completely unprepared for their stay. The discomfort of not having access to basic care items – which in other circumstances we all take for granted – would regularly affect their morale and overall wellbeing.

Following their father's experience of having to wait on a trolley for 48 hours, the Kinsellas wanted to provide a solution to this issue. Maeve put her nursing experience into practice and, along with her brother, developed Squirrel Bag.

When it comes to sleep and rest, hospitals can be seen as a hostile environment. Many things can undermine the quality and quantity of people's rest, including: bio-cognitive factors, eg. anxiety and illness, environmental factors, eg. noise and light and interpersonal factors, eg. administration of nursing care. This is particularly true when patients are left on trolleys for extended periods of time in areas such as corridors that are not designed for short-term habitation.

These factors will always be part of the hospital experience to varying degrees and therefore the goal of Squirrel Bag is not to eliminate these issues, but rather to alleviate them.

Given the importance of adequate rest in maintaining both physiological and psychological health, the clinical literature has frequently supported 'sensory reduction items' such as eye masks and earplugs as a means of promoting sleep in a simple, convenient and non-invasive manner.

Nurses are on the frontline of acute healthcare services, and must be able to respond to patients' unfolding needs. In the same way, providing quality patient care requires hospitals to adopt a service culture that continually looks for opportunities to improve care provision. Squirrel Bag hopes that their product can reduce pressures on staff by helping them to pre-empt and attend to patients' requests, alongside assisting hospitals in fulfilling the HSE's vision of delivering healthcare in a safe environment that is responsive to patients' physical and sensory needs.

ENSA report from meeting of student nurses in Brussels

INMO industrial relations officer and ENSA vice president Liam Conway represented the INMO and its student members at a recent meeting in Europe. He attended the recent ENSA mid-term meeting in Brussels which coincides with the EFN assembly. The ENSA board has been working hard over the past six months to ensure that the organisation develops and grows. However, it must be said that the board inherited a number of challenges. Firstly, ENSA was in financial difficulty. ENSA is a separate entity from EFN and therefore is a stand-alone not-for-profit organisation under the constitution of Belgian law. As part of its constitution, membership remains free. It overcame this challenge by asking for assistance of all the member nations of EFN during the ENSA report.

"I am delighted to say that the ENSA board secured voluntary donations from the Netherlands, Germany, Norway, Slovenia and France. We have now been able to clear our debts which stretched back to 2011 for the formation of the constitution of ENSA," said Mr Conway.

He further explained that the board is now set the task of planning ahead for its next AGM in Slovakia in October 2018 along with growing its nation membership in Europe.

"Our vision is for ENSA to increase its membership and to be involved in European projects through the European Commission around nursing/midwifery and health. We are also looking at the constitution of ENSA to put forward motions on how to best utilise the board going forward and to ensure consistency throughout in order to fulfil our goals and objectives," Mr Conway said.

Loneliness Taskforce seeks funding of €3 million

THE Loneliness Taskforce recently launched a report recommending that the government takes action on loneliness.

The report, *A Connected Ireland*, recommends that annual funding of €3 million be put towards combating loneliness; responsibility to combat loneliness is allocated to a specific minister and government department; a public campaign is undertaken; support is offered to initiatives and organisations which alleviate loneliness as their primary function; an action plan for volunteering is initiated; and Irish-specific research on loneliness is undertaken.

The Loneliness Taskforce was established by Dr Keith Swanick in collaboration with ALONE CEO Seán Moynihan, to co-ordinate a response to the epidemic of loneliness and social isolation in Ireland. Members of the Taskforce include Prof John Hillery, Justin McNulty MLA, Prof Brian Lawlor, Dr Eddie Murphy, Prof Roger O'Sullivan, Sabrina McEntee, Sinead Dooley, Anne Lynott and Sean Gallagher.

The Taskforce received more than 300 submissions from the general public, Oireachtas and Northern Ireland Assembly Members, MEPs, NGOs, local authorities, public participation networks, and volunteer networks across the country, both North and South.

Speaking at the launch, ALONE CEO Seán Moynihan said: "We urge all members of government not just to read this report, but to act on the recommendations we have made. The submissions to the Taskforce included hundreds of ideas for recommendations to the government to address loneliness. The level of interest in the work of the Taskforce shows how vital this issue is to the people of Ireland."

"We have recommended that €3 million in funding be provided annually to alleviate loneliness, but this is just the beginning. We need research, campaigning and support for initiatives which address loneliness to be implemented now and for the foreseeable future. I hope that this conversation and the actions the Taskforce has started will continue well after this initial funding is spent," said Mr Moynihan.

Chairperson of the Loneliness Taskforce, Dr Swanick said: "The goal of reducing unnecessary loneliness and isolation is a challenge, but it is achievable.

"As a nation, Ireland is ageing with the percentage of people over 70 growing faster than the rest of the population. It was very evident from the submissions that loneliness is not confined to the old and the rise in single-person households plus the increased pressures on young people are also contributing to the risk of loneliness," added Dr Swanick.

Caredoc welcomes students on clinical placement for the first time

Caredoc was delighted to welcome its first group of student nurses from Waterford Institute of Technology and University Hospital Waterford who have been seconded to the out-of-hours service for their third-year community placement. The student nurses have the opportunity of spending two weeks with the community intervention team (CIT) nurses as they attend to patients either in their own home or at the treatment centre. Liz Malone and Mary Burke in Caredoc – who worked closely with Deirdre Chapman, WIT student nurse allocations officer, to arrange the placements – were delighted to see the first students undertaking their placement. Pictured are (l-r): Rachel Cullen, CNM 1; Olivia O'Halloran CIT nurse; Rachel Smyth, WIT third year student nurse; Michelle Lawler, CNM 1; Nicola Coleman, CIT nurse; and Martina Brennan, CIT nurse

Award presented to Crumlin nurse celebrating 40 years of service

LINDA Phelan, a nurse in Our Lady's Children Hospital, Crumlin, has been given a lifetime achievement award. Entitled the Chris McMahon Care Commitment and Compassion Award for Nursing Excellence, the award was presented by Our Lady's Hospital to Linda.

The ceremony in Crumlin was held as part of International Nurses' Day in Our Lady's Hospital as part of a symposium celebrating nurses. The award was sponsored by the RCSI.

As part of this ceremony there was a celebration to mark the 40th anniversary of the IV Team in Crumlin, which was the first of this type of service in the world and has since been copied in other leading paediatric hospitals.

Linda was the main INMO representative in Crumlin for the past 10 years and was also a board member of the NMBI. She worked in Crumlin for more than 40 years, including 36 years on the IV Team.

This Team has delivered cannulation services to children and babies in Crumlin for the past 40 years and has revolutionised the delivery of service in the hospital. Team members have developed special skills in relation to cannulation for babies and children.

Our Lady's director of nursing, Tracey Wall, paid tribute to Linda on in her speech during the ceremony, saying: "Not only is Linda an amazing and skilled clinical nurse she also has other strings to her bow. Linda was our INMO rep for many years and kept us fair and safe because of her in-depth knowledge of industrial relations and particularly how it affected the nurse.

"She was always available to put her union hat on and give advice across nursing disciplines with the nursing teams. I know some of her INMO colleagues are here today in recognition of her commitment to this hospital and to the INMO," added Ms Tracey.

The INMO salutes Linda and wishes her all the best for the future.

– Albert Murphy, INMO IRO and Organiser

September

Wednesday 12
OHN Section Annual Conference Limerick Strand Hotel. Log onto www.inmoprofessional.ie for further details.

Tuesday 18
Retired Nurses and Midwives Section meeting, including a talk on the Fair Deal Scheme by journalist Sinead Ryan, INMO HQ

Saturday 22
PHN Section meeting, INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie for further details.

Saturday 22
Community RGN Section meeting. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie for further details

Saturday 22
School Nurses Section meeting, Midland Park Hotel (formally Heritage Hotel Portlaoise). 10.30am. Contact: jean.carroll@inmo.ie for further details

Saturday 22
Clinical Nurse/Midwife Managers Section workshop. INMO HQ. Contact: marian.godley@inmo.ie for further details

Condolence

❖ The INMO sends its deepest condolence to the family and friends of Finuala Faherty, a dedicated INMO rep who worked as a PHN on Inis Meain on the Aran Islands. Her work involved provision of 24/7 emergency care for her patients and she carried this out with dedication. She represented all of the nurses and midwives on the Aran Islands and in this she was relentless and dedicated, achieving just and appropriate working conditions for all of the nursing personnel on the islands. Our thoughts are with her husband Colm and her children Ciara and Diarmuid at this difficult time. *Ar dheis dé go raibh a anam*

Monday 24
National Children's Nurses Section meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie for further details

October

Wednesday 3
Telephone Triage Nurses conference. INMO Richmond Education & Event Centre. Contact jean.carroll@inmo.ie for further details

Saturday 6
Reunion of past Meath Hospital Nurses Clayton Hotel, Burlington Road, Dublin. 5pm. Cost €50 per person. Contact Mary Kelly, Tel: 087 9393801

Saturday 13
ODN Section meeting. 11.30am in Cavan General Hospital. Contact jean.carroll@inmo.ie for further details

Thursday 18
All Ireland Midwives Conference Crowne Plaza Hotel. Contact jean.carroll@inmo.ie for further details

Thursday 18
SALO Group INMO HQ. 12.00-2.30pm. Contact jean.carroll@inmo.ie for further details.

Tuesday 23 October
Care of the Older Person Section education session on diabetes, and section meeting. INMO Cork office. Bookings essential. Log onto www.inmoprofessional.ie or Tel: 01-6640641 to register

INMO Membership Fees 2018

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

FOHNEU 2019

7th FOHNEU International Congress – April 24-26, 2019

The Federation of Occupational Health Nurses within the European Union (FOHNEU) is pleased to announce the 7th FOHNEU International Congress where the focus will be 'WORKFORCE HEALTH = NATIONAL WEALTH'.

We welcome abstracts for presentation from occupational health nurses and others on business, management, leadership, consulting, and financial aspects in all practice areas of occupational health nursing (final date for abstract submissions, September 30, 2018).

The 7th FOHNEU International Congress will take place in Budapest, Hungary on April 24-26, 2019. More information on the Congress can be found on the conference website **http://www.fohneu2019.hu/**