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WIN

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

World of Irish Nursing & Midwifery

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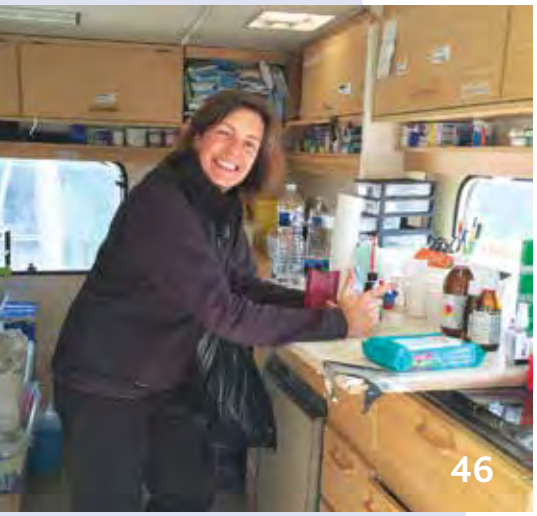
Renewed focus with new Executive Council

Restoration of pay and working hours top of the agenda



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Pay and hours restoration remains top priority

THE accelerated restoration of pay and the reduction of the working week of nurses and midwives, must, notwithstanding recent developments involving the UK and the EU, remain an absolute priority for the new government.

In the immediate aftermath of the UK's decision to leave the EU there is much uncertainty about the actual implication of this decision. In addition, and unique to Ireland, we are the only land border the UK has with a fellow member state and the impact of 'Brexit' upon that border must be reviewed.

Firstly it must be noted that whatever agreement is reached between Ireland and the UK, there must not be any return to the restrictions that were the norm a little over 20 years ago. The removal of checkpoints and their replacement with open roads which allows and encourages movement between Northern Ireland and the Republic must never be taken for granted.

In that context, the new agreements that will be decided upon arising from 'Brexit' must reflect the will of the vast majority of the people which is set out in the Good Friday Agreement and allows unfettered movement in the interests of normal relations, mutual respect and societal wellbeing.

It is also necessary for the EU to reflect on why the citizens of a member state, when given the opportunity, decided to leave. It must be acknowledged, as stated by the ICTU delegation to the recent National Economic Dialogue *(see page 6)*, that the decision to put financial Europe before social Europe was a major factor. The recent years of austerity and retrenchment, where those in need suffered most while banks and bond holders were saved and protected, must now be the source of some reflection by those who made these flawed choices.

Notwithstanding any uncertainty, there must be early acceleration of pay restoration and the reduction in the working week for nurses and midwives. It can already be sensed that employers are voicing the need for caution, financial stringency and further fiscal correction. However, it is now more important than ever, in order to continue to build upon our improving economy, that government moves to restore the pay cuts to public servants, thus increasing their spending power and stimulating growth and production within local communities.

It is also imperative that the UK decision is not used as a barrier to delay the investment in essential public services here after seven years of austerity. This period of austerity has resulted in more than 1,000 families being homeless, increased overcrowding in our emergency departments and cuts to all sectors within education. Increased investment in all of these areas must include the restoration of pay and other conditions of employment of public servants who have shouldered so much of the burden over the past seven years.

It has to be acknowledged that the decision of the UK has created uncertainty, however the reality is that business and trade will re-establish equilibrium and will reach new agreements that will ensure goods and services are traded in a free market with no unnecessary, or new, barriers introduced. This is why, when all the current rhetoric dies down, the government must, without delay, establish an environment which attracts and retains nurses, midwives and other health professionals that are in short supply.

In tandem with this, it must also be hoped that the bureaucrats within the EU realise that their ivory towers, from where they constantly speak down to the ordinary people of Europe, must be dismantled. The basic social needs of every community across the continent must be given equal treatment while ensuring continued economic growth. The purpose of every economy is to serve society and not the other way around. This lesson must be relearned quickly.

Liam Doran
General Secretary, INMO

Call for investment in public services

ICTU sets out its demands at National Economic Dialogue

THE second National Economic Dialogue took place, in Dublin, on June 27-28 2016.

At this meeting the INMO was represented, as part of the delegation from the Irish Congress of Trade Unions, by our INMO director of industrial relations Phil Ní Sheaghdha, and general secretary Liam Doran.

The opening submission from the ICTU *(see below)* summarises, in a very short and succinct format, the priorities, as seen by ICTU, at this time.

In this submission, and in all of the contributions at the plenary and group sessions during the two day meeting, the ICTU repeatedly stressed the need for the new government to prioritise investment in quality public services in this country.

In particular, with regard to health, the ICTU has fully supported the INMO demand that the public health service must, as a minimum, be allocated 10% of GDP over a sustained period. The ICTU has stressed this is 10% of GDP being devoted to the public health service and is in addition to any expenditure in the private healthcare sector in this country.

The National Dialogue saw very detailed discussions involving trade unions, employers and other community groups, under a number of headings, as follows:

- Tax reform for balanced economic growth
- Sensible spending;
- Planning for the future – a digital economy and climate change
- Economic policies to best achieve our full employment goal
- The role of education and training in securing opportunity
- Delivering on Foodwise 2025
- Housing, homelessness, urban regeneration and planning
- Sustainable infrastructure.

The INMO representatives specifically contributed to the following sub-groups:

- Sensible spending chaired by Pascal Donohoe, Minister for Public Expenditure and Reform, (Liam Doran)
- The role of education and training in securing opportunity chaired by Richard Bruton, Minister for Education and Skills, (Phil Ní Sheaghdha).

A full report on the findings/consensus emerging from the two days of intensive engagement, will be published on the INMO website, **www.inmo.ie,** and in forthcoming issues of *WIN*.

ICTU opening submission to National Economic Dialogue

FIRSTLY, I think it is appropriate that I make brief reference to the outcome of the UK referendum particularly given our role as an all-island body. It is our view that the triumph of the 'Leave campaign' is as a direct consequence of the persistent pursuit of austerity policies and the erosion of social progress which alienated workers across the continent.

'Social Europe' was sacrificed to save 'Financial Europe' and there has been a resultant loss of confidence in the entire European project. EU authorities need to grasp this reality and urgently develop a programme of substantial public investment together with a suite of measures to secure workers rights and decent jobs.

Congress believes that this country's first priority must be investment in our public service infrastructure, through a progressive taxation system, with sufficient resources targeted to support the delivery of quality public services. Notwithstanding the *(Brexit referendum)* outcome, the proposed increase of current and capital spending by just 2% for 2017 is in our view wholly inadequate. The investment target should be at least 4% which is achievable given current economic growth levels. As has been the case in other countries, our government needs to persuade the EU to stretch the current fiscal rules, in order to achieve this.

Over the last eight years, working people have paid a huge price for a crisis they did not create. While undoubtedly our economy has recently experienced strong growth, our society is deeply fractured and unequal.

Ireland is one of the richest countries in the world, yet somehow we are unable to house our people. We now have a housing emergency and this should be a matter of great shame.

The market has failed and the State needs to step in immediately and accelerate construction with a substantial increase in the capital budget for 2017. This is not a matter of policy choice – it is an absolute necessity requiring rapid delivery for all those affected.

Our broken Health Service will only be fixed by moving to a universally accessible single-tiered public system funded to a minimum of 10% of GDP on a sustained and continuous basis.

Investment in an accessible, inclusive Education system is a pre-requisite for an equal society and thriving economy.

Policy failure in childcare can be remedied by raising investment to European levels. The very high cost of childcare in this country is a major barrier to labour market entry and significantly contributes to the loss of high quality skills, experience and knowledge within the workforce. Equally the poor working conditions in the sector must be addressed. While there is little or no reference to this issue in the Summer statement, not to invest is a false economy.

Low pay and precarious work define the labour market for too many, especially young workers. The Living Wage must be the 'floor' for pay across the economy. Low hour and precarious work practices must be outlawed.

The Pension crisis requires the creation of a National Superannuation Fund, with contributions from workers, employers and government.

In our view the pursuit of these policy choices would, at least, begin to address the social fractures and inequalities so evident in our society today.

– Patricia King,
General Secretary, ICTU

Additional health funding welcomed

THE additional allocation of €500 million to the public health service announced last month has been welcomed by the INMO.

This allocation should allow for the maintenance of existing service levels as well as additional funding for such critical areas as homecare and disability services. The additional allocation contains funding earmarked for a winter initiative to be targeted at further reducing emergency department overcrowding later this year.

The INMO is seeking early meetings with Ministers of State at the Department of Health Helen McEntee and Finian McGrath to discuss issues affecting older people and disability services, respectively.

This additional allocation should also remove any confusion over the recruitment of nurses and midwives to vacant posts and assist in recruiting staff to ensure safe patient care and manageable workloads for staff, according to the INMO, .

"This additional allocation is most welcome and is required by the health service which continues to face increasing levels of demand. The subject of much confusion in recent weeks, it is imperative that the HSE immediately recommences recruitment to frontline nursing and midwifery posts," said INMO general secretary Liam Doran .

"The additional allocation, particularly earmarked funding for a renewed winter initiative, must now be subject to early discussions with the ED Implementation Group. This will ensure the system utilises this additional resource efficiently and effectively, on the frontline, in the interests of patient care and standards of service."

Pilot staffing studies set to commence on wards

THE INMO is currently involved in finalising the arrangements for the pilot staffing studies, taking place in three hospitals, as the next step in implementing the Taskforce on Nurse Staffing recommendations for medical/surgical wards.

The pilot studies are taking place in Beaumont Hospital (two wards), Our Lady of Lourdes Hospital, Drogheda (two wards) and St Columcille's Hospital, Loughlinstown (one ward).

The purpose of the pilot studies, which were recommended in the Interim Report of the Taskforce on Nurse Staffing, involved the allocation of €2 million to assess whether the Taskforce recommendations deliver improved patient care, an improved working environment for staff and, fundamentally, stable consistent staffing levels leading to improved recruitment and retention.

The context for the pilot studies is the implementation of the interim recommendations, which provide for a range of measures including:

- A 100% supervisory role for the CNM2
- The measurement, using an agreed dependency tool, of patient acuity and dependency, by the CNM2, which, combined with the CNM2's professional judgement, will lead to a determination of the required staffing levels
- All staff on the five pilot wards to be permanent thus minimising need for agency staff
- A nurse to HCA ratio of 80% to 20% once safe nurse staffing levels have been determined and are in place
- Close measurement of safety CLUEs (Care Left Undone Events) in all five wards, both before and during the pilot study to demonstrate/confirm the positive impact of safe consistent staffing levels on patient care.

The pilots are due to last for approximately four months at which time a full report will be issued to the National Taskforce which will then meet, in October/November, to review the feedback, finalise its report and issue its final set of recommendations.

INMO general secretary Liam Doran said: "The Taskforce on Nurse Staffing was established as a direct result of the INMO Safe Staffing Campaign commenced in May 2014. The Taskforce interim recommendations set a clear context for determining staffing in all medical/surgical wards for the primary purpose of improving patient care and the working environment of nursing staff.

INMO general secretary Liam Doran: *"The INMO views the work of the Taskforce as absolutely critical in addressing serious staff shortages existing right across the service at this time"*

The pilot studies will allow for the testing, of these recommendations over a three to four month period, before the National Taskforce completes its work and issues a final report before the end of the year.

"The INMO views the work of this Taskforce, on which we have been represented at all stages, as absolutely critical in addressing the serious staff shortages existing right across the service at this time and for creating, and maintaining, a greatly improved working environment for our members".

• *See also update on page 30*

INMO participating in several HSE review groups

IN recent weeks the INMO Executive Council has submitted nominations to a number of important working groups, being established by the HSE, to address a range of important issues. The details of these working groups are:

- The Development of a Strategic Vision and Educational Framework for Nurses Working with Older People – *INMO nominee to this group is Eileen Kelly, Executive Council member and staff nurse at Sacred Heart Home Roscommon*
- National Review of Maternity Care Assistants in Maternity Hospitals/Units – *INMO nominee to this group is Mary Gorman, Executive Council member and CMM2, Our Lady of Lourdes, Drogheda*
- Development of a Framework to Determine Staffing and Skill Mix Requirements for Palliative Care Nursing – *INMO nominee to this group Patricia Hayes, Athlone Branch and staff nurse, South Westmeath Hospice.*

The Organisation will actively support our nominees to these three areas of important work and regular updates will appear in *WIN* and on the INMO website, **www.inmo.ie**

ED overcrowding eases off in May

THE INMO trolley/ward watch figures for May show a 14% reduction in the number of admitted patients on trolleys compared to May 2015.

The figures *(see Table 1)* confirm that 6,627 patients admitted for care were on trolleys this year, compared to 7,713 in May 2015.

The INMO welcomed the fact that the level of overcrowding in emergency departments has eased but also noted some factors that may have contributed to the fall in figures:

- Improved weather this year
- The continued implementation of the ED agreement, between the INMO, the Department of Health and the HSE, which has prioritised the ED crisis at a system wide level.

However, the INMO warned that this positive development in trolley figures may be short lived if the recent HSE recruitment freeze is not lifted immediately.

The consequence, of any delays in recruitment of nurses and other frontline staff will result in the curtailment of services and a reduction in bed capacity, which will exacerbate pressures on emergency departments.

The INMO has repeated its call on both the Minister for Health Simon Harris and the HSE, to immediately lift any restriction on recruiting frontline staff and to ensure that all hospital managements proceed to fill all vacant frontline posts.

The Organisation is also calling for immediate engagement on finalising initiatives to expand bed capacity and services for the forthcoming autumn/winter period.

INMO general secretary Liam Doran said: "Any reduction in the number of sick patients on trolleys must be welcomed, particularly after the worst winter on record for ED overcrowding. Everyone must now re-affirm their commitment to implementing the recent ED agreement and continue to prioritise the crisis facing emergency departments in all decision making. The confusion that now exists over recruitment must be removed so that we can attract the 4,000 Irish nurses and midwives needed to fill vacant posts and safely staff our services."

Table 1. INMO trolley and ward watch analysis May 2016

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

Comparison with total figure only:

Increase between 2015 and 2016: –14%
Increase between 2014 and 2016: 13%
Increase between 2013 and 2016: –1%
Increase between 2012 and 2016: 7%
Increase between 2011 and 2016: –10%
Increase between 2010 and 2016: 15%
Increase between 2009 and 2016: 57%
Increase between 2008 and 2016: 59%
Increase between 2007 and 2016: 64%
Increase between 2006 and 2016: 57%

Talks continue to amend policy on safeguarding persons at risk of abuse

NATIONAL talks are continuing between the HSE and nursing unions on the new national policy on safeguarding vulnerable persons at risk of abuse.

This policy was introduced in December 2014 without consultation or negotiation with the INMO, SIPTU or the PNA regarding its impact on staff. As there is no agreement on the policy, the unions advised members not to involve themselves in training until national discussions concluded. Members were advised that 'Trust in Care' remained the sole policy agreed for use in allegations of abuse against staff.

Meanwhile, the third meeting on the new policy took place on June 15, when the HSE again confirmed that:

- It accepts that proper consultation, as is required, did not take place on the impact and roll out of this policy for nursing grades
- Consultation took place with social worker grades, however, it accepts and regrets that the correct process was not followed with nursing grades
- Matters relating to allegations of abuse against staff members stand to be dealt with under the 'Trust in Care' policy, of which the HSE national office has notified all regional community health offices (CHOs). The HSE accepts that until clarification on a new policy is complete, referrals of suspected abuse of an elderly person or a person with a disability can be referred by nursing staff as they had been up to now.

The HSE committed to confirming this position in writing to the INMO and other nursing unions, and this would then be notified to all CHO areas. In the meantime, the issues that arise in respect of the implementation of this policy for nursing require negotiation and consultation on the following:

- The need for clarity on the preliminary screening that is required under the 'Safeguarding Vulnerable Persons at risk of Abuse' policy and preliminary screening that is required under the 'Trust in Care' policy. Management has agreed to revise this and has advised that legal advice is being sought on this matter. Management will revert with a position to the INMO at its next meeting
- The HSE confirms that the responsibility for preliminary screening does not rest solely with one grade of staff and that if matters are raised, regardless of the form that is used, they have to be dealt with. The roles and responsibilities of various grades of staff will need to be discussed in the context of the proposed changes as set out in the 'Safeguarding Vulnerable Persons at Risk of Abuse' policy and the implications for nursing staff. In particular, it appears that the additional workload for nursing staff has not been factored in and the INMO is seeking that the implications for staffing and the resultant reduction of their patient contact time must be considered
- Definitions of abuse vary between the Trust in Care policy and the 'Safeguarding Vulnerable Persons' policy and the INMO is seeking that this matter is also discussed.

Overall, the INMO is now engaged in a working discussion which accepts that the manner in which the policy was introduced unilaterally, without any discussion or dialogue, was incorrect and now needs to be corrected. Therefore, it is agreed that the policy needs to be amended. The effects of the changes introduced, without agreement, will be discussed and any amended policy will have to provide realistic supports, such as protected time and increased staffing to nursing services if duties, other than those held prior to December 2014, are assigned to them in these areas.

The next meeting is provisionally scheduled to take place July 11. The INMO requests that members continue with the advice and practice of reporting any suspected abuse incidences as they would have prior to this policy. Members are advised that training on this policy cannot take place until such time as the amendments that are required are made.

– Phil Ní Sheaghdha, INMO director of industrial relations

Richmond refurbishment set to start

Richmond Hospital set to become new INMO Education and Event Centre

THE INMO Executive Council has announced that, following planning, design, tendering, finance and other works being completed, the refurbishment project on the Richmond Building is now due to commence.

The investment in the Richmond, to make it the INMO Education and Event Centre, will see the building become the Organisation's hub for greatly expanded education and professional development services, for members.

Work is expected to take a little under six months and the newly refurbished building will be open in the first quarter of 2017. It will have a number of lecture theatres, an auditorium, café/restaurant together with first class audio, visual and IT infrastructure. This will allow the Organisation to offer members a much wider range of programmes, fully cognisant of the competency assurance requirements which will be brought forward, in the near future, by the Nursing and Midwifery Board of Ireland. In addition, the refurbished building will also allow the INMO to rent out facilities to third parties, thus providing a further income stream to the Organisation, to continue to develop services and supports for members.

Ongoing updates on the development works will be covered in *WIN* and details of the opening of the new Education and Event Centre will be announced in due course.

New IRO for Western Area

Following open competition, Anne Burke takes up the post of industrial relations officer, based in the INMO Galway Office, from July 4, 2016.

Ms Burke has been a member of the INMO Executive Council for the past six years, and has been an officer of the Galway Branch in recent years. Ms Burke is replacing Clare Treacy in the Western Area, who is moving back to INMO HQ in Dublin.

Phil Ní Sheaghdha, INMO director of industrial relations, reports on current national IR issues

Changes in community care structures

THE structures within community healthcare organisations have altered and there are now nine community care organisations, each led by a chief officer.

The INMO and other health service unions attended a WRC conciliation conference on June 9 to discuss the roll out and other changes envisaged for community healthcare organisations and how these would affect staff employed within these structures.

The INMO sought all information that currently exists in respect of the structures and all correspondence relating to the chief operations officers' appointments and other management grades to the community care structures to date. Management has agreed to furnish this information to the INMO.

The INMO has also secured a forthcoming separate meeting dealing specifically with nursing issues, including nursing management structures and their implications, if any, for staff in the community structure.

Nursing/medical interface on the transfer of tasks

THE chairman's note of the Lansdowne Road Agreement and the Haddington Road Agreement allows for savings that accrue as a result of the transfer of certain tasks to be applied to the restoration of premium pay, which was removed from nursing grades for working the hours between 6 and 8pm.

A composite document was negotiated, on foot of the chairman's note, by the INMO, SIPTU Nursing and the IMO. This document, which can be found on **www.inmo.ie**, allows for the orderly transfer of four identified tasks on condition that training has been provided to nurses/midwives and staffing levels are adequate.

Local implementation groups have been set up in acute hospitals in order to agree certain aspects of this implementation process, and that work is ongoing.

This framework document also provides for a verification process and the national implementation group is in the process of conducting verification meetings with hospital groups. At the time of going to press verification meetings had been held with:

- National Children's Hospital Group
- SAOLTA Hospital Group
- Mid West Hospital Group
- Southern Hospital Group.

There are three remaining hospital groups to be examined: Ireland East, the RCSI and the Midlands, which are scheduled to take place soon.

To date the feedback to the verification group is positive in that there is no resistance to the roll out of the specific duties. It is clear from the documentation and the agreement reached at national level that this agreement does not require the transfer of all responsibility for these duties to nursing staff from medical staff. The agreement is quite specific that medical staff will remain involved and the most appropriate staff member, ie. a trained nurse or doctor, should provide this particular service where necessary.

The feedback from the groups whom the verification team have met to date advises of real difficulty in access to training for nursing/midwifery staff and also difficulty with staffing levels in some locations. However, it is clear that there are no impediments to the roll out other than those that would prevent the safe delivery of this service to patients.

There is a great degree of nurse involvement confirmed to the verification group, mainly in first dose IV, phlebotomy (out of hours period) and IV cannulation. Nurse/midwife facilitated discharge is taking slightly longer but is well advanced in the maternity services.

The next step is that the national committee is due to meet to review the information obtained through the verification meetings. It is the business of the committee to decide if the verification process, as set out in the agreement, has been completed and to sanction payment.

If there are any disputes, the independent chair, Sean McHugh, will be requested to arbitrate on such matters as is allowed for in the agreement. The INMO will keep members updated and informed on progress.

Talks on measurement of all hours worked

AS part of the Lansdowne Road Agreement, a chairman's note recorded agreement between the employers and trade unions that clause 1.1 of the Haddington Road Agreement would be activated in September 2015 and completed by June 2016.

Clause 1.1 states: "The standard working week for nurses and midwives will be 39 hours per week, with effect from July 1, 2013. Discussions will commence immediately on how to measure all time worked by nurses and midwives to ensure all attendance hours are captured."

These discussions have commenced and there have been a number of meetings at which the trade unions and management have explored all aspects of attendance hours, including unpaid lunch breaks and hours attended prior to and after rostered shift times. The most recent meeting was held on June 10 and further work is required in respect of this aspect of the agreement.

The unions and management have agreed to extend the timeframe to allow this work to be conducted correctly, as the first meeting did not take place in relation to this until April 2016 (not in September 2015 as per the chairman's note). The unions are keen to progress this matter and have sought that all matters relating to it are prioritised with the employer. The INMO will keep members updated on all aspects of the implementation of this chairman's note.

Who exactly stands to gain from TTIP?

ICTU warns of the potential effects of this proposed trade deal

TTIP is the Transatlantic Trade and Investment Partnership, a proposed trade deal between the US and the EU that has been in negotiation since 2013, and is arguably the largest and most significant trade deal in modern history.

How is something which has potentially far-reaching consequences for working people and governments throughout Europe largely escaped public discussion for so long?

Firstly, the detail of trade agreements is not something that is easy to get the media or the general public excited about. Secondly, there has been a deliberate strategy by the political classes to curtail debate on TTIP – it warrants not even a reference in the 155-page *Programme for Government* recently published, and the negotiations have been conducted under a cloud of secrecy with widespread objections on the grounds of democracy, openness and transparency.

What does TTIP involve?

A motion passed at the ICTU Biennial Delegate Conference in July 2015 stated the belief of Congress that 'the primary purpose of TTIP is to extend corporate investor rights'.

It is hard to object to this statement when you consider that TTIP confers special legal rights to corporations through access to a new investment court system, where private corporations have the right to sue governments for financial compensation if they believe their rights have been violated, when government actions or policy 'interfere' with their ability to make a profit. This is without doubt the most controversial provision being proposed in TTIP.

Meanwhile, trade unions, who have largely been bypassed in the negotiation process, would merely be able to seek a 'letter of criticism' from a group of eminent experts if objections are raised.

Regulation and public policy

Another concerning element of the agreement is the establishment of an unelected 'Regulatory Cooperation Board', which would seek to align regulations and standards and curtail those deemed a 'barrier to trade'.

In light of this, it is worth considering some public policy measures that have been discussed in Ireland in recent years: the introduction of plain packaging for tobacco, minimum unit pricing for alcohol, and a 'sugar tax'.

Whether you agree or not with these proposals, their stated intention is to introduce regulations in the interests of public health, which should surely be a function of sovereign governments. This function would be put at great risk under TTIP.

Examples of states being sued by corporations in similar circumstances are already evident in Canada, Australia, Germany and elsewhere, largely due to robust commitments to prioritise renewable energies in a bid to tackle climate change, or to legislate to tackle the harmful effects of cigarettes. Powerful fossil fuel and tobacco lobbies use investor-state dispute settlement mechanisms to stand in their way. Granting corporations further powers to prevent public policy actions through objections and lawsuits does not make sense in this context.

Indeed, in the powerful book recently published by Canadian author and social activist Naomi Klein, '*This Changes Everything*', she argues the passage of NAFTA (North American Free Trade Agreement) in 1994 has been the single biggest roadblock to effective action on global warming in the past two decades.

Given the massive public interventions that will be required to tackle the biggest challenges of our time – underinvestment in public services, economic inequality, and climate change – this is simply incompatible with the direction in which TTIP proposes to take us and the restrictions it will impose on public policy.

As a small open economy that is heavily reliant on foreign direct investment, Ireland is particularly sensitive and exposed in this area.

Public services

The risks posed to public services under TTIP are of particular concern.

All previous major trade agreements have utilised what is known as a 'positive list' approach. In other words, public services are protected from privatisation unless explicitly referred to. TTIP takes the opposite approach – a 'negative list', meaning all services are open to future privatisation unless explicitly exempt.

This means all future service areas will not be protected. Some 20 years ago broadband infrastructure was not a factor, but it is now a core public service need for business and quality of life. New and emerging public services could therefore be liberalised by default.

Labour standards

Another area of significant concern is that of labour standards. Given that the stated goal of TTIP is to align regulations and standards between the EU and US to remove barriers to trade, the fact that the US refuses to ratify core International Labour Organisation (ILO) conventions such as collective bargaining and freedom of association is gravely worrying.

While EU negotiators have moved quickly to give assurances that no watering down of standards in this area is imminent, recent leaks of secret TTIP papers by Greenpeace would suggest the 'red lines' which our negotiators are putting forward in public are not being reflected in the ongoing negotiations. Many commentators argue that opposition to TTIP equates to being 'anti-trade' – this is quite simply not the case. It is much more about the type of trade we are talking about, and who stands to benefit from it.

Even organisations like the Irish Farmers Association (IFA) are raising significant concerns about the impact on the Irish food and agriculture industries of further opening up of markets to US producers. Greater availability and access to cheaper but more chemically produced US meats could quite feasibly lead to a global 'race to the bottom' in food standards.

Where next?

The ICTU has formed a working group to coordinate a public awareness campaign on the dangers associated with TTIP and CETA. The INMO will be participating in this campaign and would encourage members to actively engage with their political representatives in relation to the dangers highlighted in this article.

– Deputy general secretary Dave Hughes is the INMO representative on the ICTU working group

Spotlight on OHN Section

THE Occupational Health Nurses Section is very proactive within the INMO. It represents more than 200 OHNs, both in the public and private sectors.

Occupational health is a specialty that provides a holistic approach to employee health, safety and well-being. It looks very specifically at the effects of work on health and health on work. Occupational health nurses are ideally and uniquely positioned to support and help employees stay in work and live full and healthy lives by empowering them to take ownership of their own health, safety and wellbeing.

With increasing legislation, government initiatives and business operational targets, a holistic and coordinated approach in this discipline has never been more important to ensure cost-effective compliance in delivering a duty of care to our employees. Research shows that good health is good for business and healthier workplaces have more engaged employees with better financial results. Occupational health has become a 'need-to-have' rather than a 'nice-to-have' for employers, and OHNs have a unique opportunity, by integrating occupational health into an organisation, to play a significant role in overall business strategy.

On a European level, Margaret Morrissey and Una Feeney represent Ireland on the board of the Federation of Occupational Health Nurses within the European Union (FOHNEU).

Section Officers

Chairperson

Una Feeney
feeney_una@lilly.com

Vice chairperson

Anne Marie Graham
annemarie.graham@hcsi.ie

Secretary

Margaret Morrissey
morrissey_margaret@lilly.com

Affiliation Form for INMO Section Membership

Name:_____

INMO membership No:_____

Home Address:_____

_____

_____

Tel (work):_____

Tel (home/mobile):_____

Email:_____

Place of employment:_____

Job title:_____

Second section option (to obtain information only):

_____

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

Tick ONE relevant Section you wish to affiliate with

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

Safeguarding health for all citizens of the world

Elizabeth Adams discusses a report from the Safeguarding Health in Conflict Coalition and reports from the 69th World Health Assembly

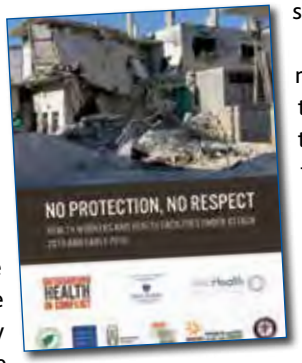
'No Protection, No Respect'

VIOLENCE against healthcare workers, facilities and patients is one of the most serious and overlooked humanitarian challenges globally. The Safeguarding Health in Conflict Coalition was established in 2010 to address the under-reporting of attacks on health workers and facilities in conflict areas. The INMO is a member of the coalition with over 30 leading international nongovernmental organisations, including the International Council of Nurses (ICN).

In recent years, the international community has witnessed an increase in attacks and interference with hospitals, health workers including nurses, patients, ambulances and transport of supplies. Aside from the human toll they take, these attacks compromise the ability to deliver care to populations in great need, impede efforts to reconstruct health systems after war, and lead to the flight of health workers whose presence in a time of great social stress is essential. Such violence is in violation of international law, the Geneva Convention and customary international humanitarian laws. The laws date back over 150 years and state that parties must not attack or interfere with health workers, facilities, ambulances and people who are sick or wounded.

Our goal is to promote adherence to international humanitarian and human rights laws that protect health facilities, health workers, ambulances, and patients during conflict. The coalition promotes the security of health workers and services threatened by war or civil unrest. It monitors attacks on and threats to civilian health; strengthens universal norms of respect for the right to health; demands accountability for perpetrators; and empowers providers and civil society groups to be champions for their right to health.

As part of the Safeguarding Health in Conflict Coalition, we have consistently focused on driving the agenda and lobbying international bodies including the UN, the World Health Organization and other key stakeholders including governments throughout the world. Recently, the United Nations Security Council adopted Resolution 2286 (2016), strongly condemning attacks against medical facilities and personnel in conflict situations. The Resolution was co-sponsored by more than 80 member states, along with medical and humanitarian personnel exclusively engaged in condemning attacks and threats. The UN Resolution 2286 is accessible at: www.un.org



In its third annual report, No Protection, No Respect, the Coalition found that during 2015 and the first three months of 2016, deliberate or indiscriminate strikes on healthcare have killed medical workers and patients, decimated medical infrastructure and robbed countless civilians of vital medical care in 19 countries around the world, including:

- 122 hospitals attacked in Syria
- 100 health facilities attacked in Yemen
- 200 plus humanitarian compounds and transports attacked and looted in Central African Republic
- 28 polio vaccination workers murdered in Pakistan
- 60 women detained and raped in a hospital in Sudan.

The report also found that, in many instances, parties to conflicts failed to take required steps to avoid harm to medical facilities, staff and patients, and obstructed access to healthcare.

Table 1: Members of the Safeguarding Health in Conflict Coalition

ACBAR (Agency Coordinating Body for Afghan Relief and Development), Alliance of Health Organizations (Afghanistan), Center for Public Health and Human Rights at the Johns Hopkins Bloomberg School of Public Health, Consortium of Universities for Global Health, Defenders for Medical Impartiality, Doctors for Human Rights (UK), Doctors of the World USA, Egyptian Initiative for Personal Rights, Friends of the Global Fund Africa (Friends Africa), Global Health Council, Global Health through Education, Training and Service (GHETS), Human Rights Watch, International Council of Nurses, International Federation of Health and Human Rights Organisations, International Health Protection Initiative, International Rehabilitation Council for Torture Victims, International Rescue Committee, IntraHealth International, Insecurity Insight, Irish Nurses and Midwives Organisation, Karen Human Rights Group, Management Sciences for Health, Medact, Medical Aid for Palestinians, North to North Health Partnership (N2N), Pakistan Medical Association, Physicians for Human Rights, Physicians for Human Rights – Israel, Save the Children, Surgeons OverSeas (SOS), Syrian American Medical Society, University Research Company, and World Vision

The after effects of attacks are far reaching and negatively impact the health of people in specific areas in need of urgent care. Healthcare deprivation is one of the major effects, due to a loss of facilities and medical staff. Such losses are detrimental to the public as a single closure can leave an entire population without access to a health facility and the appropriate staff. In recent months, UN agencies have reported an appalling number of people in dire need of healthcare access. Population displacement, lack of resources and civilian injuries are all contributing factors.

Urgent action is needed and harsher measures need to be taken in order to end such violence. Although there has been progress on raising awareness, progress is lacking on taking the correct measures to prevent gruesome attacks on healthcare workers, patients and facilities, and to ensure that those inflicting violence are held fully accountable for their actions.

The Safeguarding Health in Conflict Coalition's report: No Protection, No Respect can be found at: www.safeguardinghealth.org/report2016

Nursing and midwifery contributing to the 69th World Health Assembly

Nursing and midwifery has been historically recognised within the WHO. The World Health Assembly (WHA) is the supreme decision-making body of WHO. The professions have been central to decisions of governing bodies and the adoption of WHA resolutions which have culminated in 10 WHA resolutions since 1948 specific to nursing and midwifery.

The ICN has been a collaborating partner since the establishment of WHO and the INMO is a member of ICN for over 90 years. ICN encourages and supports nurses to attend the WHA as part of their country's delegation, or as part of ICN's delegation, in order to ensure that nurses, the largest health profession in the world, have a voice in high-level decision making and policy development.

The INMO was a member of the ICN delegation with 69 participants and spoke to a number of key agenda items at the 69th session of the WHA in Geneva in May. The six days of discussions involved over 3,500 participants, including health ministers and senior health officials from among the 194 WHO member states, as well as representatives from civil society and other stakeholders.

ICN made interventions and statements on the draft global plan of action on violence; Health in the 2030 Agenda for Sustainable Development Goals; the draft global strategy and plan of action on ageing and health; the global action plan on antimicrobial resistance; promoting the health of migrants; health workforce and services; and the Global Strategy on Women's, Children's and Adolescent's Health.

Draft global plan of action on violence

Highlighting the leading role that nurses play in addressing violence, as the first point of care for elder abuse, intimate partner violence, conflict, post-conflict and humanitarian settings, the ICN confirmed its commitment to working with governments to implement this action plan, which calls for improved access to quality healthcare by eliminating discrimination and violence in the health workplace, patient-centred and gender sensitive services, and promotion of human rights.

Health in the 2030 Agenda for Sustainable Development Goals

WHO and governments were called on to continue to actively involve nurses in the planning and development of relevant policies and strategies, and advocated for a system-wide investment in universal healthcare (UHC), with a primary focus on health promotion and prevention of illness. ICN emphasised the central role of nurses in addressing non-communicable diseases (NCDs), substance abuse, traffic accidents and injuries, sexual and reproductive health, environmental safety, and affordable, accessible models of care.

Multisectoral action for a life course approach to healthy ageing: draft global strategy and plan of action on ageing and health

A strong primary healthcare system is key to improving the health and wellbeing of older people. With this intervention, ICN called on governments to remove regulatory barriers in order for nurses to carry out their role in preventing, identifying and treating age-related illnesses, thereby facilitating the shift to primary healthcare.

Global action plan on antimicrobial resistance (AMR)

The success of the global efforts to combat AMR largely depends on the extent to which the millions of nurses around the world are mobilised and diligent in tackling this major public health threat. ICN called for coordinated and sustained efforts in reducing global AMR and promotes the collaboration of nurses, consumers, physicians, pharmacists, and veterinarians, as well as the environmental and agricultural sectors.

Promoting the health of migrants

The inclusion of migrants' health in the development of regional and national health strategies is essential for the dialogue and cooperation necessary to address their specific health challenges. Nurses play a central role in addressing the physical and mental health challenges of refugees and migrants. Therefore, ICN encouraged WHO and governments to continue to work co-operatively with nurses in their examination of the extent of the problem in their countries.

Health workforce and services

The strategy to reorient health systems towards primary healthcare and people-centred health services was strongly supported by ICN. Strengthening health systems can only be achieved through investing in nursing and midwifery as part of strengthening human resources for health (HRH), which is a fundamental strategy for the successful achievement of the sustainable development goals. ICN, therefore, affirmed its commitment to continue working with WHO and governments to strengthen health systems through HRH strengthening capacity. It urged WHO and its member states to ensure that nurses are involved in every aspect of the policy making agenda of these proposed health workforce strategies.

Operational plan to take forward the Global Strategy on Women's, Children's and Adolescent's Health

The World Health Professions Alliance (WHPA) made an intervention supporting the Global Strategy on Women's, Children's and Adolescent's Health, emphasising the essential need for effective planning and financing for an adequate and competent health workforce that meets the current and future needs of populations.

The WHA concluded with several resolutions adopted on a broad range of health issues.

Elizabeth Adams is INMO director of professional development

The ICN Congress 2017 takes place in Barcelona, Spain on May 27-June 1, 2017. The theme is 'Nurses at the forefront transforming care'. See **www.icncongress.com** *for instructions on submitting abstracts for the scientific programme and details on the themes to be addressed. Online submission of abstracts will close on October 10, 2016*

Compassion, care and commitment

Taking the helm at a critical time in the public health service, new INMO president Martina Harkin-Kelly sets out her priorities. **Tara Horan** reports

ON MEETING new INMO president Martina Harkin-Kelly, it is evident that nursing is the very lifeblood that makes her tick. The youngest of six siblings, all of whom went into nursing, Martina says it was inevitable that herself and her twin sister Carmel would follow in the family tradition.

"In nursing and midwifery today, we are coming full circle back to the core values of compassion, care and commitment, as was reaffirmed at the recent national nursing and midwifery conference in Farmleigh," Martina said.

"These are three key elements that I would have lived and breathed every day at home. There was always a caring element – my sisters and brother caring for one another, my mother caring for her elderly mother. My mother was very pivotal within our community looking after families that may have had less than we had. That was the mindset I was brought up in so it wasn't a huge leap into nursing," Martina said.

Martina grew up near Glenmaquin, just north of Letterkenny, Co Donegal, and attended secondary school in Loreto Convent, Letterkenny. She trained as a general nurse in Sligo General Hospital from 1983-86, qualifying at a time when Ireland was nearing the end of a long recession. While she got some hours in Sligo after qualifying, she was anxious to spread her wings, she recalls.

"I can understand today's students having that hunger to spread their wings too, although there are more post-registration opportunities here now than there were then. The amount of courses available here in 1986-87 was minimal in comparison to the broad spectrum of post-registration courses on offer in the UK at the time," she said.

While there is a much wider choice now, she said it is worrying that there is not always enough uptake for some higher diploma courses to go ahead as students go abroad. She points to the time lapse between qualifying and the start of the academic year as a factor for qualifying nurses/midwives going abroad.

"We cannot compete at the moment with the packages on offer from the UK and further afield. Locked into those packages are usually continuing professional development or post-registration education."

How can we address this? "We have to look at incentivising nurses and midwives within this country. The government has to put a value on the nurse/midwife and on their professional qualifications, which to me is on the same level as all other healthcare professionals. I don't see the nurse or midwife as any different to the occupational therapist, the physiotherapist, the radiographer. They have all come out with a degree from a third level institution. Yet, there is no parity from a professional perspective, from a financial perspective, and certainly no parity on a working hours perspective. We are the only health professionals with a 39-hour week," Martina said.

Continuing education

"CPD is now pivotal to everything that nurses and midwives do. You have to keep absolutely up to date with everything going on. Unfortunately, from a legislative perspective, CPD is not locked in as a sacrosanct, as it is with the medical profession. The only training that nurses and midwives are released for at the moment is their mandatory training – and even this is falling behind due to staffing shortages. The rest is at the discretion of line managers."

Shortly after qualifying, a strong interest in ophthalmics prompted Martina to take up a staff nurse position in Moorfields Eye Hospital, London, where she obtained a Diploma in Ophthalmic Nursing.

Martina spent a total of four years at this pioneering eye hospital, returning to Ireland with her husband Alan in 1991, when she was successful in securing a staff nurse post back at Sligo General Hospital.

"I settled back into Sligo General immediately. It was a wonderful feeling being back," she said, while admitting she had to readjust to the Irish way of doing things.

"The system in England was very flattened hierarchy wise and very different to the handmaiden system I came back to in Ireland. We have moved on a bit now from the medical model of care in Ireland but it still dictates the immediate care of a critically ill individual. And there is still not the recognition there should be of the role of the advanced nurse/midwife practitioner.

"We talk about the extension and expansion of the role but people often get confused about those two entities. Extending something is extending something that you've already done. So if I have been involved in, for example, taking out a drain from a wound then wound care is an

extension of that role. Whereas expanding the role is taking on something that we as nurses or midwives have never done before. So advanced practitioners, for example an ANP in dermatology, would be in theatre doing biopsies – they are minor operatives. This is a huge expansion of the role of what the profession would have been seen as."

Recognition of extended role

She believes society needs to be educated on what the role of the nurse and midwife is today. The Commission on Nursing in 1998 fundamentally transformed the management structures within the professions, she said. "However, we now need to look at the role of the nurse/midwife and give recognition to the extended, expanded role. The importance of care needs to be linked to the wellbeing of the individual patient. I want the vital roles of the nurse and midwife to be put out there in neon lights. I want us to be acknowledged professionally, financially and above all for the time and commitment we give to the professions."

Clinical teaching

After working in the clinical area in Sligo for three years or so, Martina was approached by Kay Craughwell, then director of nursing at Sligo General and INMO president from 1991-96, to work at the School of Nursing in Sligo General. "As I had done a clinical teaching course during my time in London, this was a natural progression for me. However, I always kept my toes dipped in the clinical area, supervising the students in their clinical proficiency. So I enjoyed the clinical and classroom side of it – being a natural born talker," she quipped.

She took a permanent position in the School of Nursing in 1996, just prior to the Diploma in Nursing coming to Sligo General. Being good at maths, she was given the job of rostering the students from 1996 onwards, allocating the places for all three cohorts of students (certificate, diploma and degree).

"Further education is now the linchpin to keep our newly qualified graduates. While there has been a review of the degree programme, I feel it didn't go far enough with regards to linking in a post-reg year on a higher diploma with a choice of going into a specialist field of nursing/midwifery automatically, so that we are not losing newly qualified nurses and midwives in October while waiting to start something the following year.

"There will always be natural attrition. Nursing and midwifery have always been professions that allow you to travel. But I think there is a journey at home as well that needs to be completed. As well as incentivising graduates to stay by setting up CPD programmes, there should also be greater encouragement of healthcare assistants wanting to do nursing/midwifery through national scholarships. We need to look at more avenues if we want to build up the potential number of nurses and midwives into the future."

Civic honour: *At a Civic Reception held by Sligo County Council to honour her becoming president of the INMO, Martina Harkin-Kelly is pictured (above, left) with Councillor Rosaleen O'Grady, Cathaoirleach of Sligo County Council, and (above, right) with her son Robbie and husband Alan*

Believing in the importance of the wider outlook, Martina undertook a degree in economics and sociology from 1995-1999 and more recently completed a Masters in Humanities, looking at the culture of nursing. "It's important to have a wider angle on what's going on from a political economic perspective – it gives you a helicopter view of why policymakers do what they do."

INMO involvement

Martina has been a member of the INMO since her student days, becoming extremely involved in 1999 during the nurses strike. She subsequently became the INMO rep for the Centre of Nurse Education and has been a rep ever since, with her office becoming known as a repository for information of all kinds. She was also very involved in the Sligo Branch, which she chaired for four years.

Martina has served on the INMO Executive Council for the past four years and took over as second vice president in December 2015. Martina has been elected as president for the 2016-2018 period, taking the helm at a critical time in the Irish public health service. In recent years, nurses and midwives have been hit by a 16% pay reduction, the loss of 5,200 posts and an increase in working hours – all of which has led to the current crisis in recruitment and retention.

Martina's key objectives for her time in office are:

- For the INMO to take a leading role in a national health summit, involving all stakeholders, in order to gain consensus on the shape, structure and funding of a public health service fit for purpose
- Early, positive movement on pay and working hours to address the severe recruitment and retention problems
- A campaign for additional beds, staff and services across the healthcare system
- Zero tolerance of verbal or physical abuse of staff in all care settings.

"There is currently an overwhelming feeling of disquiet among members due to their pay and conditions. Not only can we not recruit nurses and midwives from abroad, we are losing members who have many years of experience on the frontline. This is due to the ongoing impact of wage restraint where members find the cost of living extremely difficult to manage.

"I intend to be a strong and vocal advocate, on behalf of members and patients, demanding a clinical environment where safe practice can be delivered by our members and safe care for our patients can always be maintained. Our recent ADC clearly identified our agenda for the next year, and I will begin immediately, with the Executive Council, to implement the agenda given to us by delegates."

She is also looking forward to planning the INMO's centenary celebrations in 2019, when the Organisation will be celebrating 100 years since its inaugural meeting in February 1919.

Importance of family

On a personal level, Martina loves her adopted county of Sligo, where she lives with her husband Alan and 16-year-old son Robbie in the village of Grange. In this area of outstanding beauty between Benbulben and the sea, Martina is very involved locally with training people from the local GAA club, athletics club and schools in basic life support. She was honoured recently by Sligo County Council at a recent civic reception to mark her achievement of becoming INMO president.

Family is what is most important to Martina – and she would see nursing as an extension of her family. With 225 years of combined family nursing experience – in general, midwifery and psychiatric nursing – it is evident that Martina's journey to the INMO presidency is etched in her DNA.

Incoming Executive Council 2016/2018

***The incoming INMO Executive Council for 2016/18 and staff pictured after the group's first meeting in June**. Front row (l-r): Oona Sugrue, ADC co-ordinator and secretary to the Executive Council; Elizabeth Adams, director of professional development; Dave Hughes, deputy general secretary; Margaret Frahill, second vice-president; Liam Doran, general secretary; Martina Harkin-Kelly, president; Mary Leahy, first vice-president; Edward Mathews, director of regulation and social policy; and Phil Ni Sheaghdha, director of industrial relations. Back row (l-r): Eileen Kelly; Karen Clarke; Bridget O'Donnell; Frances Cullen; Claire Mahon (ex officio); Gráinne Walsh; Bernadette Stenson; Karen McGowan; Darren O'Cearruill; Mary Gorman; Helen Butler; Karen Eccles; Eilish Fitzgerald; Deirdre Munro; Maria Hernandez; and Kay Garvey. Missing from photo: Ailish Byrne; Catherine Sheridan; Kate Finnamore*

All photos by Lisa Moyles

Officers

President

Martina Harkin-Kelly, specialist co-ordinator and nurse educator, CNME Sligo/Leitrim and West Cavan, HSE Cregg House Campus. This is her first term as president having served on Executive Council since 2012. Martina qualified as an RGN in 1986 and holds a BA in economics and sociology and a research MA in humanities. She has worked in the specialities of ophthalmics, coronary care, orthopaedic theatre and nursing administration. She is also a dual qualified BLS instructor and community first responder.

First-vice president

Mary Leahy, RGN, RM, RPHN. Qualified mediator. Mary works as a PHN at Doughiska Primary Care Centre, Galway. She worked as a staff nurse and midwife in Galway and also worked as a practice nurse in clinical and managerial roles in the UK. Mary holds a hDip in public health nursing. She has 20 years experience as a PHN and now works in a busy primary care team in Galway. Mary is chairperson of the Galway Branch and vice chair of the PHN Section. She has been on Executive Council since 2012.

Second-vice president

Margaret Frahill, CNM3, Mercy University Hospital Cork. Margaret trained in general nursing at the Mercy University Hospital and in midwifery at the Doncaster Royal Infirmary in the UK. She has worked in the theatre department of the Mercy University Hospital since 1986. Margaret has been actively involved with the INMO for many years and has held positions ranging from chairperson to secretary and treasurer at branch level. This is her second term on Executive Council.

Ex-officio

Claire Mahon, outgoing president, CNM3, University Hospital Waterford. Claire trained as an RGN and has a diploma in higher education and professional issues and a BSc in nursing. She has served on Executive Council since 2008 and served two terms as president. Claire has worked in community care, medical and surgical wards and theatre. She has been a member of the INMO since her student years and worked for a period as an industrial relations officer. In 2002, she received the Gobnait O'Connell Award.

Clinical

Ailish Byrne, senior staff nurse, Muiriosa Foundation, Laois Family Support Services. Ailish trained as an RNID in Moore Abbey, Monasterevin before completing her training in general nursing in University Hospital, Kerry. She has worked in surgical areas in University Hospital Waterford and St Luke's, Carlow/Kilkenny, and was a local rep in Laois Disability Community Services for the past 10 years. Ailish is the chairperson of RNID Section. This is her second term on Executive Council.

Frances Cullen, RN, works as a staff nurse in Ballina District Hospital, Co Mayo, a short-term care service for the elderly, and is an advocate for patients and staff in the hospital. Frances has served as hospital rep for the last six years and is currently vice-chairperson of the Ballina/Belmullet Branch. She is qualified as an RN and has a postgraduate degree in gerontology and a certificate in teaching and assessing in clinical practice. This is her first term on Executive Council.

Clinical

Karen Eccles, staff nurse, Cavan General Hospital. She qualified as an RGN in Kent and completed the ENB 183 theatre and anaesthetic course in St Thomas's, London. Karen also worked in the Blackrock Clinic and as a CNM in theatre in St Vincent's Hospital, Dublin. This is her second term on Executive Council. Karen has attended joint reviews, the LRC and the Labour Court representing members, as well as being involved in the recent ED negotiations.

Kate Finnamore, staff nurse, Letterkenny University Hospital on surgical 2. During her student years, Kate became active in the Drogheda Branch. She was the student representative and has undertaken rep training. Kate was an active member of the Student Section and attended the LRC in support of the claim for internship students pay to be reinstated. Additionally, Kate has completed media training with the INMO. This is her first term on Executive Council.

Eilish Fitzgerald, PHN, South Lee Community Care Cork. Eilish qualified as an RGN and RM from the University Hospital and University Maternity Hospital, Limerick. She worked as a staff midwife in St Finbarr's Hospital, Cork and later completed a hDip in public health nursing from University College Cork. Eilish also works as a school PHN. She holds a diploma in nursing management from RCSI and is the education officer for the Cork HSE Branch. This is her first term on Executive Council.

Kay Garvey, acting manager, MiDoc, Athlone, facilitator for stress management, Midlands HSE. Kay is a long-term member of the INMO and started her career in Jervis Street Hospital. She has also worked in the Rotunda, St Brendan's and Texas. She is currently a member of the INMO Athlone Branch. Kay has been a member of Executive Council for three separate terms. She has also worked in most areas of Midland Regional Hospital, Tullamore, including the coronary care unit and administration.

Mary Gorman, CMM2 for maternity/gynaecological OPD, foetal assessment, Our Lady of Lourdes Hospital, Drogheda. Mary qualified as an RGN from Beaumont Hospital and an RM from the Rotunda Hospital. She holds a postgraduate diploma in midwifery clinical practice and a diploma in health service management. In 2015, Mary was appointed by the Minister for Health, to the Maternity Strategy Steering Committee as a midwife representative. She is vice chairperson of the Drogheda Branch.

Maria Hernandez, staff nurse, St Columcille's Hospital. Maria graduated from Unciano Colleges Manila, Philippines with a BSc in nursing. She then passed the Professional Regulation Commission Licensure exam and has worked in St Martin de Porres Charity Hospital in the Philippines. Maria is currently chairperson of the Dublin East Coast Branch. She was very involved in the 39-hour working week dispute in St Columcille's, which had a favourable outcome for members. This is Maria's first term on Executive Council.

Eileen Kelly, staff nurse, Sacred Heart Hospital, Roscommon. Eileen trained as a nurse in Beaumont hospital and holds a certificate in psychology, a diploma in gerontology, a bachelor's degree in journalism and a masters degree in international law and human rights from National University of Ireland, Galway. She has been a member of Executive Council since 2012 and has been secretary of the Roscommon Branch for a number of years.

Deirdre Munro, staff midwife, University Hospital Galway. Deirdre graduated with a masters in health systems research from NUIG and was recently awarded an international fellowship in leadership and innovation in Canterbury, England. She founded the global village of midwives network on Twitter and is a certified change agent (School for Health Care Radicals). Deirdre is education officer for the Midwives Section. This is her second term on Executive Council.

Bridget O'Donnell, staff nurse, ED, University Hospital Limerick. She believes that 100 years on from the 1916 Rising, nurses and midwives are involved in their own rebellion; there is a constant battle with understaffing, overcrowding and layers of bureaucracy that nurses and midwives must wade through. She thinks nurses and midwives need to unite. On Executive Council since 2012, Bridget will continue to advocate for nurses and midwives seeking better working conditions.

Catherine Sheridan, staff nurse, University Hospital Galway. Catherine trained in St James's Hospital and completed postgraduate training in sick children's nursing at the National Children's Hospital. She is the lead instructor and training site co-ordinator at Croí, West of Ireland Cardiac Foundation and is also an honorary clinical fellow at the School of Medicine, NUIG. Catherine is also the education officer for the Galway Branch. This is her second term on Executive Council.

Bernadette Stenson, CNM2, St Vincent's University Hospital, Dublin. Bernadette's professional qualifications include, RGN, St Vincent's University Hospital, Dublin; RSCN, Children's University Hospital, Temple Street; hDip adult emergency nursing; hDip children's emergency nursing; and a BSc nurse management/leadership/healthcare planning and organisation. She has been active with the INMO for 14 years and is currently involved in the ED Forum at the Ireland East Hospital Group. This is her first term on Executive Council.

Gráinne Walsh, PHN, Waterford Community Care (WCC). Gráinne completed a higher diploma in nursing in 1993 and a higher diploma in midwifery in 1997 followed by a postgraduate diploma in theatre nursing in 2003. She did her PHN training in Waterford where she has been employed as PHN for the last nine years. Gráinne has been an active member of the INMO for over 18 years and is currently secretary of the Waterford Branch. This is her first term on Executive Council.

Education

Karen Clarke, CPC, CNM2, Our Lady of Lourdes Hospital, Drogheda. Karen trained as an RGN and has worked in London and Galway. She has a degree in business studies and healthcare management and has worked as a staff nurse, CNM1, infection control nurse and overseas nurse facilitator. Karen has been the secretary of the Drogheda Branch of the INMO for four years and an active member of the INMO since 2001. This is her second term on Executive Council.

Student

Darren Ó Cearuill is a third-year integrated children's and general nursing student, Dublin City University, affiliated with the Children's University Hospital, Tempe Street and the Bon Secours Hospital, Dublin. Darren is actively involved in the Dublin Northern Branch and in student and new graduate issues. He has attended the LRC and Labour Court meetings and has met and lobbied the Minister for Health and the Chief Nursing Officer during campaigns on student/new graduate issues. This is his second term on Executive Council.

Management

Helen Butler, DoNM, St Luke's Hospital, Carlow/Kilkenny. Helen trained in London and has a diploma in HR and industrial relations, a BSc in health services management and a diploma in executive coaching training with LIT. Helen has been a member of the INMO since 1987, having served as chairperson, treasurer and secretary at branch level. She is the chairperson of the Directors of Nursing/Midwifery/PHN Section. This is Helen's second term on Executive Council.

Karen McGowan, candidate advanced nurse practitioner, ED, Beaumont Hospital, Dublin. Karen trained as an RGN in Beaumont Hospital and completed her Bachelor's of Nursing Science in Dublin City University. She later undertook a PGDIP in emergency nursing and an MSc in the RCSI. Karen has also completed a certificate in drug prescribing and ionising radiation, as well as a certificate in advanced assessment in UCD. Additionally, she serves a local nurse representative. This is her first term on Executive Council.

Q and A Bulletin Board

With INMO director of industrial relations Phil Ní Sheaghdha

Query from member

I have recently joined the public health service in a staff nurse position. I was not employed in the public service before and I am trying to get information on how I transfer my private pension to the public service pension. Can you give me any information on this?

Reply

As you correctly state a new 'single scheme pension' was introduced to the Irish public service in 2013. New entrants to the public service, including nurses and midwives working in the public health services, will be entered into this pension scheme. As with the current pension scheme there are facilities to transfer pension credits from private sector pensions to the public service scheme, these are weighted and what is termed purchase tables set the rate or value of same in the context of public service pension benefits.

As part of the Public Service Committee of the ICTU, the INMO has had a number of meetings on this issue with the Department of Public Expenditure and Reform (DPER). The most recent meeting was held on June 14. The DPER has advised us that purchase tables are currently being prepared. The ICTU Public Service Committee has engaged an actuary who is liaising with, and in consultation with, the actuary for DPER and they have now reached agreement in respect of the purchase tables that will apply. It is anticipated that these tables will be prepared and circulated to the Public Services Committee and, following that, employers will be notified. We will notify members when this facility is in place.

Query from member

I recently made a self-referral to occupational health as I did not want my manager to be aware that I was attending. Occupational health assured me that they would not notify management. Subsequently I have been on sick leave and have been out for six weeks. Yesterday I was notified by phone from work that an occupational health appointment has been arranged for me in two days time. I was surprised as I had no indication that this referral was being considered. Do I need to attend this appointment as I have, only very recently, attended occupational health following my self-referral?

Reply

There are two ways that employees may be referred to, or have access to, the occupational health department. One is a management referral, and the other a self-referral. Self-referrals do not have to be notified to management, unless the employee specifically requests same. Under the managing attendance and sick leave policies, management is obliged to refer to occupational health where appropriate. It is normal that management would notify the employee in question of their referral being made. The purpose of a referral to occupational health is to:

- Ensure that employee has access to competent advice on the implications of their health problem in relation to their work
- Ensure that they are supported in securing early and effective treatment where appropriate
- Provide them with advice and to provide their managers with advice on managing the employee's attendance.

Page 17 of the Managing Attendance Policy for the health service states "the employee should be made fully aware of the reasons for the referral and given a copy of the referral form". Therefore, it should not be a surprise that you are being referred to occupational health; management is obliged to notify you of that fact and also set out the reasons for the referral. There is no obligation on you to attend, however, not attending can be viewed as non-compliance with the attendance policy. Therefore, the INMO always advises that if your manager refers you to occupational health, you should attend. In the event that you have recently attended and your condition has not changed, you can, if you wish, notify management of the fact that you have recently attended and would they be happy to receive the report from that visit. If they require you to attend on the referral that you have been notified of, our advice is that you should attend and raise with your HR department the fact that you were not notified in advance and that it is a bit unreasonable to expect you to attend at very short notice, without any correspondence from your employer in relation to the reason for the occupational health referral. I hope this is helpful and if you have any further queries, please do not hesitate to contact us.

Quality & Safety

A column by Maureen Flynn

Framework for Improving Quality in our Health Service

THIS month's column introduces the 'Framework for Improving Quality in our Health Service'. The framework *(see Figure 1)* is about creating an environment in which a culture of person-centred quality of care continuously improves, where change and improvement can thrive. It is about leading differently and in a way that fosters innovation; and it is about providing you with the tools, techniques and support that will enable you and your colleagues to implement ideas for improvement.

What is the framework?

The framework is not a method. It is not prescriptive. It explains the six critical success factors for delivering and supporting continuous improvement. It is evidence-based following research into international and local best practice. The six drivers are:

- *Leadership for quality* – championing change in the current environment can be demanding. Management is not leadership but managers can be leaders. Leadership can happen at any level. Any staff member can provide leadership in improving patient experience in the same way as a chief executive can. Everyone can benefit from understanding leadership skills and behaviours. The key is creating the space to develop leadership skills and providing the time to allow leaders to lead
- *Person and family engagement* – in whatever we do, we must strive to continually deliver and improve safety, experience and outcomes. Service users are the only people who know what it is like to experience our services end to end. They can see both the strengths and weaknesses of the whole pathway while staff tend to have a only a partial view of the pathway. Engaging with service users to understand their experience, needs and suggestions provides unique insight
- *Staff engagement* – each individual working in the service has a unique insight into the challenges faced by their service and knows what can be improved. This knowledge also means that staff are often best placed to develop creative, practical and sustainable solutions when given the time to do so. An engaged workforce is one where staff are valued, listened to and provided with the tools, resources and skills to do meaningful work
- *Use of improvement methods* – having a structured approach to delivering improvement helps to accelerate improvement and ensure that solutions address the root cause rather than the symptoms of the problem. There are different methods, eg. model for improvement, microsystems, etc. What method you use is not important – what is important is that you have a structured approach and you use it in tandem with the other five success factors outlined in the framework
- *Measurement for quality* – there are many views on how to improve healthcare but it is critical that those views are objective and focus on the proven root cause of issues rather than the accepted perceived wisdom. Knowing how to use data to analyse and illustrate variation in patient safety, experience and outcomes and demonstrating improvement is key
- *Governance for quality* – methods and data are not sufficient to sustain change. Direction and oversight is central. Questions that must be considered include: Who is accountable for managing a pathway and actioning variation in data? At what meeting is the quality improvement data discussed? Who chairs these meetings and with what frequency? Clear governance ensures that the energy for change does not dissipate as people involved in initiatives move on.

As with care bundles for clinical practice, it is the combined force of the framework drivers applied that creates the environment and acceleration for improvement.

Benefits

The framework has been developed to bring together a collection of proven tools and techniques to help staff design and implement quality improvement projects to enhance patient and staff experiences. Our health services are currently under considerable strain and it is exactly in such an environment where a focus on improvement is critical to orientate the planning and delivery of healthcare away from crisis management to proactive service improvement.

The quality improvement division of the HSE will provide information sessions over the coming months to raise awareness of the framework across all service areas and will partner with frontline care teams to translate the framework into useful actions to guide improvement. More information on the help and support available can be accessed at **www.qualityimprovment.ie** Alternatively, contact Deirdre O'Keeffe at Tel: 021 4928527/086 7872212 or email: deirdre.okeeffe@hse.ie

Figure 1: Framework for Improving Quality

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

Acknowledgements
Dr Mary Browne would like to thank all the staff who informed the development of the Framework for Improving Quality in our Health Service

Shane O'Curry, with the support of the INMO Executive Council, calls on the Irish government to enact hate crime legislation urgently

ON MARCH 8, International Women's Day, Victoria Curtis posted a photograph of her recently bruised face on Facebook, and wrote: "This is what misogyny looks like. This is what being a faggot looks like. This is what happens women on Saturday nights walking home with their friends. This is what a man did to me after I told him it wasn't cool for him to tell us to take off our trousers, pull down our knickers and show him our arses... This is Ireland 2016."

Ms Curtis's post went viral. It grabbed the attention of national radio and momentarily re-opened much needed debate about hate crime. The discussion provided a sober reminder that, post marriage equality, in spite of formal equality before the law, Ireland isn't yet an equally safe place for all who live here.

Almost uniquely among member states of the European Union and the Organisation for Security and Cooperation in Europe, Ireland lacks effective hate crime legislation. The inoperable 1989 Incitement to Hatred Act cannot be counted. The Irish government has been criticised for this by the Council of Europe's European Commission against Racism and Intolerance, the EU Agency for Fundamental Rights, and the United Nation's Committee for the Elimination of Racial Discrimination. Ireland is also likely to be in breach of the 2008 EU Framework Decision on Racism and Xenophobia, and the 2012 EU Victims Directive.

Last July, *The Examiner* broke a story about 'Jane', a working mother living in west Dublin whose young family had been subjected to a year-long and escalating campaign of racist bullying, harassment, threats and criminal damage. This culminated in two masked men spraying 'blacks out' on her living room window and front door, and slashing all the tyres on her car. After six years of investing in relationships in her local community Jane threw in the towel, took her children out of school, and fled to stay with relatives in Donegal. In spite of best will and intentions, the Gardaí and the local authority were powerless to protect Jane and her children.

Jane's experience is not unusual. The **iReport.ie** confidential racist incident reporting system administered by ENAR Ireland records around 137 criminal acts motivated by racism each year. The State with all its resources logs fewer than 45 such acts. The deafening silence from our State on racism and hate crime reflects the silence of wider society.

This is a situation which is unacceptable to ENAR Ireland and its 54 member organisations, including the INMO. To lead the fight against racist and other forms of hate crime, we supported the formation of Action Against Racism (AAR), a campaigning group comprising people who have experienced racism. Some of the key activists in AAR are members of the INMO and have been working hard to promote its work. This year AAR launched the 'Love Not Hate' campaign to push for the enactment of hate crime legislation, a campaign which INMO members have been working actively to resource, support and promote.

The campaign has produced promotional material, including a video that has gone viral, explaining how hate crime works. On March 19, to mark European Day Against Racism, members of AAR dressed as love hearts and offered free hugs to amused shoppers on Dublin's Grafton Street. The tactic was effective in promoting an online petition that has already collected thousands of signatures. There will be a strong Love Not Hate contingent at this year's Dublin Pride march.

As reported in last month's *WIN*, the recent INMO annual delegate conference unanimously passed a motion, presented by the International Nurses Section, calling for support for the campaign and urging the government to pass hate crime legislation. The motion, which was greeted with a standing ovation by delegates when it was passed, is the latest development in a campaign that is growing and gaining momentum. The support of the INMO grassroots and leadership in this campaign is a significant and welcome development in the fight for equality and justice in Ireland.

Hate crime laws are not a panacea. On their own they will be limited in their ability to address structural and institutional racism, and other forms of bias, of which hate crimes are a violent manifestation. However, the experience from the UK, Sweden and Finland, where such laws have been enacted longest, shows that such legislation can provide our criminal justice system with a better range of instruments to target these behaviours and to safeguard a culture of diversity in a manner that would ensure that Victoria Curtis could challenge bigotry, and Jane could live and work in a neighbourhood and raise her children, without fear.

Information about the hate crime campaign can be found at: **enarireland.org/hatecrime/**

Shane O'Curry is director of the European Network Against Racism in Ireland, a network of over 50 civil society organisations working together to combat racism. The network includes the INMO, many of whose members contribute significantly to ENAR Ireland's work

Safe staffing in practice

Several elements are being tested in the pilot phase of the safe staffing and skill mix framework, write **Dr Philippa Ryan Withero** and **Liz Roche**

The Taskforce on Safe Staffing and Skill Mix for Nursing was established by the Minister for Health as a direct result of the INMO Safe Staffing Campaign launched in May 2014. It is currently in its pilot phase, following the publication of the Taskforce's report in February 2016. The Taskforce, which the INMO was instrumental in establishing, is one of the most important developments for nursing and midwifery since the Commission on Nursing. Here representatives from the Department of Health and the HSE give an update on the pilot phase

The Taskforce report, published in February 2016 complete with a framework and recommendations, set out for the first time, an evidenced-based approach to determine safe nurse staffing and skill mix levels across general and specialist medical and surgical inpatient care settings in acute hospitals. A key report recommendation was piloting of the framework across a range of acute hospitals of varying size.

On February 2, the Taskforce Pilot Planning and Implementation Group was established to plan, implement and evaluate the pilot. The group is chaired by chief nursing officer Dr Siobhan O'Halloran. Similar to the Taskforce Steering Group, this group has a partnership approach that includes: representation from acute hospitals, national human resources from the HSE and the Department of Health, the office of the chief financial officer (HSE), the office of the chief information officer (HSE), the office of the nursing and midwifery services director, group directors of nursing, academic expertise, the INMO and SIPTU.

As an initial step, the group developed a detailed project plan. One of the first actions was the selection of pilot hospitals. This was a challenging task, as the level of enthusiasm across hospitals to be included in the pilot was clearly articulated to the group. To ensure a robust and transparent process, the group developed a set of criteria based on the outputs from the pilot, to select the three pilot hospitals. The three hospitals selected are: Beaumont Hospital, Dublin; Our Lady of Lourdes Hospital, Drogheda; and St Colmcille's Hospital, Loughlinstown. A total of six wards, drawn from across the three hospitals, are participating in the pilot.

Each of the hospitals has established its own local pilot planning and implementation team, chaired by group directors of nursing, Sheila McGuinness and Ann Donovan, and supported by local directors of nursing and the management team. These teams, like the other groups above, are using a partnership approach with membership from: directors and assistant directors of nursing, clinical nurse managers from participating wards, CEO/hospital manager, HR, finance, ICT, the INMO, SIPTU, nurse practice development, quality and safety and the ONMSD project lead. These local teams have regular meetings, and their chairs are part of the Taskforce Pilot Planning and Implementation Group, so there is communication between all groups.

There is a range of components being tested in the pilot and a few of the critical ones are discussed here. To determine safe nurse staffing and skill mix levels requires the collection of fundamental pieces of evidence, not only about the workforce but equally about the demand for workload intensity related to patients.

After all, this new way to determine safe nurse staffing is all about the evidence to inform these decisions safely and effectively. The framework maps out this information under each of the four core assumptions along with the use of this information to inform appropriate nursing workforce governance decisions from ward to board and board to ward. As this data is critical, the Pilot Planning and Implementation Group, in conjunction with the office of the chief information officer, tendered for an ICT application capable of collecting and collating this information. A company called Trendcare is working with all pilot groups to train and tailor the tools to capture the data outlined in the framework.

As a first for Ireland, the pilot and its outcomes are critical to inform future national roll-out decisions. To ensure robust evaluation of the pilot, the Pilot Planning and Implementation Group collaborated with the Health Research Board to develop a research call. The successful research team is that led by Prof Jonathan Drennan, University College Cork, with a collaborative team between UCC, University of Southampton, University of British Colombia and University of Technology Sydney.

The purpose of the research is to measure the impact of implementing the pilot of the framework on nurse-sensitive patient outcomes, staff outcomes and organisational factors. It will also measure the economic impact, along with providing an evidence-based assessment of the adoption and implementation of the framework in practice.

Finally, research in this area finds that patients and nurses in the quartile of hospitals with the most favourable staffing levels had consistently better outcomes than those in hospitals with less favourable staffing.[1] For each of the participating wards, safe staffing and a healthy work environment will be the order of the day to test the robustness of the framework to deliver on its intended outcomes.

The pilot is due to conclude in December 2016, with a report and recommendations on its outcomes and impact in January 2017. The process that has been engaged in to pursue a safe nurse staffing and skill mix approach, is one that we expect will lead to a sustainable and stable workforce for the future. The taskforce would like to take this opportunity to thank all those supporting its work across all services.

Dr Philippa Ryan Withero is deputy chief nursing officer at the Department of Health and Liz Roche is area director, Nursing and Midwifery Planning and Development, ONMSD HSE. (For further information contact: Dr Philippa Ryan Withero, Tel: 01 635 4131 or via email: Philippa_ryanwithero@health.gov.ie)

References

1. Rafferty et al. Outcomes of variation in hospital nurse staffing in English hospitals: cross-sectional analysis of survey data and discharge records. Int J Nursing Studies 2007 (Feb); 44(2): 175-182

Type 1 diabetes mellitus

In the latest clinical update in this continuing professional development series, we examine the diagnosis and management of type 1 diabetes mellitus

DIABETES mellitus is defined as a group of metabolic disorders which either are caused by inadequate insulin secretion (type 1), resistance to the action of insulin (type 2), or a combination of these factors.

The effect of insulin deficiency or resistance is a persistent elevated level of glucose in the blood stream, which causes a variety of harmful effects. The term diabetes mellitus comes from Latin, 'diabetes' meaning to pass through, and 'mellitus' meaning honeyed or sweet.

Diabetes is one of the most common chronic diseases and its prevalence is on the increase.[1] The total number of people currently living with diabetes in Ireland is estimated to be 225,840.[2]

Type 1 diabetes is defined as an absolute insulin deficiency, which occurs when insulin-producing cells in the pancreas are destroyed. This results in an inability to secrete insulin into the body. The most common cause of cell destruction is autoimmunity. The absence of insulin allows persistent elevated levels of glucose (hyperglycaemia) to circulate in the blood, which can cause both chronic and acute complications. People with type 1 diabetes must receive insulin replacement otherwise they would die within days or weeks.

In comparison, type 2 diabetes is classified as insulin resistance along with a relative insulin deficiency, which results in persistent hyperglycaemia. Type 2 diabetes can be managed using a stepwise approach with a combination of diet and lifestyle changes, oral antidiabetic drugs, and insulin.

Type 1 diabetes can occur at any age, although it most commonly presents in children and young people. Incidence peaks in early childhood (age six months to five years) and again during puberty.[3] Currently there are approximately 14,000-16,000 people living with type 1 diabetes in Ireland.[2]

The term type 1 diabetes has replaced older labels such as 'insulin-dependent diabetes mellitus' and 'juvenile-onset diabetes', which are considered potentially misleading as type 1 diabetes can develop during adulthood and some people with type 2 diabetes are treated with insulin.

Risk factors include a combination of genetic and environmental factors. About 15% of people diagnosed with type 1 diabetes have a first-degree relative (parent, sibling or child) with the condition.[4] There is some evidence that suggests that in genetically susceptible people, unknown infectious agents or some features of diet in early childhood can trigger the development of autoimmunity which then causes type 1 diabetes.[5] Further research is needed in this area to confirm the true cause of the disease.

Diagnosing type 1 diabetes

According to NICE guidelines on type 1 diabetes,[1] the disease should be diagnosed largely on clinical grounds. The NICE criteria for suspecting type 1 diabetes include if a person presents with hyperglycaemia (random plasma glucose more than 11mmol/L) and one or more of the following: ketosis, rapid weight loss, aged under 50 years at onset, a body mass index (BMI) below 25kg/m^2, or personal and/or family history of autoimmune disease.

In a child or young person, type 1 diabetes should be suspected if the child presents with hyperglycaemia (random plasma glucose more than 11mmol/L) and characteristic features of polyuria (abnormally large volume of urine), excessive thirst, weight loss or excessive tiredness.[3] If diabetes is suspected the person should be immediately referred to a diabetes specialist team or a paediatric diabetes care team.

Complications

A variety of potential complications can occur in people with type 1 diabetes. The risk of complications is greatly reduced by keeping circulating glucose levels to as near normal as possible in order to reduce tissue damage. Indeed, disability from complications can often be prevented by early detection and active management.

Approximately one in four people with diabetes will develop chronic kidney disease during their lifetime. Kidney disease accounts for 21% of deaths in people with type 1 diabetes. Diabetes is a leading cause of preventable blindness in people of working age. Diabetic retinopathy accounts for approximately 7% of people who are registered blind in the UK.[1]

People with diabetes are estimated to be up to 30 times more likely to have an amputation compared with the general population. Cardiovascular risk is also increased; people with diabetes are at a higher risk of stroke and myocardial infarction.[1]

Mental health can also be affected and can include conditions such as anxiety, depression and eating disorders. In children and young people, behavioural and conduct disorders can present, as well as risk-taking behaviour, which can include non-adherence to recommended treatment.

Although the life expectancy for people with type 1 diabetes has generally increased, it is still lower than that of the general population.

Assessment and examination

An initial diabetes assessment should include a general examination and review of the person's medical history, long-term and/or recent diabetes history, other medical history, family history of diabetes and/or cardiovascular disease, medication history and/or current medications. Social, cultural and lifestyle history should also be discussed.

Vascular risk factors, smoking status, weight and BMI should be assessed. Foot, eye and vision examinations should be undertaken and tests carried out for urine albumin excretion, urine protein on dipstick and serum creatinine. Psychological wellbeing should be assessed as well as attitudes to medication and self-care, immediate family and social relationships, and availability of informal support.

Treatment plans

Life-long insulin treatment is essential for type 1 diabetes. Treatment is individualised and includes a variety of insulin regimen options, which are taken at varying intervals. As type 1 diabetes is caused

Above: Deirdre Lang and Sharon Morrow in the 'jungle' caravan clinic

Out in the Calais jungle

Four Irish volunteer nurses report from the infamous 'jungle' in Calais, which is home to 4,500 people seeking refuge and asylum

THE first thing we noticed about the 'jungle' was the bitter cold – that sense of cold that gets into your bones. We were glad of the layers of clothes we had worn that protected us from the piercing chill.

Myself and Sharon had no idea what to expect on arrival in Calais, on the north coast of France, even though Elena and Fintan, nurses involved in the genesis of the first-aid support for refugees in Calais, had tried their best to prepare us. All we knew was that we needed to be there to help in whatever way we could.

As veterans of the system, Elena and Fintan ensured that we had all signed up with a Facebook group called Care4Calais, with the Refugee First Aid and Care Team and with Ireland Calais Refugee Solidarity. This provided access to a great support network and allowed us to roster ourselves to the caravans which are the site's first- aid clinics that provide a vital service for the 4,500 people who call the 'jungle' home.

We had fundraised individually in the weeks before we travelled out and, with the help of family and friends, we were able to take suitcases of supplies with us. Tallaght Hospital was particularly generous and supplied us with a large number of dressings, which were put to good use in treating the many injuries we encountered. We were on-site for four days during which we saw approximately 180 people a day.

The ailments ranged from head colds and flu to lacerations, soft tissue injuries and bruising, fractures, anaemia, scabies, lice and sexually transmitted infections (STIs). Anyone with a serious ailment or injury, the kind which required diagnostics or prescribed medication, could be referred to a nearby health clinic run by French volunteers or to a nearby hospital.

However, the first-aid caravans were the first port of call for most; they felt cared for there and described feeling like human beings as we cared for each one of them with compassion. So many of these people were traumatised and had fled their homes, terrorised, to escape war, the Taliban, ISIS or Assad, and were now reduced to living in sub-human conditions in a former rubbish dump on the outskirts of Calais.

Conditions at the site are miserable, with hardly the most elementary of services available. Hygiene is basic, with multi-function water troughs used for all cleaning needs – pots and pans, clothes and personal hygiene. The toilet facilities are plastic booths which afford some degree of privacy, but the pleasantries end there, and to use these facilities is a stomach-churning experience.

Diagnosing the ailments that people presented with in the caravans was often a complicated affair, as many people didn't speak much English and there is only so much sign language one can employ when the condition is more than a cold, and has the potential to become a serious illness. We were so grateful for the skills and commitment of the men from the camp who translated for us from morning to night, as without them we would not have been able to do any more than offer socks, lozenges and tissues – things which we always seemed to run short of in the caravans.

Through these translators, many of whom spoke at least four languages, we heard stories that the bruising and head lacerations were caused by the guards at the entrance to the camp, who were liberal with their use of their batons on these people fleeing terrorism. We were told that many of the beatings happened when someone was caught trying to flee to England on a lorry and, once discovered, in addition to dealing with the disappointment of not being able to leave the camp, they then had to deal with the possibility

Conditions in the caravans are very basic

of physical abuse and detention at the hands of the French police.

Many people arrive at the camp after months of travelling from Sudan, Eritrea, Ethiopia, Syria, Pakistan or Afghanistan, and are tired and weak. Hence recovery from injuries and ailments takes longer than in normal circumstances.

Some of those we met in the camp were young men fleeing the Taliban; their parents selling all possessions so that their sons could flee to a land where they might live. Many had witnessed their parents being murdered in front of their eyes, and were now on the run, terrified and traumatised. Yet despite all of this, these lovely human beings will look you right in the eye and thank you with a level of sincerity that leaves you feeling humbled and inadequate.

When the children arrive and you realise they are only 10, 12 or 15-years-old, and that they are unaccompanied – all alone in the world – the impact really hits you. One group of Sudanese boys were at school when their village was attacked and burnt, and all their parents were murdered. They fled and now live in terror in the Calais jungle, with no way home and no way out.

A 19-year-old boy has become their guardian and this boy prostitutes himself to ensure the younger boys are fed. He cries to one of the volunteers that he is not a bad boy and you can feel your heart sink in your chest, followed by a sense of intense anger and disbelief that this is actually happening.

The south camp was bulldozed a few months ago, and the displaced who had been sheltering there were again displaced. A staggering 120 children are missing since then and no one can account for their whereabouts. A mere hour from London by car, and there are 120 children missing, believed to be trafficked and there isn't a word about it! If these were white French children, there would be an outcry and they would have been found and returned home, and those who had dared to take them would be punished.

Despite all of the horror, the people of the jungle cling to the hope of a better future. We met people of all nations, but in truth they all belong to one – a nation of humanity. They hold each other up. The majority of the people in the camp, despite experiencing the stuff of nightmares, dust themselves down, hold their heads high and walk like kings.

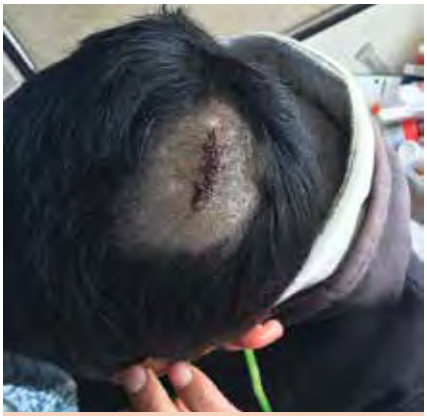
And then there are those who can no longer do it, who have run out of stamina and hope, who have seen and lost too much. But yet they smile as that's the only gift they have left to give you. Leaving them in the jungle has broken our hearts, and we each have left something of ourselves there. But we will be back, as once they touch your heart you can never again be the same.

We do not want history to remember us as merely standing by and letting such abuse and neglect continue. We are but a generation away from the atrocities of the concentration camps. We do not want to be counted among those who did nothing, and we would urge you to do likewise. We urge you to contact your local TD or MEP and raise the plight of these people and children.

At the time of writing the authors were planning a return trip to Calais. Contributions towards this cause can be made via the following gofundme link: www.gofundme.com/23p93xmn

Deirdre Lang is director of nursing, HSE national clinical programme for older people; Sharon Morrow, chief executive officer, Laura Lynn Children's Hospice; Elena Lydon, RANP, emergency department, Mayo General Hospital, and Fintan Sheerin, Faculty of Nursing, TCD

French police patrol the camp



The head laceration of a 15-year-old boy who is unaccompanied in the camp

One camp resident showing what he said was the result of a beating

Rising risk of assault

The risk of assault faced by hospital staff and work to rule action at Our Lady of Lourdes Hospital, Drogheda hit the headlines this month. **Ann Keating** reports

THIRTEEN staff a week are attacked at acute hospitals according to a report in the *Irish Daily Mail* on June 20.

"Thirteen staff members in the HSE are physically assaulted every week on average in Ireland's acute hospitals, according to figures obtained by the *Irish Daily Mail*.

"In total there were 1,360 reported incidents of physical assaults on mostly frontline HSE staff members, including nurses, doctors, porters and ambulance personnel over the past two years. And according to the Irish Nurses and Midwives Organisation, these figures represent only the most severe cases and are 'unlikely to portray the actual level' as there is significant under reporting.

"One of the more worrying figures is that there were 20 assaults perpetrated by staff members last year on their fellow workers – compared with just one such incident in 2014. Meanwhile, in 2015 there were 448 occurrences of verbal assaults, verbal harassment and physical harassment reported by healthcare staff across Ireland's 33 acute statutory hospitals – compared to 358 in 2014.

"The figures provided did not break down the nature of the physical assault or what may have been said in cases of verbal attacks. Assaults and harassment on staff are reported using the National Incident Management System which is hosted by the State Claims Agency on behalf of the HSE. There were 716 physical assaults reported to that system in 2014 and 644 in 2015. There were also 28 assaults by members of the public, two by a staff member's peer or student, and 47 by a family member or relative. In 2014 there were 28 assaults carried out by family members.

Dave Hughes, INMO deputy general secretary, said: "We have recently reached agreement that all EDs are designated working places under the Safety, Health and Welfare at Work Act, and we have nurse health and safety reps elected in all 26 EDs for the first time ever." He added: "The numbers of people who impose it [violence] on nurses are a minority but the effect and impact when it occurs is traumatic. The protections and mitigating actions are not sufficient and the overcrowding makes the environment an agitating factor. In some situations, departments can be like a powder keg."

Our Lady of Lourdes Hospital, Drogheda

The *Mid Louth Independent* (June 8) gave space to the ongoing action at Our Lady of Lourdes Hospital, Drogheda under a headline **Lourdes action set to escalate – work to rule protest at local hospital will continue until staff recruited or ward is closed**.

"Staff at Our Lady of Lourdes Hospital in Drogheda will decide whether or not to escalate their action over the coming days, it has been revealed. Members of the Irish Nurses and Midwives Organisation implemented a work to rule at the hospital last Tuesday in protest at staff shortages at the hospital. There are currently over 100 vacant posts at OLOL.

Speaking on LMFM recently Liam Doran, general secretary of the INMO, said: "Whether we expand the work to rule to include additional measures, that's something members will decide over the coming days' but he said this was a 'distinct possibility.'

"At present, nursing staff say they are focused on patient care as a priority and the work to rule is affecting admin duties only. You can't run a health service and leave posts vacant, said Mr Doran. The very first thing we said to the new Minister for Health is you have to get a handle on recruitment. He said the work to rule situation at Lourdes will continue indefinitely until staff are recruited or a ward is closed. We need every bed in the hospital but our members cannot ignore the fact that every ward is understaffed."

May trolley/ward watch analysis

The *Westmeath Examiner* (June 18) gave coverage to our trolley/ward watch statistics for May – **Overcrowding eases in May**. "The latest Irish Nurses and Midwives Organisation trolley/ward watch comparative analysis for May shows a 14% reduction in the number of admitted patients on trolleys compared to May 2015. The figures show that 6,627 patients admitted for care, were on trolleys this year, compared to 7,713 in May 2015."

According to Liam Doran: "This positive development will be short lived if the recruitment pause recently announced by the HSE is not stood down. The consequence of delays in recruitment will result in the curtailment of services and a reduction in bed capacity which will exacerbate pressures on the emergency departments."

He said: "Any reduction in the number of sick patients on trolleys must be welcomed, particularly after the worst winter on record for ED overcrowding. Everyone must now reaffirm their commitment to implementing, on a 24/7 basis, the recent ED Agreement and continue to prioritise the crisis facing emergency departments in all decision-making. The confusion that exists with regard to recruitment must be removed so we can attract back the 4,000 Irish nurses and midwives needed to fill vacant posts."

Meanwhile the *Western People* (June 13) noted Mayo trolley figures at highest in 10 years and the *Limerick Leader* (June 13) reported University Hospital Limerick overcrowding highest in Ireland.

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Cherish the children equally

Joan Devin shares her views from the Annual Student Midwife Debate on whether contemporary maternity services reflect the commitment made to women and children in the 1916 Proclamation

THUS far 2016 has been a year of celebration and commemoration of the centenary of the 1916 Rising, and the birth of the Irish Republic. It was a fitting theme on which to base the annual NMBI Annual Student Midwife Debate during Midwives Week 2016, as the 1916 surrender itself was delivered by midwife, Elizabeth O'Farrell.

The debate was held in Trinity College Dublin on May 4, 2016. Guests of honour at the event were Sabina Higgins – wife of President Michael D Higgins, and Marie Fitzpatrick – grandniece of Elizabeth O'Farrell. The debate itself asked whether contemporary maternity services reflect the commitment made to women and children in the 1916 Proclamation. The proposers were Jennifer Corrigan of TCD, Roisin O'Mara of UCD and myself (Joan Devin of DKIT). We were opposed by Mary O'Shea Barry of UL, Vanessa Ahern of UCC, and Rebecca O'Brien of NUIG. The focus of my speech, which I summarise below, was the commitment declared in the Proclamation to 'cherish the children of the nation equally', and how this is demonstrated in contemporary Irish maternity services.

Historically in Ireland, not all children were cherished. The treatment and fate of so-called 'illegitimate children', or those born outside of marriage, is one of our most shameful legacies as a country. Thousands of unmarried pregnant women were detained in mother and baby homes in the years following the Rising. Babies and children in these homes were subjected to various forms of abuse, including experimental vaccination trials.[1]

The Tuam Mother and Baby Home was open from 1925-1961. A total of 1,101 births were registered during those years, and 796 deaths.[1] The media coverage last year was widespread when the skeletal remains of children were discovered in a septic tank, their life and death passed over without ceremony. In 1916, 81 per 1,000 infants died in their first year of life, due to conditions associated with the poor general living conditions of the time.[2] The mortality rate for an illegitimate child was 1 in 51. These children were never cherished by the maternity services. Today our perinatal mortality rate is 6.7 births per 10,003. We break down our statistics to reflect birth weight or gestation, not legitimacy of birth. Congenital malformation and complications of prematurity are the main causes of mortality, not malnutrition, diarrhoea or neglect. The aim of the Registration of Maternity Homes Act of 1934 was to ensure that designated maternity centres were fit for purpose.[4] The nuns in these homes were trained nurses and midwives.[5] Yet, a child born in the slums had a better chance of survival than one born in a mother and baby home.[1,6] Vows of poverty and chastity did not guarantee a caring or competent professional.

Childbirth in Ireland has historically been wrapped in a shroud of fear, understandable when mother and baby homes were once considered to be adequate places of birth.[7] Even today, women in Ireland say that safety for their baby remains the most important factor when choosing the type of maternity care they want.[8] Through professional accountability, contemporary maternity services are working to improve birth outcomes.

Since 2009, Ireland has volunteered its maternity services statistics to CMACE, now MMBRACE, which by association improves the lives of newborns. The National Perinatal Epidemiology Centre audits all of Ireland's maternity centres to improve perinatal care. This year saw the publication of both a National Maternity Strategy for Ireland, and National Guidelines on the Use of Oxytocin, both research-based documents which ultimately aim to improve birth outcomes. The Baby Friendly Hospital Initiative, extensive childhood vaccination programmes, and postnatal and GP newborn assessments provided for by the Maternity and Infant Care Scheme, aim to promote infant health. Access to ultrasound scans, electronic foetal monitoring and foetal blood sampling, allows midwives to detect and reduce the likelihood of perinatal morbidity and mortality. We also know when technology is unnecessary. The Nurses and Midwives Act 2011 placed midwifery firmly as a distinct profession, allowing us to promote our philosophy and maintain normality in the maternity services.[9] Babies today are not exposed to interventions without clinical indication.

Ireland committed to promoting infant and children's rights when it signed up to the UN Convention on the Rights of the Child in 1992, guaranteeing to act in the best interests of the child.[10] Babies born in Ireland today will live on average 25 years longer than babies born in 1916.[2] This is largely due to continued improvements in our maternity services, and a willingness to make evidence-based, midwifery-led changes to our national policies, thereby promoting long-term health.

Today professional accountability and collaborative confidential enquiries can do much to improve our services, when findings are responded to in practice.[11] Irish maternity services have seen many changes since 1916, such as an increasing and culturally diverse population, more complex perinatal cases associated with morbidities such as obesity, and neonatal resuscitation at the limits of viability, and they are continually improving.[11,12,13,14]

The perinatal and neonatal mortality rates of 100 years ago will never be acceptable again. The heartbreaking sight of babies' and children's bodies dumped in a septic tank; that would not happen in Ireland today. The modern maternity services emphasise that all children should be cherished, reflecting the commitment made to children in the 1916 Proclamation.[10]

Joan Devin is a student midwife at Dundalk Institute of Technology

References on request (quote: Devin J. WIN 2016; 24(6): 50

ICNP – driving change in service delivery

Dr Pamela Hussey reports on the progress of the DCU SNHS ICNP user group, including the work towards achieving a standardised language among healthcare professionals

The successful award of accreditation to the Dublin City University School of Nursing and Human Sciences, International Classification for Nursing Practice (DCU SNHS ICNP) user group was reported in *WIN* earlier this year. The INMO, as a member of the International Council of Nurses, endorsed this accreditation and is working in partnership with DCU on the centre's development.

Here we report on the centre's goals for year one and outline why healthcare professionals need to engage with informatics education and training, particularly in relation to implementation of standardised language in service delivery.

Standardised terminology

Across many services in Ireland similar concepts and terms are reported in nursing and midwifery documentation. While they are alike and, from the healthcare professional's perspective, have the same meaning, they are presented differently across services, and from a national perspective have no shared concept definition.

For example, different organisations may have different approaches to a referral, its purpose, and the core terms included in the template. As we migrate to using more information and communication technology in our services, the computer based on logic cannot handle different terms with similar meanings. It cannot for example compute 'fluid intake poor' and understand that it means the same as 'minimal fluid intake'. We therefore need to present this concept using a clear definition with an associated set of pre-defined terms and codes.

Figure 1 shows that the ICNP browser demonstrates that the concept of 'inadequate fluid intake' can be either documented in practice as a diagnosis or an outcome. As it is presented in standardised format, it also has a preferred term 'impaired fluid intake', and it can be associated with a section of the electronic record which deals with fluid intake or impaired nutritional intake. From a technology perspective it has a code 10029873 which means that this information can be transferred between computers and, more importantly, from a service delivery perspective it can be transferred across services in a clear and unambiguous manner, optimising patient safety at transition of care.

Figure 1. Sample search on ICNP browser for the term 'fluid in' (available at www.icn.ch/ICNP-Browser-NEW.html

The Health Information and Quality Authority (HIQA) is doing excellent work in this area, providing a set of shared data concepts. For further information see national data standards on the HIQA website **www.hiqa.ie/healthcare/health-information/datasets**

In this centre we wish to help practitioners identify the codes they need to deliver standardised language for future service delivery. However, we also wish to make sure that the concepts selected are the best 'fit' to demonstrate not only the nursing and midwifery contribution but to achieve optimal patient-centred integrated care. The resources available for standardising language are vast. In the international terminology dictionary SnomedCT there are over 400,000 concepts and terms.

Progress to date

In the proposal to establish a national ICNP accredited centre for research and development, we defined a set of goals to drive the deliverables over a four year timeframe. Here we present our progress to date.

Goal 1: Establish the DCU SNHS ICNP User Group Centre as a formal ICNP centre to advance uptake and use of ICNP in Ireland.

- This centre will open over the summer of 2016 with first user group meetings scheduled for the autumn
- To facilitate knowledge transfer the INMO Professional Development Centre has developed two informatics workshops, which will be offered later this year – 'Introduction to Nursing Informatics' and 'Introduction to International Classification for Nursing Practice (ICNP)'
- To date we have presented at a number of national team meetings including the Council of Clinical Information Officers **www.ehealthireland.ie/Stakeholder-Engagement/CCIOs/** and the Office of the Nursing and Midwifery Services Director (ONMSD) Nursing and Midwifery Languages and Terminology Forum and also presented a masterclass in the School of Health and Social Science in the Institute

of Technology Tralee. Active participation in social media can also be seen on Twitter @CCIO_HSE

Goal 2: Establish a research cluster with existing partner services scaling to other partner services over the four year timeframe.

- At practice development level a number of presentations have been delivered and have led to some early practice development initiatives which are now underway. One example is a clinical nurse specialist group with St Mary's Campus for older persons services, Phoenix Park. This group has recently been established to explore the role of CNS activity and how CNS participants can link in with the overarching centre's design approach. The focus to date in St Mary's Campus has been to consider the CNS role and define a specific problem (analysis and formulation), and consider a selection of methods that can be used to predict the knowledge needed to solve the problem or attempt to do so. It is anticipated that the groups can grow organically over time with relevant academics but a core principle for the group is clinical leadership
- Enquiries on national projects scheduled for development within the HSE are also underway, with working group formation commencing in July.

Goal 3: Promote the use of ICNP equivalence tables with SnomedCT with national clinical programme objectives through the Integrated Services Framework in OCIO Directorate Authority.

- A number of activities relating to the uptake and use of SnomedCT were completed in quarter two of this year. Specific projects relating to community support include future design plans for integrating patient outcome measures within clinical workflow.

Goal 4: Build on established relationships with existing ICNP accreditation centres and seek funding for future initiatives through research funding streams.

- At a European level ICNP user groups met at the International Congress in Nursing Informatics held in Geneva in June, to develop specific projects and to seek funding for future initiatives. This work will be reported on as it progresses over the course of the year.

Goal 5: Disseminate information on research activity both nationally through *WIN*, conferences and peer reviews.

- Annual summary reports on the progress of the centre will be featured in *WIN*, of which this is the first
- The centre has also invested in teleconferencing facilities to communicate with interested practice development groups both across Ireland and the EU member states; the contact details will be posted on **www.dcu.ie/snhs/icnpusergroup.shtml** (website is currently under revision).

Why get involved?

There is significant top down activity underway in delivering the eHealth Ireland agenda, all freely available to view at **www.ehealthireland.ie** This service plan is the single most significant investment in health and social care in Ireland since the formation of the State. The success of similar national programmes has been variable and one of the key issues identified as critical to success is early clinical involvement.

The Council of Clinical Information Officers (which comprises clinical leaders including more than 15 nursing and midwifery members) has taken on the role of championing this nationally. They do this because they recognise that a bottom up approach to service improvement and integrated care is key to realising the proposed strategy to optimise citizen's health and wellbeing. We cannot assume the role of passive employees, waiting for senior HSE management and Department of Health leaders to deliver top down strategic plans; to deliver eHealth Ireland in an isolated fashion will not work.

Nurses and midwives traditionally make excellent change agents and can drive this transformation; the healthcare systems we create over the coming years will be used for all our families in the future. Core features that need championing include identification of the generic patient centred processes, which will break down traditional boundaries for safer care delivery and integration of outcome measures within clinical workflow initiatives.

Evidence suggests that there is a need for cross functional teams (clinical and technological) that can focus on the delivery of specific patient outcome measures to support individuals living in place. Such teams can provide detailed insight by monitoring implementation plans locally, while identifying potential gaps which may impede future anticipated deliverables such as effective continuity of care. Driving the agenda are top down standards 'with teeth' such as the EU Data Protection legislation which took effect on May 27, 2016 and which provides two years for all member states to set in place national legislation to demonstrate compliance.

What is not helpful are the 'us and them' scenarios that detract from the core message, which is that this is everyone's business, this is our healthcare system and we want to ensure value for money for all our citizens.

Words in language are like instruments in a tool box, they can be used by nurses and midwives to fit their requirements, but like tradesmen with tools, nurses and midwives need to understand the overall design of the task at hand. The contribution of practising nurses and midwives is required on early design and definitions to select specific words (concepts and terms) that will represent nursing and midwifery activity for many years to come.

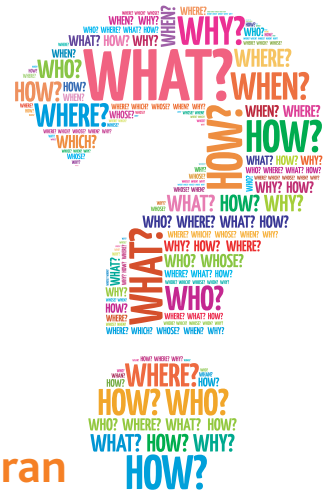
The ICNP user group team is happy to visit services for some focused discussion; just contact us to arrange a site visit or for us to come to one of your meetings *(number and email as below)*.

Those who complete the INMO introductory workshops on nursing informatics and International Classification for Nursing Practice participants will be considered as having recognised prior learning (RPL) for future study on the DCU SNHS postgraduate modular framework. See **www.dcu.ie/snhs/index.shtml** for further information.

Note that completion of the INMO workshops does not guarantee a place on the DCU SNHS postgraduate modular framework. Individuals may however wish to consider completing a Level 9 module entitled 'Informatics in eHealth' which is scheduled to commence in February 2017 *(pending approval)*.Please contact the School of Nursing and Human Sciences at Tel: 01 7005947 or email: snhsenquiries@dcu.ie for further details.

Dr Pamela Hussey is a lecturer in health informatics/ nursing at Dublin City University, School of Nursing and Human Sciences

Questions – the key to good practice



We must be ever-questioning in order to continuously expand our professional knowledge, writes **John Corcoran**

IN OUR every action as a nurse or midwife we say something about the kind of person we wish to be and the kind of values we wish to live by. Every action says something about how we regard the people most directly involved with us – as people with different needs whose dignity is equal to our own, or as individuals who are 'superior' or, worse, as only a means to an end.

In the past, nursing and midwifery work was perhaps overly focused on the end result. Consider the behaviour of a nurse or midwife presuming they knew what was best for the patients under their care and doing that, rather than interactively explaining and discovering what was best for each patient. Being overly focused on the end result could put a tension on the means of achievement, requiring a nurse or midwife's sense of identity to be entangled with procedure, process and patient expectation. For that reason, a nurse or midwife may have chosen to 'simply do what they were told'. The acceptability of one's contribution in such a system was therefore based on their seniority or hierarchical position within a hospital. The craft of nursing and midwifery was what existed, instead of professional experience and self-directed decision making.

Personal reflection

A nurse or midwife's interpretation surrounding their professional experiential decision-making is vital for further expanding their knowledge. All nurses and midwives are agents of knowledge, but those who fall short of defending their experiential learning when under assault may need to be taught how to reason out their knowledge positions and defend their professional decisions as being 'right'.

Research suggests that personal reflection could lead to the development of a sound nursing and midwifery epistemology.[1] Personal reflection would, at the very least, compel nurses and midwives to re-evaluate or revisit some of their long-held beliefs.

Reflecting on professional experiences in a peer-review setting might present change possibilities for contemplation. In a hospital setting, what choice is really about is recognising the true extent of your human freedom and having the professional courage and personal integrity to do what is right and truthful. In the context of advancing nursing and midwifery's disciplinary knowledge base, it is about each nurse and midwife being individually conscientious towards, and accountable for, their ethical workplace performance and reasoned attitudes to would-be critics.

The judgements that practitioner nurses or midwives make should not be based on how they feel or their intuition. Coming to the 'right' decision in a hospital involves a more serious and ongoing task that requires nurses/midwives to prioritise demands that characterise often complex situations. Reflection is one remedy that could be used by nurses and midwives to provide a basis.

Reflection enables nurses and midwives as human beings to engage a cognitive process, involving choice and thought, which allows them to come to a willingness to defend their position and act on reasoned insight. It is underpinned by a proposal that they must have sufficiently consistent ethical understandings and judgements to justify the decisions they take; that nurses and midwives should seek to rise above their subjectivities and deference to other professionals by focusing on their attention to the detail and data they actually experience, by displaying intellect in their understandings, a rationality and reflection at all times in their judgements, and rigorous accountability in respect of their actions and behaviours.[2]

To fully understand the relationship between decision-making and personal reflection, we first need to fully comprehend the cognitive process of decision making that all nurses and midwives undergo. This has four basic structures:

- The first is the sense-perceptual experience, planning and research phase. Nurses and midwives must concentrate on what it is they are seeing, reading, hearing, touching, imagining and conceiving
- This leads to the second structure, which is their understanding; they must enquire, seek to understand, observe and formulate their professional experiences
- Thirdly, they must make judgements – reflect, weigh the evidence, which ultimately leads them to make a judgement
- The fourth structure involves human knowing, which is associated with choice or decision. They need to recognise the significant power they have to make a professional judgement of what is good for their practice and decide to see through the action that follows from that.

Knowing should not be based on experience, understanding, judgment or decision alone. It only occurs as a result of all four activities – it requires experience, understanding, judgement and a freely chosen decision.

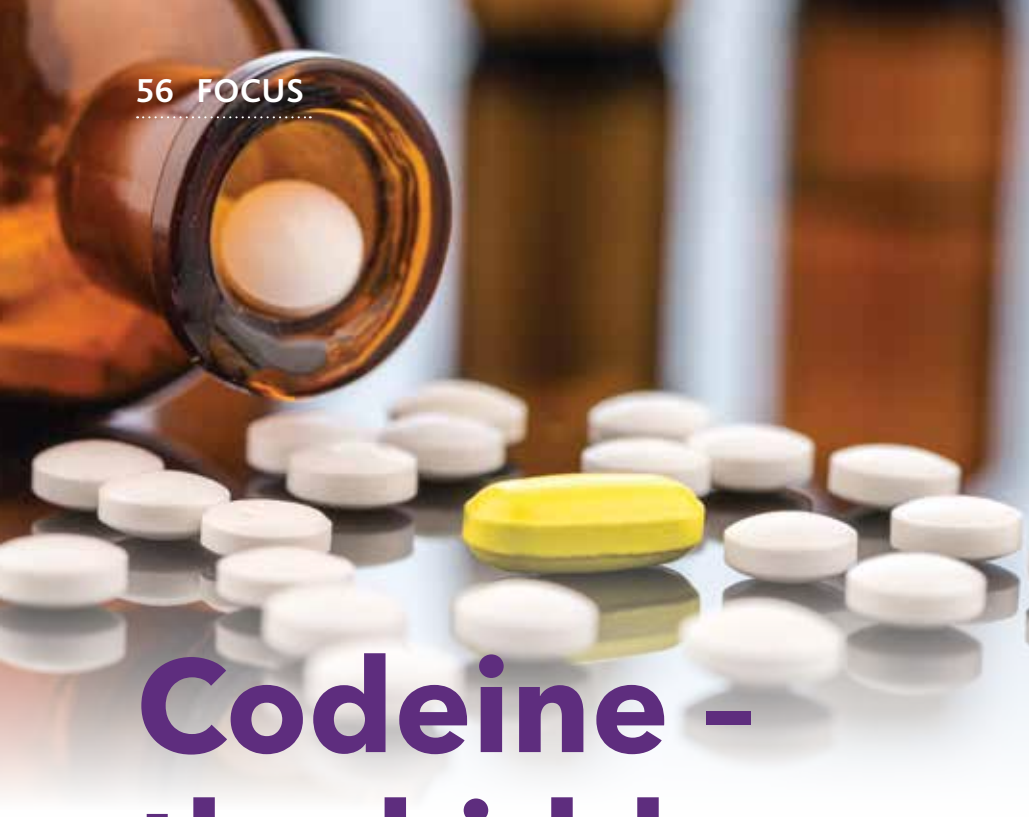
Applying the framework

Applying the framework correctly requires a nurse and midwife to become an ever-questioning professional. Factors that can stop nursing and midwifery practitioners questioning their professional environment and seeking to develop new knowledge include: fear of losing face, not wishing to disturb the group harmony on a ward, nervousness; fear of criticism, intimidation, pressure to conform with hospital norms; and not being courageous and confident enough to speak the truth to other disciplines or superiors.

The nursing and midwifery professions need to encourage each other to ask the right questions at the right times for the right reasons, if they truly wish to augment nursing and midwifery's disciplinary knowledge base. Nurses and midwives would do well to remember that in a modern hospital environment, the only stupid question is the one not asked and that asking questions is a good way to stop others asking questions about you.

John Corcoran is a nurse in the emergency department at Children's University Hospital, Temple Street

References on request quote: Corcoran J. WIN 2016; 24(6): 55



Codeine – the hidden addiction

With the rising level of codeine dependencies in Ireland, it is important to understand the harmful effects this drug can have on a person's health, writes **Gerry Ryan**

ADDICTION to codeine-containing medications, whether over the counter (OTC) or by prescription, is a problem in Ireland that manifests itself in all areas of society, including among nurses and midwives.

Codeine is a relatively mild analgesic used for pain relief in treating many common ailments, however its potency cannot be underestimated. While far from being as strong as morphine or its derivatives, codeine is metabolised in the body in the same way as morphine so it has a similar but milder opiate effect.

Codeine is easily accessible. In Ireland it can be obtained without a prescription, with most people being unaware of the potential for addiction when starting to use codeine. Neither are they aware of the detrimental health effects and long-term damage it can cause to their organs. Many OTC preparations contain codeine, for example Solpadeine and Nurofen Plus, as well as a wide range of prescription-only products such as Solpadol and Tylex.

While these products can be legitimately used on an ad hoc or prescribed basis and in accordance with instructions, transition from use to misuse of codeine occurs at the point when people begin to neglect the directives set out with their doctor or pharmacist. As with any other medication, addiction is defined as continued, compulsive abuse of a substance despite adverse consequences, which begin to mount.

The who, how and why of codeine

People use OTC codeine medications for many reasons. Guidelines have been introduced in Ireland to help regulate usage of codeine and deal with addiction to codeine-based medications. These guidelines regulate how OTC codeine products are sold by pharmacies. Those who develop problems with codeine are often not the type we would consider typical drug misusers. They hold down good jobs, many in professions including healthcare, the legal world, the IT sector, teachers etc. They can have good family relationships and appear to be very 'normal'. Many people have cited their codeine use developed from dealing with 'stress and the physiological effects of stress on the body'. This can make identifying and intervening in codeine misuse/addiction difficult.

People present with many common ailments, such as period pain, migraine, back pain and other mild to moderate pain concerns. This makes it hard for medical professionals to notice the signs of addiction or misuse. Add to this the many pharmacies in an area, making it easy to 'pharmacy hop'. The behaviours the misuser develops over time are especially adept at obtaining the substance, the more that tolerance develops. This means misuse often goes unnoticed, and makes it difficult to facilitate an early intervention.

Causes of misuse

The easy availability of codeine is the main cause of misuse of the drug. Early introduction to codeine can be from managing symptoms of a hangover, minor aches and pains from sport or activity, and other such complaints that are normalised circumstances. Where prescription-only medications containing codeine are used, these prescriptions are often not fully consumed for one reason or another. They are then left in the medicine cabinet 'in case someone needs one'. Family members and friends share these while confiding in each other about their ailments and conditions. While naively meaning well, they cannot know how a person will be affected by codeine. This is a similar naivety to how benzodiazepines were advertised as 'mother's little helpers' in the 1950s and 60s.

For the most part people who use codeine-based medication use them properly and with the guidance and support of a GP or pharmacist. However, addiction to this substance is increasing with many treatment services recording an increase in OTC codeine use and dependence.

Addiction

The stages of addiction include: experimentation, recreational use and problematic use, through to physical and psychological dependence. These stages are more difficult to spot with codeine addiction as the beginning of misuse may grow from a short-term prescription for an injury or other common ailment. Pain relief will always be needed so people will come into contact with codeine. Understanding codeine and how harmful it can be is vital.

People with a codeine addiction can name a range of physical ailments to obtain access to the drug. With new pharmacy codeine laws this is making it slightly more difficult for people as they won't want to be

questioned by the pharmacist. However, I have known clients to drive to parts of Northern Ireland in order to access the drug, mainly because they could access packets of 36 tablets there as opposed to the maximum of 24 in the Republic of Ireland.

People can also stock up when abroad as some other European countries are more lax with the sale of OTC codeine-based medications. This ease of access only enables the addiction and tolerance of codeine to increase. It is often at this point of dependence that relatives and friends of an individual begin to notice behavioural changes, such as mood swings, loss of appetite, loss of interest in positive activities, lack of organisation, confusion and flu-like symptoms.

Tolerance builds quickly so people who use codeine would need to take more and more to get the same effect. This leads the individual to increase dosage to overcome impending withdrawal symptoms. People often state that they did not see the problem becoming increasingly difficult to manage as the entry point into codeine use was via prescription or the use of a seemingly innocuous OTC product.

As addiction develops, prolonged use may bring health issues for the user. Also any change in usage pattern (such as beginning to use the drug intravenously, adding other drugs or significantly increasing daily doses) brings with it more severe health implications. These may include exposure to hepatitis B or C, liver function problems, development of sleep apnoea, respiratory disorders and effects on heart rhythm.

Withdrawal

Withdrawal can be difficult to spot in the mild to moderate misuser, especially when you don't have a daily or weekly relationship with the individual. This makes assessment difficult and is a key reason for pharmacist assessment with each individual who requests codeine. Withdrawal symptoms and their severity vary from patient to patient and depend on the level of usage. Symptoms include: mood swings, restlessness, insomnia, depression, runny nose, watery eyes, nausea, stomach cramps, vomiting, diarrhoea, aches, pains, loss of appetite and weight loss.

Treatment

Addiction to codeine can be treated. Physical withdrawal can take up to seven days, with individuals displaying a varying degree of symptoms, from mild to severe. Some people may need a detoxification drug to alleviate the symptoms; the use of opioid substitution is rare but possible. A GP can support patients through the withdrawal process. Ongoing rehabilitation in most cases is advisable, with many counselling, self-help and other services available to those wanting to remain abstinent.

Conclusion

Codeine has fast become a daily support for those living busy lives with high stress levels and also to those in isolation of some kind. What we do know is that most misusers, if not all, initially use these medications for relief from pain of some kind, but it fills a void and becomes a 'friend'. However, recovery is possible regardless of person, place or situation. Anyone can become addicted to codeine – the most important thing is to seek help.

Gerry Ryan, project manager, Tolka River Project, Addiction Rehabilitation Centre, Mulhuddart, Dublin
Email: tolkariverproject@gmail.com
Website: www.tolkariver.ie ; Tel: 01 640 5847

In addition to the Tolka River Project (details above), the following organisations help those with an addiction:

- *Rutland Centre, Addiction Treatment, Knocklyon, Dublin, Tel: 01 494 635*
- *National Drug Treatment Centre, Pearse Street, Dublin, Tel: 01 648 8600*

Helping your sick child

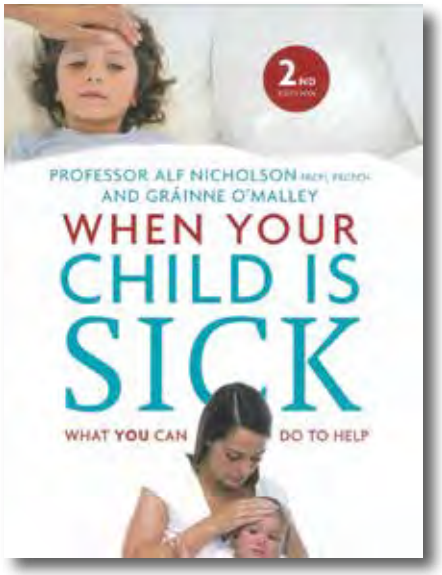
In this second edition of *When your child is sick – What you can do to help*, Prof Alf Nicholson and Grainne O'Malley reflect on some of the changes in child health that have taken place in the seven years since the first edition in 2009.

When the first edition was written, and reviewed in this journal, Prof Nicholson expressed his concern about the overcrowding in hospitals and parents bringing their children to the doctor more frequently than ever, despite these children belonging to one of the healthiest generations ever, thanks to vaccinations.

Prof Nicholson says the above is still the case, but a major health concern that has received much attention since the first edition is that of overweight and obesity in children in Ireland. To reflect this, Prof Nicholson has made significant additions to the chapter on obesity, as well as those on hyperactivity and allergies, which remain of big concern to many parents.

The aim of the book remains the same: to provide a clear and well-written overview of the 20 most common ailments in childhood, how to treat these at home and when to call the doctor.

It also aims to provide parents with basic



knowledge about these ailments, which, according to Prof Nicholson, "crop up time and again" as the child progresses through childhood and into adulthood.

Each one of the 20 ailments is described in detail, includes a Q&A section, recommendations for home treatment, and a 'red alert' box which describes when a parent urgently needs to contact a doctor or hospital. Each ailment also includes an 'inside track' box, which discusses the general thinking and knowledge about an ailment.

The second part of the book discusses what to expect of a child as he or she grows. This starts with a Q&A section on 'what's normal' in the newborn child. This part of the book also discusses safety issues and the most common causes of accidents and how to prevent them, as well as a chapter on dental growth and health.

The third part of the book discusses in more detail what to look out for in the pre-teen years, and parents may be surprised at how early children are exposed to drugs and alcohol temptations.

The final part of the book discusses the value of natural therapies (and lack thereof), what medicines to keep at home and why vaccinating children is still so vital in order to avoid potentially lethal illnesses.

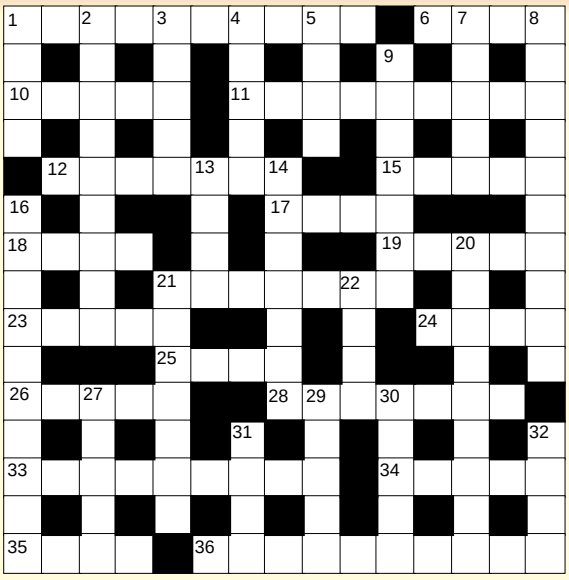
This is a truly comprehensive guide for parents who want to be more knowledgeable about the most common childhood ailments, and perhaps stick with 'home treatment' as it is, most often, adequate.

– Sonja Storm

'When your child is sick – What you can do to help', by Alf Nicholson and Grainne O'Malley, 2016 is published by Gill Books, an imprint of MH Gill & Co, RRP €24.99
ISBN 978-0-7171-6922-1

Crossword Competition

WIN A €30 BOOK TOKEN



Across

1. Might this missionary saint snub a locum? (10)
6. Pack away (4)
10 & 11. Therapeutic use of light to dispel the maternal retest (5,9)
12. Sporting fishermen (7)
15. Chronometer (5)
17. South American country (4)
18. In Greek mythology, the ship in which Jason sailed (4)
19. Get as far as (5)
21. Might the C.I.A. deny making poison like this? (7)
23. Thumb a lift (5)
24. Soft French cheese (4)
25 & 32d. This plant can be seen around the area, love (4,4)
26. Cook a particular cereal in this utensil (5)
28. Large marine crustacean (7)
33. Garment associated with snooker players (9)
34. Overweight (5) 35. Weeps (4)
36. One could possibly make a tractor eat such colourful earthenware (10)

Down

1. Young horse (4)
2. Yesterday evening has a final connotation (4,5)
3. Wall painting (5)
4. Essential oil from flower petals (5)
5. Availed of (4)
7. Unit of heat, equivalent to 100,000 BTU (5)
8. As trundles beneath a float? (5,5)
9. Height and build (7)
13. Nervous, agitated (4)
14. The plane is diverted by a dog (7)
16. American-style potato dish (4,6)
20. Consensus (9)
21. Alms (7)
22. A minstrel poet turns up looking dull (4)
27. Ascend (5)
29. Peripheral kind of route (5)
30. Unemotional, uncomplaining type (5)
31. Perforation (4)
32. See 25 across

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

The prize will go to the first all correct entry opened.
Closing date: Friday, August 19
Post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin

Solutions to June crossword:

Across:
1. How 3. Photocopier 8. Adonis 9. Identify 10. Tiber 11. Rules 13. Lapel 15. Re-elect 16. Agitate 20. Lagan 21. Raven 23. Bones 24. Coincide 25. Create 26. Desperadoes 27. Tot

Down
1. Heart murmur 2. Woodbine 3. Prior 4. Triceps 5. Owner 6. Icicle 7. Ray 12. Spreadsheet 13. Local 14. Log on 17. Abundant 18. Egghead 19. Avoids 22. Niche 23. Barks 24. Cod

The winner of the June crossword is: Jane Durkan, Naas, Co Kildare

PHNs recognised for outstanding care

FIVE public health nurses were recognised recently for the exceptional care they provide and their commitment to promoting public health nursing in the community at the recent AGM of the Institute of Community Health Nursing (ICHN).

The annual ICHN awards recognise nurses for their professional commitment to nursing in the community and for their work in the promotion and development of best practice and services for identified health needs of varying population groups.

Clare Lewis, clinical care manager for the older people in Dublin North, was named the overall winner at the ICHN awards, in addition to being named regional winner for the east for her dedication to the patients in her local community and also for the support and mentoring of community nurses in dealing with older clients with complex care needs.

A lifetime achievement award was presented to Violet Hayes, director of public health nursing, West Cork, who was recognised for "always going that extra mile when dealing with the patients."

Ms Hayes was also recognised for the huge support she has given to her staff at both a professional and personal level.

Pictured at the ICHN Community Health Nursing Awards (l-r): Grainne O'Brien, clinical care manager, Cobh; Violet Hayes, director of public health nursing, West Cork; Johanna Downey, ICHN president; Marie Chambers, public health nurse, Achill; Clare Lewis, clinical care manager, North Dublin; and Margaret Keogh, public health nurse, Longford/Westmeath

The regional awards were presented to:

- Midlands – Margaret Keogh, PHN, Longford Westmeath
- West – Marie Chambers, PHN, Achill Island
- South – Grainne O'Brien, Clinical Care Manager, Cobh
- East – Clare Lewis, clinical care manager for older persons, Dublin North, CHO Area 9.

Speaking at the ceremony, ICHN president Johanna Downey said: "On behalf of the ICHN and the public health nursing service, we would like to congratulate all of our winners. Their initiative, motivation and care given in the workplace is inspirational. Those awarded continually go above and beyond in the care they provide within their community."

Good practices in pain management

ACTIVE Citizenship Network is launching the first 'EU Civic Prize on Chronic Pain – Collecting Good Practices', which aims to give evidence of existing good practices in European countries in terms of pain management.

The prize will represent the recognition of ongoing excellence in the treatment and management of chronic pain.

Healthcare workers who wish to enter should fill in a form (available at **www.activecitizenship.net/bp/2016/form/new.php)** in which they should detail their guide to best practice, including the development of good practice in pain management and obstacles which may come in the way of good practice. The closing date for submissions is August 31, 2016.

See **www.activecitizenship.net/patients-rights/projects/204-european-civic-prize-on-chronic-pain-collecting-good-practices.html** for more information.

Blood Bike volunteers help to relieve pressure on local hospitals

BLOOD Bike South, a charitable organisation run by a group of motorbike enthusiasts, operating primarily in the southern region of Ireland, assists hospitals and other medical facilities by providing a voluntary motorcycle transport service of blood and other urgent medical materials on an out-of-hours basis.

Their services are provided by volunteers, who have advanced training and undergo regular reviews of their skills.

Similar to existing blood bike groups in Ireland and the UK, Blood Bike South acts as a voluntary rider service that helps relieve sickness and protect health by providing the transportation of blood, blood products, patient records, drugs and other medical requirements between hospitals and blood transfusion banks, primarily, but not exclusively in the southern region.

It aims to take some of the pressure off local hospitals in relation to their rising costs in transporting these goods and hopes that this saved money will be redirected into primary care areas such as staffing and facilities. It also aims to relieve the use of emergency vehicles in the transport of these items so that they are always available and ready to answer emergency calls.

Pictured (l-r): Volunteers Joe Curtin, Jim McAuliffe and Pat Murphy of Blood Bike South

Investing in nursing and midwifery

A SERIES of recent meetings, held by the International Council of Nurses (ICN) in advance of the World Health Assembly, highlighted the need for governments to invest in nursing and midwifery in order to achieve universal health coverage and the sustainable development goals.

Nursing regulators from 28 countries attended the ICN's Credentialing and Regulators Forum, co-hosted by the International Confederation of Midwives (ICM), to discuss key topics including evidence-based regulation and credentialing; how regulation can advance the professions and protect the public; continuing professional development; and addressing the future of the nursing and midwifery workforce in light of global health mandates.

Elizabeth Adams, INMO director of professional development, was an invited speaker and presented to the global regulators on the comprehensive services provided by the INMO to support nurses and midwives in maintaining their continuing professional development and lifelong learning. She stated that: "Fundamental to ensuring quality and safe care for every patient, there is a responsibility on the regulator and the employer to ensure nurses and midwives are provided with the opportunity and resources, such as study leave and funding to maintain their CPD and lifelong learning."

The International Council of Nurses sent a delegation of 69 people to the 69th World Health Assembly

The ICN and ICM also co-hosted the sixth Triad meeting, the purpose of which was to address issues of common interest and concern resulting in sharing of ideas and experiences and collaborative actions.

Speaking in relation to TTIP, Liam Doran, INMO general secretary, said: "Our attitude is in line with that of the Irish Congress of Trade Unions in that we are strongly opposed to the inclusion in Transatlantic Trade and Investment Partnership (TTIP) – or indeed any trade agreement – of the Investor State Dispute Settlement (ISDS) and want to see our government send a clear and unequivocal message that it should be removed. This proposal is an affront to democracy as it allows investors to sue governments in secret courts composed of corporate lawyers, at which other people have no representation, for compensation over national laws or rules that affect their activities. Health and education services are already spread between public and private providers – often on a competitive basis. The risk is that TTIP could lock in existing arrangements and leave States and public service providers open to legal challenge via private tribunals."

Registered Nurse in Intellectual Disability Section Conference

Date: Tuesday, November 1, 2016
Venue: Dublin

Topics will include, amongst others, the following:

- Federation of Voluntary Bodies
- Assisted Decision Making (Capacity) Bill 2013
- Behaviours that challenge

'RNID Nurses in the community' sessions will include:

- Early intervention
- Palliative care
- Breast check
- Dual diagnosis

For further information please contact INMO section development officer at email: **jean.carroll@inmo.ie**

Inheritance tax: a practical guide

Ivan Ahern discusses how to protect your beneficiaries against inheritance tax

IRELAND has one of the highest inheritance taxes in the world. Changes in inheritance tax rules commenced in 2009 but it is only now that people are starting to realise the impact this is having as property prices and asset values begin to recover.

The tax bill faced by beneficiaries can be substantial, depending on three main factors:

- The relationship between the deceased and the beneficiary (this determines the maximum tax-free threshold that applies, eg. the group threshold)
- The net/taxable value of the inheritance
- Any previous gifts or inheritance received.

What many people don't realise is payment of this tax bill needs to be paid soon after the inheritance. The onus is on the beneficiary to pay it and complete a full tax return. If you do not plan ahead, your family could lose part of their inheritance or be faced with a difficult decision between having to sell part of the inheritance, or borrow the money to pay the tax bill.

If your family is likely to have to pay inheritance tax when you die, it may be a good idea to protect them against this beforehand.

What are the thresholds and capital acquisitions tax rate?

Inheritances can be received tax-free from capital acquisitions tax up to a certain amount. The tax-free amount varies depending on your relationship to the person giving the gift (group threshold).

There are three different groups. Each group has a threshold that applies to the total value of the inheritances you have received in that group. The current rate of capital acquisition tax is 33% *(see Table 1)*.

What are your options to protect your family against inheritance tax?

The tax liability for beneficiaries can be avoided in a number of ways:

- *Affecting a 'Section 72 life assurance policy'*: This funds the capital acquisitions tax liability that arises on the benefits inherited from your estate and the proceeds of this are exempt from inheritance tax. This policy is relatively straightforward to set up, however it is subject to medical underwriting and therefore the earlier this is done, the better
- *Gifting a maximum of €3,000 per person annually:* Your beneficiaries can each get gifts of up to €3,000 a year from you without paying tax. This exemption, which is known as the small gift exemption, is useful if you can afford to drip-feed your inheritance while you are still alive
- *Gifting the family home to a child:* You could save your children thousands of euro in tax by encouraging them to move into any second homes or investment properties you intend to leave to them.

It is important to note that different guidelines apply for those passing on a business or farm to a child, for which one should seek professional advice.

Table 1: Capital acquisitions tax group thresholds (after 14/10/15)

Group	Beneficiary	Tax-free amount*
A	Son or daughter	€280,000
B	A parent, brother, sister, niece, nephew or grandchild of the person giving the gift (In certain circumstances, a parent taking an inheritance from a child can qualify for group A threshold)	€30,150
C	All other relationships, other than those mentioned in A or B	€15,075

**CAT only applies to amounts over the relevant group threshold* *(Source: www.revenue.ie)*

Table 2: Example of how inheritance tax works

Net/taxable value of inheritance	€700,000	
Number and type of beneficiaries: Two (son and daughter)		
Breakdown of inheritance due	**Jamie**	**Deirdre**
Gross inheritance to each beneficiary	€400,000	€300,000
Less tax-free amount (threshold for relationship: child, eg. Group A)	€280,000	€280,000
Gross taxable inheritance per child	€120,000	€20,000
Less personal capital gains tax exemption	€1,270	€1,270
Net taxable inheritance per child	€118,730	€18,730
Tax payable at 33% per child	€39,181	€6,181
Overall inheritance tax due	**€45,362**	

Ivan Ahern is a director of Cornmarket Group Financial Services Ltd.

July

Thursday 14
Assistant Directors of Nursing/ Midwifery/Public Health Nursing/ Night superintendents Section meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Wednesday 27
Clinical Placement Co-ordinators Section meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

September

Tuesday 6
Care of the Older Person Section meeting INMO HQ. 11am. Session on pensions. Denis Brophy, financial consultant. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Wednesday 7
RNID Section meeting. 11am. INMO HQ. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 10
Midwives Section meeting. 2pm. Limerick Regional Maternity Hospital. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 10
CNM/CMM Section meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie for Tel: 01 6640648 for further details

Thursday 15
Emergency Department Nurses' Section meeting. INMO HQ. 11.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Tuesday 20
Retired Nurses/Midwives Section meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 24
School Nurses Section meeting. INMO HQ. 10.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Wednesday 28
Telephone Triage Section annual conference. Castletroy Park Hotel, Limerick. Contact jean.carroll@inmo.ie for further details

October

Saturday 8
ODN Section meeting. 11.30am. Cavan General Hospital. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Thursday 13
All Ireland Annual Midwifery Conference. Crowne Plaza Hotel, Dublin. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Reunion

- A class reunion for nurses who trained at the Limerick University Hospital between February 1976 and May 1979 is being held on Saturday, October 15, 2016 at Bunratty Castle Hotel. Overnight stay with dinner. Contact Eilish Fitzgerald (née O'Doherty) at Tel: 0868423301 or email ellenfitzgerald@hotmail.com

Conference

- A special one-day conference on maternal morbidities will take place on Tuesday, November 8, 2016. The conference theme is 'Minding Mothers with Morbidities'. For more information see **www.trinityhirc.com**

Training programme

- One-day ear irrigation training programmes with Category 1 NMBI approval and four continuing education units will be held on September 22 and November 17, 2016 in the Education and Conference Centre, Royal Victoria Eye and Ear Hospital, Adelaide Road, Dublin 2. For further details contact Sabrina Kelly, nurse tutor at Tel: 01 6644652 or email: sabrina.kelly@rveeh.ie

INMO Professional Development Centre Library Opening Hours

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

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

INMO Membership Fees 2016

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

Congress

- The 7th Congress on Women's Mental Health will take place from March 6 to March 9, 2017 in the RDS, Dublin and will coincide with International Women's Day on March 8. For further information see **www.iawmh2017.org/wp/** or contact Jacqueline Healy at email: jacquelineh@nwci.ie

Condolences

- The INMO would like to extend its sincere condolences to Assunta Mc-Carthy (CUMH) and Lar McCarthy (Brothers of Charity) on the recent death of their mother Anna McCarthy. RIP
- INMO president, Martina Harkin-Kelly, Executive Council, members and staff of the INMO would like to extend their sincere condolences to Executive Council member Catherine Sheridan on the death of her father, Paraic Corbett. May he rest in peace
- INMO staff and colleagues would like to extend sincere sympathy to Jean Carroll on the death of her beloved father Milo Carroll. RIP
- Sincere sympathy, from all her INMO colleagues, to Jude Maher on the loss of her beautiful baby girl Pearl Patricia. May she rest in peace
- The INMO would like to extend its deepest sympathy to Mary Connor and her family on the recent passing of her father Thomas Connor. RIP

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