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WIN

World of Irish Nursing & Midwifery

Journal of the
Irish Nurses and
Midwives Organisation

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WIN,
MedMedia Publications,
17 Adelaide Street,
Dun Laoghaire,
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Website: www.medmedia.ie

medmedia publications

Editor Alison Moore
Email: alison.moore@medmedia.ie
Tel: 01 2710216

Production & news editor Tara Horan

Sub-editor Sinéad Makk

Designers Fiona Donohoe, Paula Quigley

Commercial director Leon Ellison
Email: leon.ellison@medmedia.ie
Tel: 01 2710218

Publisher Geraldine Meagan

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INMO
Irish Nurses and Midwives Organisation

Editor-in-chief: Liam Doran

INMO editorial board:
Martina Harkin-Kelly; Mary Leahy; Margaret Frahill; Frances Cullen; Kay Garvey; Mary Gorman; Karen McGowan

INMO editor: Ann Keating
Email: ann.keating@inmo.ie

INMO editorial assistant: Freda Hughes

INMO photographer: Lisa Moyles

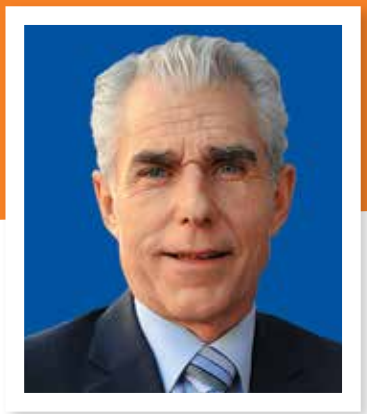
INMO correspondence to:
Irish Nurses and Midwives Organisation,
Whitworth Building,
North Brunswick Street,
Dublin 7.
Tel: 01 664 0600
Fax: 01 661 0466

Email: inmo@inmo.ie
Website: www.inmo.ie

www.facebook.com/irishnursesandmidwivesorganisation

twitter.com/INMO_IRL

Pay = recruitment = staffing



THE Executive Council, at a special meeting on June 30, 2017, decided to defer any decision, with regard to a recommendation on the proposals on public service pay, until late August with a nationwide ballot of members now to take place between August 29 and September 14, 2017.

The decision to defer any action on the latest pay proposals arose following an assessment by the Executive Council of the ongoing implementation of the staffing agreement reached with the Department of Health/HSE in April. It will be recalled that a cornerstone of this agreement is a funded workforce plan which will bring the number of nursing/midwifery posts in our public health service to more than 37,000 within this calendar year.

Despite this funded workforce plan, and the requirement for the HSE to furnish the Minister and the Oireachtas with quarterly progress reports on its implementation, the INMO remains extremely concerned at the pace of recruitment and the implementation of critical strands of the agreement, ie. permanent posts for all nurses/midwives on panels and 2016/2017 graduates. In that regard it was interesting to note that the latest staffing data from the HSE confirm that the number of staff nurses had increased by only 1.2% but the number of senior managers – Grade 8 and above – had increased by 5.6%.

Against this background the Executive Council decided that members should only be asked to consider the pay proposals in the context of clear progress being shown with the delivery of additional nursing/midwifery posts, arising from the commitments contained within the April staffing agreement.

In regard to the pay proposals themselves, the INMO, following the adoption of an emergency motion at our May annual delegate conference, had two clear objectives going into the negotiations. The first was the earliest possible restoration of all pay cuts in recent years, and the second was a process leading to progress on our claim for parity of pay and hours with other health professionals working in our health service. A full briefing document on the proposals can be found on the centre pages of this issue of *WIN*. Members are asked to consider these, as well as attend the regional meetings commencing on August 29 or local hospital meetings, before casting their ballot in their local workplace.

It is evident that these issues, ie. pay/recruitment/staffing are interlinked, as without proper pay and conditions you cannot recruit, and without successful recruitment you will not be able to address the critical staffing deficits. It is therefore essential that, prior to commencing our ballot, absolute clarity exists on the commissioning of a special initiative by the Public Service Pay Commission to look at the recruitment/retention/pay issues within nursing and midwifery, which are the root cause of our staffing shortages. The Executive Council is aware that, in addition to, and separate from, the need to implement the staffing agreement, members have complete clarity about how the parity claim will be examined within the strands of the proposed pay agreement before being asked to vote on it.

The Executive Council's plan is that the balloting will now be completed by September 14 and counted on September 15 and the INMO will attend a special meeting of the Public Services Committee of ICTU on September 18 to assess the overall position of the 19 unions within that committee towards the current pay proposals. It will then be for the INMO to make a decision, in light of what members have decided, what approach we will take to the proposed three year pay agreement for all public servants.

In summary, this Organisation has reached decision time with regard to how, in addition to pay restoration, our longstanding claim for parity with other degree-level health professionals will be progressed. Whatever decision we take, every member can be assured that the INMO will be united, across our 40,000 members, in pursuance of our legitimate goal for pay equality for the role nurses and midwives play in our public health service.

Liam Doran
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

Pay talks

AS YOU know the pay talks got under way on May 22 and concluded on June 8, just outside the initial and somewhat ambitious two-week timeframe. A set of proposals emerged and the Executive Council decided to defer a decision regarding any recommendation until their meeting on August 28, ahead of balloting from August 29 to September 14. This would allow time for consultation with key activists/campaign committee members and to seek clarification from the Minister for Health with regard to the recruitment/retention section of the proposals (*see centre pages for full details*).

The talks coincided with the Fine Gael leadership battle which saw the appointment of Leo Varadkar as Taoiseach. Some stability has been given to the health portfolio with the reappointment of Simon Harris as Minister for Health. We will continue to work closely with the Minister to bring forward the initiatives that are required to deal with the severe crisis in our health service.

ICN Congress and Conference, Barcelona

I ATTENDED the ICN Congress and Conference in Barcelona which saw close to 8,108 nurses from 135 countries gathered to share knowledge and discuss global healthcare priorities under the theme 'Nursing at the forefront transforming care'.

The International Council of Nurses (ICN) is a federation of more than 130 national nurses' associations representing millions of nurses worldwide. The event this year held particular significance from an Irish perspective, as Annette Kennedy, former director of professional development with the INMO and who served as third-vice president of the ICN (2013-2017) and president of the European Federation of Nurses (2005-2007), was elected as the 28th president of ICN.

Annette has extensive experience in dealing with nursing policy issues at national, European and global level. On behalf of the INMO I hosted a congratulatory event for Annette in the AC Barcelona Hotel, which saw tributes from Dr Siobhan O'Halloran who also read a letter on behalf of the Minister for Health; Essene Cassidy, NMBI president; Suzanne Dempsey, IDNAM president; Judith Shamian, outgoing ICN president; and myself. I would like to take this opportunity, on behalf of all INMO members and staff, to wish Annette every success in this vitally important role. You can access more information on this year's event in Barcelona at **www.icnbarcelona2017.com/en**

Other events

ALONGSIDE Clare Tracey, IRO, I represented the INMO at the National Women's Council of Ireland AGM. The event was attended by many national women's groups and saw 22 motions being debated on societal issues that impact on women's lives. Please see the President's Corner on **www.inmo.ie** for the full report.

On behalf of the membership, I also attended the Chief Nursing Officer's 'Nursing and Midwifery Values in Practice' conference in Dublin Castle on May 16, which was addressed by Minister for Health Simon Harris. This brochure link will give you a snapshot of the conference content: **http://health.gov.ie/wp-content/uploads/2017/05/Nursing-Midwifery-Conference-Brochure.pdf**

I would like to take this opportunity to wish every success to all of your sons and daughters who sat the Leaving or Junior Cert exams recently. I hope that you and your family will get a much needed break from your work environment over the summer as it is vital to recharge the batteries.

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

Quote of the month

"The best way to predict the future is to create it!"
Peter Drucker

Report from the Executive Council

THE Executive Council met on June 12 and 13. Top of the agenda was consideration of the outcome from the Pay Talks referred to as the Public Service Stability Agreement 2018-2020.

The Executive Council took the decision to meet again on Friday, June 30 following the consultation with activists and the Minister for Health to make a final decision with regard to any recommendation pertaining to the pay proposals.

At that meeting it was decided to hold off on making any recommendation on the proposals until our August meeting to see what progress would be made in filling nursing and midwifery posts following an agreement reached in April with the employers. We also need clarity around the progression of our claim for parity of pay and hours with other health professionals.

Balloting will take place from August 29 to September 14 with the count being held on September 15. Please familiarise yourselves with the agreement, attend information meetings and cast your vote.

Get in touch

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

Phil Ní Sheaghdha to become INMO general secretary in January

FOLLOWING public competition, the INMO has appointed Phil Ní Sheaghdha, currently INMO director of industrial relations, to the position of general secretary designate from July 1, 2017. Ms Ní Sheaghdha will replace the current general secretary, Liam Doran, when he retires on January 1, 2018.

Ms Ní Sheaghdha qualified as a general nurse in 1988 from Jervis Street Hospital. She then moved to the UK where she specialised as an intensive care nurse. She has worked in Ireland, the UK, Australia and the US as an ICU nurse. On her return to Ireland in 1993, she joined the staff of St Vincent's University Hospital, Dublin.

Ms Ní Sheaghdha joined the INMO as a full-time industrial relations officer in 1998. She subsequently completed an MA in industrial relations and trade union studies in 2007, and was appointed INMO director of industrial relations in 2008. In addition, she obtained a Higher Diploma in employment law in 2015.

Ms Ní Sheaghdha has been a member of the Executive Council of the ICTU for many years and currently sits on the ICTU General Purposes Committee. She is currently chair of the Health Service Staff Panel – the collective body for all unions representing staff in the health service and, in this capacity, has led the union side in many different sets of negotiations. She was previously a member of the Employment Appeals Tribunal.

General secretary designate Phil Ní Sheaghdha: *"As general secretary, my agenda will be very forthright in progressing and improving the conditions of employment for nursing and midwifery"*

Ms Ní Sheaghdha is a native of the West Kerry Gaeltacht, is bilingual and her first language is Irish.

Speaking after her appointment, she confirmed her vision for the INMO is to continue and develop the good work of Liam Doran. "I would like to thank Liam and all the INMO colleagues I have worked with over the past 19 years. I have been very fortunate to have had such a great mentor as Liam, and such committed colleagues within the Organisation. I am delighted the Executive Council has approved my appointment. While I do not underestimate the challenges involved, I would like to assure INMO members that, as general secretary, my agenda will be very forthright in progressing and improving the conditions of employment for nursing and midwifery, and developing the role that they play in healthcare management and delivery.

"I am confident that, surrounded by the excellent team of staff and proactive Executive Council, this can be achieved."

INMO president Martina Harkin-Kelly, on behalf of the Executive Council and all INMO members, welcomed the appointment saying: "The INMO is very fortunate to be in a position to appoint such a formidable and committed person as Phil Ní Sheaghdha as our general secretary designate. I know that Phil, working with the entire team in the INMO, will continue to build, and further strengthen, this Organisation as we strive, on each and every front, to improve the professional and working environment for every nurse and midwife in this country. Phil has a track record of achievement, second to none, and I look forward to working with her during my tenure as president to address all of the issues that are so challenging at this time".

INMO general secretary Liam Doran said: "Phil's appointment is another milestone in the development of this great Organisation. Phil has a commitment to the INMO, and each and every member, which is exemplary and this, combined with her expertise and knowledge, will ensure that the INMO goes from strength to strength in the years ahead. The INMO in the expert, competent and assured hands of Phil Ní Sheaghdha will face, and overcome, all challenges ahead".

Annette Kennedy elected as new ICN president

ANNETTE Kennedy, INMO director of professional development from 1994-2012, has been elected to the prestigious position of the 28th president of the International Council of Nurses (ICN).

Ms Kennedy was previously third vice president of the ICN from 2013-2017 and president of the European Federation of Nurses (EFN) from 2005-2007. The election took place in late May at the ICN's governing body meeting, the Council of National Nursing Association Representatives (CNR), of which the INMO is a member, during the ICN International Congress in Barcelona. More than 8,100 nurses from 135 countries gathered at the Congress to share knowledge and discuss global health care priorities.

"It is a great pleasure to congratulate Annette Kennedy and the new Board members on their appointment, said Dr Frances Hughes, ICN chief executive officer. "I look forward to working closely with them as we continue to move the ICN forward to advance nursing, nurses and health around the world."

Ms Kennedy has extensive experience in dealing with policy issues at high levels and has long been involved with the ICN through her vice-presidency, EFN and INMO roles. "I believe ICN has the potential to influence the delivery of global nursing care and health policy," said Ms Kennedy. "Over the next four years I aim to ensure that this worldwide organisation is fit for purpose in the changing economic and healthcare environment, meeting the needs of members and allowing them, in turn, to meet the needs of their patients/clients."

• *A forthcoming issue of WIN will feature an extended interview with Annette Kennedy*

Consultation with campaign committee members:
At the INMO's special meeting in late June, key activists and campaign committee members articulated the huge frustration among the nursing and midwifery workforce on the frontline at the slow progress in providing adequate numbers to care for a growing number of patients

Executive Council postpones decision on recommendation on pay proposals

Frustration at slow progress on recruitment and retention agreement

THE INMO Executive Council took the decision to hold off on making a recommendation on the proposals for pay restoration, which have emerged under the Public Service Stability Agreement LRA (2), until its August meeting. The INMO will now be balloting its members from August 29 to September 14.

In arriving at this decision, the Executive Council expressed frustration at the slow progress made by the HSE regarding implementation of the existing Safe Staffing Recruitment and Retention Agreement for nurses and midwives.

The Organisation reached agreement with the employers in April, which provided for the filling of all nurses and midwives posts, including replacing those absent on maternity leave, and increasing the overall number by 1,208 by the end of the 2017.

Recruitment remains very slow, retention continues to be problematic and the INMO has sought to ensure that the first quarterly report, due to be issued to the Minister on June 30, reflects this reality.

The Executive Council expressed frustration that, once again, the Organisation is being put through a tedious process of having to ensure that the national agreement is implemented in all locations, with some employers pleading lack of finance and blocking the intended delegation for recruitment and retention to directors of nursing and midwifery.

INMO deputy general secretary Dave Hughes said: "There is huge frustration among the nursing and midwifery workforce on the frontline at the slow progress in providing adequate numbers to care for a growing number of patients."

Phil Ni Sheaghdha, INMO general secretary designate, said: "In spite of a National Implementation Group operating at senior level, progress is slow at regional level and the barriers to recruitment and retention remain.

"The INMO is committed to working proactively with the HSE and the Department of Health at national level throughout the summer months to get a workable implementation process at regional and local level."

Consultation with campaign committees

The Executive Council had previously deferred any decision regarding a recommendation to allow time to undertake the following:

- Consult with the Organisation's key activists/campaign committee members at a special meeting in late June
- Seek clarification, from the Minister for Health on the recruitment/retention section of the proposals, once he was appointed as part of the new cabinet.

INMO general secretary Liam Doran said: "This will be a critical decision for the Organisation as we seek to progress our longstanding claim for parity of pay and hours with fellow degree level health professionals."

INMO public sector pay proposals regional information meetings

Date	Time	Venue
Monday, August 28	7.30pm	INMO HQ, Dublin
Tuesday, August 29	7.30pm	Tullamore Court Hotel
Wednesday, August 30	7.30pm	Kingsley Hotel, Cork
Wednesday, August 30	7.30pm	West Court Hotel, Drogheda
Wednesday, August 30	7.00pm	Clayton Hotel, Galway
Thursday, August 31	8.00pm	Clayton Hotel, Sligo
Thursday, August 31	7.30pm	South Court Hotel, Limerick
Thursday, August 31	7.30pm	Tower Hotel, Waterford

Phil Ní Sheaghdha, INMO general secretary designate, reports on current national IR issues

Pre-retirement initiative reintroduced

THE Staffing, Recruitment and Retention Agreement – High Level Implementation Group continues to meet on a weekly basis.

Arising out of a recent meeting, the pre-retirement initiative for nurses and midwives has been reintroduced. This follows on from the INMO's campaign to improve staffing and retention measures and the resulting negotiated proposals which the INMO members voted to accept in April 2017.

The HSE has issued the circular required to commence the process of applications for this scheme. Under the scheme nurses/midwives in full time, permanent positions aged 55 or over may apply to work on a 0.5 WTE job-sharing basis for a maximum of five years prior to retirement until they reach age 65. The five years or less in question will then be reckoned as full-time service for superannuation purposes.

Applications from eligible nurses and midwives should be forwarded to:

- Group directors of nursing – for acute hospital applications
- Directors of public health nursing for PHN applications
- Directors of nursing for the service/employer for all other applications.

Any queries on the scheme should be directed to the above and/or to the HSE officer with responsibility for this scheme, Mairead Lyons, email: mairead.lyons3@hse.ie

If you require INMO assistance, contact the information office or your local IRO.

Update on CNMI posts

Also arising out of the High Level Implementation Group meetings, the CNM1 posts for medical/surgical wards should now have been advertised. Current CNM1 vacancies include:

- Saolta Hospital Group – 116
- South/South West Hospital Group – 79
- Ireland East Hospital – 31
- Dublin Midlands Hospital Group – 32
- RCSI Hospital Group – 18
- University Hospital Group – 30
- Children's Hospital Group – 6.

Advanced nurse practitioners

It was also confirmed that the backfilling of 120 advanced nurse practitioner posts will be funded in 2017.

Permanent full-time contracts for student nurses

It was agreed that the HSE will communicate to all relevant parties that there is financial provision made to enable recruitment of student nurses and revert to the group with an update on this recruitment drive.

CNM1 in ID services

The HSE is currently collating figures on CNM1s employed in the intellectual disability sector and draft numbers are to be submitted for the July meeting of the implementation group.

Rehiring of retirees and recruitment from abroad

The HSE agreed to prepare an updated circular on changes that had been agreed at the High Level Implementation Group regarding the rehiring of retirees and a circular on recruitment of nurses/midwives from abroad.

Both of these circulars were due to be submitted to the group meeting scheduled for June 28.

See **www.inmo.ie** for ongoing updates on all IR issues

Second phase of ED taskforce now underway with focus on consultation

THE ED Taskforce on Staffing and Skill Mix Phase 2 continues to meet on a monthly basis.

This phase of the work includes focusing on national consultation on the draft framework. Consultation meetings took place throughout June in various venues around the country.

These meetings included specific consultation for members of nurse interest groups, including the Acute Medicine Nurse Interest Group, Emergency Nurse Interest Group, ANP Forum and the Local Injury Group.

Despair as trolley figures on rise again

May 2017 figures up 23% on same month last year

EMERGENCY departments and hospitals experienced record levels of overcrowding in May this year, compared with the same month in previous years, with 8,154 admitted patients being cared for on trolleys during the month.

This was the result of the latest analysis of the INMO trolley/ward watch figures. Given that the April figures showed a marginal improvement, the INMO said the latest figures were all the more disappointing. The May figures also show that increased levels of overcrowding were apparent both in the greater Dublin area and country areas, when compared to May 2016.

The hospitals showing the highest number of trolley figures included the Mater and Tallaght hospitals in Dublin, the University and Mercy hospitals in Cork, together with Limerick, Galway, Kilkenny and Waterford hospitals.

The hospitals with the highest numbers of patients on trolleys in May were Galway (671), Limerick (627) and the Mater (533).

INMO general secretary Liam Doran said: "This record level of overcrowding, showing a 23% increase when compared to 2016, is very disappointing coming at this time of year and after a marginal improvement in April.

"The figures confirm yet again, that our health service remains far too small to cater for demand, with this difficulty exacerbated by bed closures due to nursing staff shortages. Due to these shortages, we now have both acute and long-term beds closed in many areas, ranging from Donegal to Waterford. The figures reaffirm the extent of the crisis, arising from the recruitment/retention difficulties in nursing, which must be addressed, through pay related initiatives, as an absolute priority. Until the shortage of nurses, is addressed, both beds and services will remain curtailed and trolley numbers will continue to grow."

Table. INMO trolley and ward watch analysis (May 2006 – May 2017)

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

Comparison with total figure only:

Increase between 2016 and 2017: 23%
Increase between 2015 and 2017: 6%
Increase between 2014 and 2017: 38%
Increase between 2013 and 2017: 22%
Increase between 2012 and 2017: 32%
Increase between 2011 and 2017: 10%
Increase between 2010 and 2017: 42%
Increase between 2009 and 2017: 93%
Increase between 2008 and 2017: 96%
Increase between 2007 and 2017: 101%
Increase between 2006 and 2017: 94%

INMO gets valuable media coverage

2016 was again an excellent year for the INMO in terms of media coverage, generating a total value of €19.56 million. This figure is measured by the Advertising Value Equivalent (AVE) which would be the equivalent cost of buying advertising space for all the reportage the Organisation received.

The INMO's press and broadcast coverage amounted to €9.78m while online media also garnered coverage worth €9.78m. INMO general secretary Liam Doran generated €7.78m and the INMO trolley/ward watch campaign accounted for over €2.44m.

During 2016 the INMO appeared in the media, in some format, the equivalent of 22 times per day, including featuring in 3,380 internet articles, 3,309 radio and television segments and 1,453 print articles.

Significantly, the Organisation received €4.49m worth of coverage on RTE and appeared on the front page of 98 newspapers or eight times per month.

In addition, the INMO's social media accounts have gone from strength to strength in 2016, with almost 1.3 million total impressions on Facebook and almost 750,000 on Twitter. The INMO launched its Instagram account in December 2016 and encourages members to use dedicated Instagram hashtags at INMO events, conferences and protests to highlight the Organisation's activities and campaigns.

The INMO trolley/ward watch campaign kept the Organisation in the news every day in 2016. The trolley and ward watch figures are circulated to all media outlets and appear daily on Twitter and Facebook and are used by journalists, politicians and members of the public to highlight the overcrowding crisis in hospitals. Individual tweets can be seen by thousands of people. Members are urged to use the hashtag #trolleywatch if they wish to contribute.

A booklet recording the Organisation's substantial presence in the media in 2016, which includes a photo gallery of events throughout the year, was distributed to delegates at the annual delegate conference in May. The booklet is available from the Media Office.

Ann Keating, INMO media relations officer, said: "Media spokespersons have a key role in promoting the needs and interests of nurses and midwives in Ireland. It is important that we have members available to speak to the media to discuss what is happening on the ground. We appreciate your support and will continue to ensure that your voice is heard in the media."

Members who are interested in becoming a media spokesperson should contact Ann Keating, media relations officer. To find out more and to sign up for free training, email: ann.keating@inmo.ie

• *See page 14 for further details on INMO social media*

Sláintecare report welcomed but needs funding

THE INMO welcomed the recent publication by a cross-party Oireachtas committee of a special report on the Future of Healthcare in Ireland *(Sláintecare)*.

This publication is a historic milestone in relation to healthcare in Ireland, as it is the first time there has been political consensus about the shape and form of our public health service. The INMO said that, in particular, the acceptance that need should be the sole determinant of access, to care, and not the ability to pay is most welcome, right and proper.

The Oireachtas committee, in formulating the report, has correctly identified the need to shift the vast majority of healthcare out of the hospital system and into community/primary care services. This shift is absolutely central to the development of a public health service where the patient/client receives the care they require, from the professional they need, close to their home.

To facilitate this increased access to care, the report is also correct in highlighting the need to significantly increase the capacity of the health service, both in terms of capital and human resources, through earmarked funding. This will require the current recruitment difficulties with nurses/midwives being addressed as an immediate priority.

The INMO also welcomed the recommendations to:

- Establish a National Health Fund to ensure the protection of funding for the public health service
- Ensure all health professionals and staff are fully utilised in the delivery of care
- Focus on, and highlight, the need for integrated care to be the central requirement of all decision making
- Identify the need to provide earmarked (and increased) funding for disability and mental health services over the next five years.

The INMO has concerns about the level of additional funding outlined to allow the public health service to grow, in terms of capital infrastructure and staff, to meet the challenges that will arise from demographic and other factors.

However, the key question now, in the context of the consensus for a single tiered public health service accessible to all, will be whether future governments, in each and every Programme for Government, commits to implementing the recommendations of this report over the next 10 years.

The report must act as a catalyst and foundation for continuous implementation, within the timelines identified, in the years ahead. In implementing the report, and allocating the resources necessary, all future governments must highlight the benefits, to all sectors of society and the economy, from a world class accessible and equitable public health service

The INMO Executive Council is considering this major report in detail, and will engage with all political parties seeking assurances that they will move to implement same if and when they are in government.

INMO deputy general secretary Dave Hughes said: "The report correctly identifies that if we are to improve access, for every citizen, then we must dramatically increase the physical and staffing resources available to our 'new' public health service. The question of the funding allocated, in the report, requires closer examination to ensure that it provides the necessary resources to address the serious shortcomings, which currently exist, within our underfunded public health service."

The impact of austerity inevitably falls on the most vulnerable in society, writes deputy general secretary **Dave Hughes**

Justice delayed is justice denied

While health service issues such as long waits in overcrowded emergency departments and extended waiting lists for operations get much attention, it is worth looking at the way people who depend on the state for other services are treated.

The following case studies show how the Department of Social Welfare, in two cases, and the Department of Justice, in the third have deprived individuals of their entitlements for long periods and forced them to seek other interventions to achieve their entitlement.

Joe's case

Joe is an honest, hard-working individual who worked in a manual labour job from leaving school up to reaching his 50th year. He paid all of his taxes and PRSI. A single man, he did not pay sufficient attention to his own health and wellbeing and developed type 2 diabetes. Initially he ignored the symptoms and it was only when severe blisters and numbness in his feet became apparent that he sought medical help.

Joe became an emergency case – his sight was at risk, he had to have toes amputated, his fingers were at risk and he required skin grafts. He is now severely disabled and both his local community health service and his local authority have responded to his needs providing him with necessary daily healthcare and adapting his home. Although his place of work was close by, Joe could no longer walk that short distance and was certainly unable to work. Joe's medical attention from his GP to his consultants, nurses and physiotherapist, have all been of great help and have verified, on numerous occasions, that he is permanently disabled and, in medical terms, entitled to a permanent disability pension.

However, Joe spent over 18 months appealing his application through the Department of Social Welfare. Every appeal failed and the gaps between appeals were prolonged with repetitive questions being asked, but significantly no individual from the Department ever visited or spoke to him.

Even his former employer made representations to the Department, but no final decision could be made. Ultimately it took a direct approach to the Minister for the Department before the real human tragedy that had befallen Joe was recognised. Thankfully, the Department eventually approved his application for a permanent disability pension.

Michael's case

Michael, a hard working tradesman, again having paid full PRSI and taxes throughout his career, discovered in the course of donating blood that his platelets were low. He was referred immediately to his GP and was diagnosed with a rare form of leukaemia. His prognosis is very poor, even with a bone marrow transplant. Again the medics, nursing and other healthcare staff have confirmed the severity of Michael's condition. Michael's wife, who herself has gone through the throes of cancer treatment, ensured that the paper work was in order when making the application and submitted everything from birth to marriage certificates and medical certification to demonstrate that Michael would be unable to work into the future, was undergoing serious treatment and was entitled to an invalidity pension. Again Michael's application lay in waiting and every phone call provided half promises that it would be reviewed shortly.

The financial crisis for Michael and his family grew and all income ceased without a decision. While discussing the family's dire straits in passing with a union official they knew, the offer of assistance was made. Contact was made with the Department on Michael's behalf, and because this contact was at a very senior level, Michael received communication from the claim's section. After a period of months the claim's section sent back the original claim form, pointing out that a particular answer box that required a tick contained an X rather than a tick and, therefore, the claim could not be processed. A fresh application was immediately made and sent by registered post. Subsequently the Department denied having received the birth and marriage certs and medical certification and only when they were told that Michael had stamped copies with a reference number, did the Department accept it had the documentation. Michael has now been informed that his pension will be approved. The unnecessary stress caused to a man with such an illness is immeasurable.

Asylum seeker's case

On May 13, 2017, the Supreme Court found that the absolute prohibition on asylum seekers seeking employment indefinitely was unconstitutional. Justice Donal O'Donnell said it would be difficult, if not impossible, to justify the failure to put a time limit on the processing of asylum applications, as its effect was to deprive highly educated and qualified individuals from seeking employment in Ireland. The Court found that a right to work, at least in the sense of a freedom to work or seek employment, is part of the human personality. Humans, the Court went on, must be held equal before the law and that right cannot be withheld absolutely from non-citizens as is the case with asylum seekers.

The Department of Justice in this case appears to have used the tactic of long waiting lists and delays to deprive individual asylum seekers of their right to seek employment.

Justice delayed

The old adage 'justice delayed is justice denied' can surely be applied to the way that our public services are now delivered. Whether the person with the dependency on the state requires healthcare, social welfare payments or is an asylum seeker seeking simple justice and the right to work, the Irish system seems to have used delay to deprive people of their human dignity.

Austerity is a cruel policy. Its impact inevitably falls on the most vulnerable in society and its influence apparently forces civil servants to act in a way contrary to their ethos of serving the public to the best of their ability. When politicians talk about recovery, let us not fall into the trap of believing that austerity has not imposed long term permanent damage. Let us instead demand ethical and just responses from all our public services, as a matter of policy, from all future governments.

The recently-published cross-party report on the future of healthcare and health policy in Ireland, *Sláintecare,* is one example of politicians finally putting their heads together, in an attempt to ensure equal access for all to quality healthcare.

Mid West hospitals fail to fill CNM positions

THE INMO has requested the assistance of the Workplace Relations Commission (WRC) in the ongoing failure by the University Hospitals Limerick Group to fill vacant CNM positions in Limerick, Ennis and Nenagh.

Since last October the INMO has pursued appointments on behalf of individual members who are on panels. The Organisation has received repeated assurances from the HSE that all positions were approved for filling, yet seven months later nurses remain on the panels and in some instances are working in the promotional position without recognition.

The INMO is awaiting a date for the WRC hearing.

In the interim, if any member has a query relating to appointment to a vacant position, please contact INMO Limerick office, Tel: 061 308999, email: inmolimerick@inmo.ie

– Mary Fogarty, INMO IRO

Terms and conditions at Bon Secours, Limerick

THE INMO has written to the Bon Secours Hospitals Group requesting engagement to discuss terms and conditions of employment and nursing governance structures within the newly acquired former Barrington's Hospital, Limerick.

All members affected will be notified of progress via local meetings and updates.

– Mary Fogarty, INMO IRO

INMO secures safer care for patients in new Limerick ED

THE new emergency department which opened at University Hospital Limerick on May 29 is a superb new state of the art clinical environment for the patients and staff.

Up to the weekend in advance of the opening, critical issues raised by nurses had unfortunately not been addressed or even acknowledged, despite months of engagement with the HSE.

These included concerns in relation to the diluted nursing skill mix and the HSE proposal on the placement of admitted patients which was only received 10 days prior to the opening.

The INMO therefore had to place on the public record these concerns as our members were not prepared to take on sole responsibility for patient safety matters. The members were clear in the message to the union that they advocate for patients and have a Code of Professional Conduct requiring them to notify senior management of any issue of concern.

In advance of the opening at a meeting on Friday, May 26, the INMO secured an acknowledgement from management of the concerns of nurses. Therefore, a second clinical skills facilitator was appointed immediately to support new staff.

Management further committed to ensuring that the nursing roster has CNM1 and CNM2 positions allocated as previously agreed to mentor and support junior/new staff and advised that all new nurses had been given a mentor.

Management reaffirmed that the responsibility for admitted patients on trolleys rests with the operational assistant director of nursing, including allocating nurses to care for the patients.

The INMO had already secured at national level an additional 10 nurses for Limerick ED to care for admitted patients and, in the interim, management committed to making available additional hours/overtime to fulfil this roster requirement.

The INMO continues to object to the proposal from management to permanently place admitted patients in the new ED, which can never be accepted as appropriate. This particular issue remains unresolved with management advising the INMO at the meeting that further correspondence from the CEO will issue. This will obviously require further engagement and at the time of going to press this correspondence was awaited.

The commitment of the three INMO representatives, Ingrid O'Brien, Sarah Watkins and Bridget O'Donnell, throughout the engagement process on behalf of all INMO members was greatly appreciated and significant in getting agreements on staffing levels, rosters, rotations, etc.

– Mary Fogarty, INMO IRO

IROs mindful of yoga benefits

In the course of a recent training day for INMO industrial relations officers held in Trim, Co Meath, the team took part in a mindfulness refresher course, facilitated by Aparna Shukla, which took place on International Yoga Day, June 21.
This day is celebrated all across the globe to raise awareness about yoga and its holistic approach to health. The IRO's mindfulness training focused on yoga for a healthy state of mind through the practice of mindfulness. Mindfulness is a type of mental exercise that brings us out of autopilot mode so that we can live every moment to its full capacity. Mindfulness is defined as "paying attention in a particular way, on purpose, in the present moment non-judgementally" (Jon Kabat Zinn). Activities on the day included mindful breathing, mindful eating, forgiveness meditation and some mindful yoga postures. Pictured at the session were (l-r): Albert Murphy, Liam Conway, Mary Rose Carroll, Liz Curran, Mary Fogarty, Maura Hickey, Mary Power, Philip McAnenly, Anne Burke, Edward Matthews, Dave Hughes, Noel Treanor, Michael Dineen, Joe Hoolan, Lorraine Monaghan, Dean Flanagan and Tony Fitzpatrick

Escalation policy regularly invoked at Letterkenny

THE deteriorating bed capacity problem at Letterkenny University Hospital has caused the escalation policy to be partially invoked repeatedly in recent weeks in order to deal with increasing bed demand.

Elective work continues at the hospital despite the increased attendances at the emergency department. The national escalation policy is designed for use in exceptional circumstances as opposed to everyday use. Nursing staff at the hospital are seriously concerned regarding the health and safety of patients and say this cannot continue.

INMO members are fearful that patients are being put at risk on a daily basis while they strive to deliver basic care. There are wards in the hospital with insufficient nurses to deliver basic nursing care. Nurses are regularly taken from an already short staffed ward to cover in other areas.

The INMO is seeking:

- The HSE to implement its own escalation policy in response to this crisis situation
- The immediate cancellation of planned elective procedures, so that existing patients can be cared for in a safe manner
- An independent review of the existing practices/processes at the hospital.

INMO IRO Maura Hickey said: "The problem cannot be solved by placing extra beds on inpatient wards. This is a tried, flawed and failed practice of the past which should never be revisited."

A sample day at Letterkenny University Hospital (Wednesday, May 31)

On Wednesday, May 31 a total of 46 patients were waiting for beds in an unsafe and unsatisfactory environment including:

- 24 on trolleys – 14 in the ED and 10 on corridors
- 4 patients in treatment rooms awaiting admission
- 11 patients being cared for in the Acute Admissions Unit (AAU)
- 7 escalation beds were opened

Further beds closed in Dungarvan

GIVEN the continuing difficulties being experienced by the inability to recruit nursing staff to fill 16.5 vacancies at Dungarvan Community Hospital, the HSE and local management made the decision to close a further 19 beds at this care of the older person facility.

This has resulted in a total of 40 closed beds in Dungarvan Community Hospital, due to nursing staff shortages. The outcome of these closures restores, almost completely, the nurse: patient ratio for the remaining 105 patients residing in the hospital. Subsequent successful negotiations on operational issues concluded with members voting in favour of cessation of their work to rule.

– Mary Power, INMO IRO

Progress on St Patrick's, Kilkenny dispute

PROGRESS has been made on a dispute at St Patrick's Centre, Kilkenny which had escalated since October 2016 when management began introducing a wide range of changes in the service without consultation with the unions.

When management refused to confirm they would attend a WRC conciliation conference, the INMO and other nursing unions voted overwhelmingly to take industrial action.

Management then engaged an external industrial relations consultant to engage with the unions on all issues of dispute and industrial action was postponed to allow for negotiations, with the proviso that management would agree to any issues outstanding being referred to a third party forum.

Protracted negotiations have now resulted in a comprehensive restructuring of the service, with many new posts created and policies agreed to apply in the service. Crucially, the INMO secured agreement to maintain all nursing promotional posts in the service, which management was initially intending to 'phase out'. Some issues of dispute remain and will continue to be the subject of union/management negotiations in the service.

INMO IRO Liz Curran said "INMO members in St Patrick's Centre have shown patience, strength and maturity in the past few months in securing the re-establishment of appropriate negotiations with management on a wide range of issues. They have clearly demonstrated to management that they will not be ignored or disrespected, and will engage actively with management through their union representatives to secure improved terms and conditions for themselves, and for the clients they care for every day."

World news

Nurses and midwives in action around the world

Australia

- Project Sydney: Push for more nurses to boost patient safety

Brazil

- Nurses and health workers strike

Canada

- New study finds violence against Canadian nurses on the rise while patient safety is declining

France

- Shortage of nurses in the hospital

Honduras

- Nurses on strike

Kenya

- Nurses resort to weekly protests in pay deal push

New Zealand

- CNMI hospital to increase salaries of nurses
- Assaults in Wakari ward concern union

Portugal

- Nurses threaten to strike
- Nurses threat of 'burnout' will have consequences if it materialises, says Minister of Health
- Striking nurses denounce pressures

Spain

- Understaffed nurses attend to 200 daily emergencies in La Inmaculada
- Emergency workers report overworking to treat influx of new patients
- Almost all health centres will close in the afternoon in summer
- Doctors and nurses agree to create consensus text on prescriptions

UK

- RCN calls on May for greater focus on health and social care
- Simply too few nurses working in Scotland's NHS

OHN conference focuses on mental health and wellbeing in the workplace

SOME 80 delegates gathered last month for the annual INMO OHN Section conference, the theme of which was 'Occupational health: wellbeing strategies that work.

The conference, which was held in Cork, received excellent feedback from all attendees and had an excellent line-up of speakers.

INMO president Martina Harkin-Kelly opened the event and spoke on wellbeing and resilience, along with the importance of conferences such as the OHN conference to draw on the networking opportunities that the Section structures within the INMO offer to its members.

The formal presentations opened with an overview of the HSE Workplace Health and Wellbeing Unit from Dr Lynda Sisson and Sibeal Carolan who work in this unit. They also spoke on the forthcoming Occupational Health Service Standards, devised in line with HIQA standards, which were due to be published at the end of the month.

Dr Deirdre Gleeson, medical director of Medwise, delivered an informative talk on returning to work following mental illness. She outlined the benefits of work and mental health, legislation versus reality, returning to work, the role of occupational health, and the resources available. She also talked about and distributed the 'green ribbon" **(www.greenribbon.ie)**, highlighting the importance of starting a conversation about mental health. You don't have to be an expert to talk about mental health and it is important to talk but listen too – simply being there will mean a lot. Mental illness is common, work is good for your mental health, attitudes are changing and supports are improving, albeit slowly.

Pictured (l-r) at the OHN Section conference were: *Alan Shortt, presenter; Catherine Kenneally, speaker; Deirdre Gleeson, medical director, Medwise; Martina Harkin-Kelly, INMO president; AnnMarie Graham, OHN Committee; Margaret Morrissey, OHN committee; Prof Jim Lucey, medical director, St Patrick's Mental Health Services; and Mary Forde, OHN committee*

Dr Mark Rowe, GP and author, spoke to the conference on a prescription for happiness. Dr Rowe is a renowned speaker and delivers talks all over the globe on this topic. He spoke about his journey of transformation, and how it all started with his GP practice burning down. His prescription for happiness includes such things as expressing gratitude regularly, making time for what matters, exercising regularly and having the courage to choose.

Alan Shortt, media presenter, writer and producer, also spoke at the conference. He gave a really interesting talk entitled 'storynomics – the communication hack', inspiring each and every delegate to make their message matter, whether it be at home with the family or in the boardroom with the company directors.

The afternoon session was taken up with a talk on the dangers of sugar, the health effects of a high-sugar diet, foods to watch out for and how blood sugar balance supports good health. This talk, which was delivered by Catherine Kenneally, nutritional therapist and lecturer, was full of practical tips for the occupational health nurses to bring back to the workplace.

The day finished off with an outstanding talk from Prof Jim Lucey, director of St Patrick's Mental Health Services, entitled 'a life well lived – wellness?' He outlined the five steps to wellbeing to delegates:

- Connect
- Be active
- Take notice
- Keep learning
- Give.

These are simple activities that we can all engage in every day of our lives.

The OHN Section extends its thanks to all of the speakers for their valuable contributions to the day and looks forward to welcoming delegates back to the next conference in 2018.

Section news round-up

Call for posters for RCM/ INMO All Ireland Midwifery conference

THIS year's annual RCM/ INMO All Ireland Midwifery conference, which is taking place on October 12, is calling for poster submissions.

The theme of this year's conference is 'actions speak louder than strategies' and it will be held in the Armagh City Hotel in Armagh.

Application forms and guidelines are available to download from www.inmo.ie or by contacting Helen O'Connell at Tel: 01 6640616

Upcoming Telephone Triage Section conference

The 13th Annual Telephone Triage Section conference will be held in the newly refurbished Midlands Park Hotel, formerly the Portlaoise Heritage Hotel, on Wednesday September 27.

Topics will include headaches, domestic abuse updates, epilepsy and legal updates, among others.

To book your place go to **www.inmoprofessional.ie**

Please see page 22 for full details.

Retired Nurses and Midwives Section outing

The Retired Nurses and Midwives Section day trip to Newbridge Estate, Donabate will take place on Thursday, September 7. Train departs Connolly Station at 11.17 and 11.45. Entry to estate is €6.

Human Resources for Health Forum set for Dublin

Elizabeth Adams focuses on international nursing and midwifery initiatives and activities of interest to INMO members

THE fourth Global Forum on 'Human Resources for Health – Building the Health Workforce of the Future' will be held in Dublin from November 13-17, 2017. The Forum welcomes participation from a range of actors across education, health, labour/employment and finance sectors. It is the largest open conference on human resources for health-related issues and is expected to gather more than 1,000 delegates from across the globe.

The adoption of the Global Strategy on Human Resources for Health: Workforce 2030 and the work of the United Nations high level Commission on health employment and economic growth have made a significant economic case for investing in the health and social workforce and intensified intersectoral collaboration.

INMO activity

The INMO has contributed to a number of the Forums in the past, since the first Forum held in Kampala in 2008.

I was previously the socio-economic welfare consultant, nursing and health policy, and at the same time was the director of the International Centre for Human Resources in Nursing and the director of the Global Positive Practice Environments Campaign with the International Council of Nurses (ICN).

As part of the campaign, I delivered an all-day workshop on positive practice environments (PPE) at the second Global Forum on Human Resources for Health, which was held in Bangkok, Thailand in January 2011.

The PPE Campaign, launched in 2009, with the Global Health Workforce Alliance as the supporting partner and the core partners consisting of ICN, the International Hospital Federation, International Pharmaceutical Federation, World Confederation for Physical Therapy, FDI World Dental Federation and the World Medical Association was the central focus of the workshop. The Campaign's international collaborating partners and others contributed including CapacityPlus, Cordaid, CGFNS International, Global Healthcare Information Network, Health Care Without Harm, International Commission on Occupational Health, Public Services International, World Federation of Occupational Therapists and the World Health Organization (WHO).

The Kampala Declaration and Agenda for Global Action, agreed at the first Global Forum on Human Resources for Health in 2008, addressed six key areas including leadership, evidence, education, retention, migration and investment. The focus of the forum was on the achievement of the Millennium Development Goals 2015 and the urgency of all stakeholders to work towards human resources for health and health system strengthening, to respond appropriately, efficiently and effectively.

In 2013, I was invited by the International Labour Organization's (ILO) health services specialist Christiane Wiskow, and the WHO, to facilitate an IntraHealth session at the third Global Forum on Human Resources for Health.

The theme was 'human resources for health: foundation for universal health coverage' and the post-2015 development agenda was held in Recife, Brazil from November 10-13, 2013. This was the largest ever forum focusing on health workers and global health, with 93 member states, over 1,500 policy makers, experts and advocates in the health workforce field and frontline health workers.

It was organised by the Global Health Workforce Alliance (GHWA), under the patronage of the government of Brazil, the WHO and the Pan American Health Organization. The INMO facilitated and chaired the ILO, WHO and IntraHealth session under the theme 'empowerment and incentives: harnessing health workers' voice, rights and responsibilities in moving towards universal health care.'

The session focused on the security, safety, wellbeing and motivation of health workers with special focus on work in difficult contexts including conflict, poverty and other complex situations. It examined the necessary enabling environment, as well as measures for the protection of health

workers from violence in conflict areas and from exposure to health risks, including psychological and emotional trauma.

It included the competencies and support needed to provide quality services to cover the population in hardship situations and explored ways for empowering health workers to actively express their needs and shape their demanding daily work.

The outcome from the third forum was the Recife Political Declaration on Human Resources for Health with governments of 57 countries, including Ireland, renewing commitments towards universal health coverage. Some 27 other entities also made commitments, with 93 countries in total participating.

Measures listed in the declaration are multiple and all are of critical and equal importance. Some linked to increasing financial resources, while others focus on improving the use of existing resources through improved governance, improved management and performance, task sharing, better equality and accessibility, improved training and better distribution and retention of existing staff. It emphasises the importance of strengthening health human resources information systems, adopting innovative solutions and investing in research.

Each country was charged with taking appropriate measures according to its own situation, keeping in mind that funding is only one part of the problem. The Recife Declaration is available at **www.who.int/workforcealliance/forum/2013/3gf_finaldeclaration/en/index.html**

Global Forum in Dublin

This year's Forum is co-hosted by Trinity College Dublin, Irish Aid, the Irish Department of Health and Health Service Executive, the Global Health Workforce Network and the WHO. Nurses and midwives are invited to join the Forum in November 2017 to collectively help shape our future health workforce by the three key leaders:

- Jim Campbell, director, Health Workforce Department, Global Health Workforce Network, WHO, Co-chair Programme Committee, Fourth Global Forum on Human Resources for Health.
- Charles Normand, professor of health policy and management, Trinity College Dublin, chair of Organising Committee, Fourth Global Forum on Human Resources for Health
- David Weakliam, Global Health lead, Health Service Executive, Ireland, chair, Global Health Workforce Network.

In their welcome they state that "the global community is presented with an unprecedented challenge and an opportunity: to avert a potential 18 million health worker shortfall and shape increasing demand for additional health and social workforce jobs. In doing so, we will make progress towards universal health coverage and global health security while also contributing to gains across the 2030 Agenda for Sustainable Development, eg. quality education, gender equality, reduced inequalities, decent jobs and inclusive economic growth.

The Forum programme will feature high-impact decision-makers, leaders and investors, representing all stakeholder groups, to discuss and debate innovative approaches towards advancing the implementation of the Global Strategy and the Commission's recommendations. High-level plenaries, side sessions and skills building workshops with exhibition areas, poster presentations and much more will contribute to an exceptional opportunity for professional development and networking.

The main objectives of the forum are:

- Advance the implementation of the Global Strategy on Human Resources for Health and the Commission's recommendations towards achieving universal health coverage and the Sustainable Development Goals
- Promote innovations in policy, practice and research
- Promote the engagement of Human Resources for Health stakeholder groups in learning, knowledge sharing, networking and collaborative actions.

The main sessions are based on a call for submission process, now closed having received more than 500 submissions, and are built around four sub-themes:

- *Sub-theme one: Aligning education and utilisation of skills to optimise workforce performance*

This sub-theme focuses on optimising workforce performance to meet population health needs through scaling up high-quality education and lifelong learning, ensuring a proper skill mix of health workers and distribution (geographical, among sectors and across levels of the health system) to match population health needs and enabling them to work to their full potential. It is about planning and ensuring the right skills for the right jobs in the right places.

- *Sub-theme two: Policies and planning for labour market transformation and employment for health*

The second sub-theme focuses on evidence-informed policies and reforms to address labour market challenges, as well as actions to stimulate investments in creating employment opportunities that respond to the current and future needs of the population to achieve universal health coverage, health security and the Sustainable Development goals.

Submissions are expected to cover, but are not limited to, health labour market analysis, matching health workforce supply to population needs, health workforce planning and implementation, forecasting and modelling, workforce performance and productivity, dual practice, social and economic benefits of health employment, migration and labour mobility, demographic and epidemiological changes including the ageing workforce and innovative ways of meeting increasing demand for the health workforce.

- *Sub-theme three: Decent work, rights and responsibilities*

This sub-theme covers policies, actions and investments to ensure decent work for all jobs across the health economy. Decent work involves opportunities for work that is productive and delivers a fair income, security in the workplace and social protection for families, better prospects for personal development and social integration, freedom for people to express their concerns, organise and participate in the decisions that affect their working lives and equality of opportunity and treatment for all women and men.

Sub-theme four: Moving forward– improving governance for effective implementation of the Global Strategy on Human Resources for Health

The fourth sub-theme addresses governance actions, at global, regional, national and local levels, that are needed for the development and transformation of health systems and the workforce to progress towards universal health coverage and sustainable development goals.

Youth Forum

There are also a number of side sessions being developed in advance of the main Forum including the Youth Forum on November 14, 2017. This is being led by the International Federation of Medical Students Association. For more information and to get involved email: reddys@who.int.

Further information on Forum registration, the full programme and other details are available at **www./hrhforum2017.ie/**

Elizabeth Adams is INMO director of the Richmond Education and Event Centre

Q and A Bulletin Board

With INMO director of industrial relations Phil Ní Sheaghdha

Query from member

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

Reply

In the public service, and in most organisations funded by the health service, the policy for investigating a complaint in respect of allegations of abuse is 'Trust in Care'. Abuse is defined in this policy as "any form of behaviour that violates the dignity of patients/clients. Abuse may consist of a single act or repeated acts. It may be physical, sexual or psychological/emotional. It may constitute neglect and poor professional practice."

On receiving a complaint, an employer is obliged under this policy to conduct a preliminary screening. The preliminary screening must be carried out to establish the facts pertaining to the complaint. This would include establishing whom the complaint is against. There have been many cases where we have successfully established that the complaint is not against the person management determined it to be, for example:

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

In the first instance, we would need to establish the facts on which management is confirming the complaint is against you and you are entitled to be represented at this forum. I would advise you to seek advice and assistance and representation from an INMO official in respect of this. The INMO will then make contact with your employer on your behalf, as a matter of urgency, to ensure these facts are established correctly.

I hope this answers your query but please do not hesitate to contact us in the event that you require our assistance.

Query from member

I work in a very busy surgical ward. Regularly, I do not receive a break during my shift. My line manager says I can get the time back at another time, but that is not possible as we are always short staffed. What is the INMO's position on this?

Reply

As you may have seen, we are currently undertaking a joint examination with the HSE of the frequency of unpaid breaks not being taken due to staffing shortages. Seven pilot sites for this project were selected; these include the acute sector (including maternity services), and the primary and social care sector (PHN/CRGN/RNID).

Beaumont Hospital, Galway University Hospital, St John of God's Drumcar, Rotunda Maternity Hospital, OLOL Drogheda, St Claire's Ballymun and Community Nursing/Community Nursing in Galway, and CHO 03 were selected to participate in the pilot programme.

This pilot project commenced at the end of May 2017 and to further aid this process, local measurement groups were set up. Nursing/midwifery representatives from the selected wards along with relevant trade union officials are nominated on these groups. The aim of these groups is to manage, promote and oversee progress/identify areas of concern with the pilot project and compile a report that will then be forwarded to the relevant parties in the HSE.

An FAQ, which is available on our website **www.inmo.ie**, has been developed to provide guidance to the local measurement team and assist in the process. Weekly reports/templates are being forwarded by the local management group to HSE management. The INMO and other nursing unions will meet with management to discuss and evaluate progress/areas of concern at a national level.

At the end of the pilot project, all feedback from the local measurement groups, HSE management, the INMO and other nursing unions will feed into a national implementation plan for the measurement of all hours worked.

In your case specifically, you should request, each time this happens, that you are paid for the period, and if you have worked in excess of your contracted hours, then overtime should be paid as per the qualifying overtime conditions. Contact the INMO IRO with responsibility for your work location if you have difficulty in relation to implementing your rights.

New reps for the west

INMO organiser **Albert Murphy** highlights some recent activities of interest to members

A BASIC rep training course was held recently in Sligo and was attended by nurses from various locations in the west of Ireland. Maura Hickey, IRO for the area, and I, also attended the training course. The INMO would like to thank IMPACT, Sligo for the use of its facilities.

The advanced rep training course was held in the INMO's Cork Office on June 27 and 28, 2017. This course was designed for reps who have attended the basic course and includes sessions on organising meetings, the uses of social media and mainstream media to get your point across on behalf of your members.

It also included a session on advanced negotiating skills and one on trade union democracy. If you are interested in attending this course in the future, please contact Martina Dunne at email: martina.dunne@inmo.ie or Tel: 01 6640626.

Pictured (l-r) at the basic rep training course in Sligo were: *Eithne Gucklan, St Patrick's Hospital, HSE NW; Mary Rynn, St Patrick's Hospital, HSE NW; Cathy O'Reilly, UCHG; Maura Hickey, IRO; Mary Filan, St Patrick's Hospital, HSE NW; Emma Kiernan Haupt, St Patrick's Hospital, HSE NW; and Kathleen Douglas, Letterkenny University Hospital*

Visit from QNMU

The INMO welcomed Terri Buckley, call centre supervisor for the Queensland Nurses and Midwives Union, to INMO HQ in May. The Queensland Nurses and Midwives Union have changed their name recently and are now known as the QNMU. There was an exchange of information on union structures and recruitment strategies at the meeting, which I attended along with Clare Treacy, IRO.

The QNMU is open to mainly staff nurses, healthcare assistants and enrolled nurses and this has resulted in a significant increase in members for the QNMU.

The QNMU has successfully campaigned on the introduction of patient/nurse ratios and the INMO received a briefing on these discussions and collective bargaining activities involved.

Groupscheme competition

The INMO and the INMO Groupscheme have agreed to a summer competition for new and existing members who joined the INMO Groupscheme.

The competition will run until August and all new INMO members who registered for the Groupscheme and those existing members that visited the website will be entered into a draw to take place in August.

There are five prizes of €100 vouchers up for grabs. The INMO Groupscheme has recently announced that it has a special offer for INMO members to avail of up to 40% discount on cinema tickets for the Cineworld group and the Odeon group. For further details of this offer please visit the INMO Groupscheme site at **www.inmo.ie/inmogroupscheme**

Albert Murphy is INMO industrial relations officer/organiser; Email: albert.murphy@inmo.ie

INMO top job for Kerry woman

The appointment of Phil Ní Sheaghdha as gen sec designate and the ongoing overcrowding crisis gave the INMO its fair share of media coverage in June. **Ann Keating** reports

KERRY'S Eye (June 15) gave space to the appointment of Phil Ní Sheaghdha as general secretary designate – **Kerry woman's top INMO job**. West Kerry woman Phil Ní Sheaghdha has been appointed as the general secretary designate with the Irish Nurses and Midwives Organisation. "Phil was serving as INMO director of industrial relations but was this week announced as the new general secretary designate and she will take up the new position from July 1 – replacing Liam Doran. Phil says she plans to continue to develop the good work done by Liam Doran…While I do not underestimate the challenges involved, I would like to assure INMO members that, as general secretary, my agenda will be very forthright in progressing and improving the conditions of employment, for nursing and midwifery, and developing the role that they play in healthcare management and delivery."

Assaults at work

The *Kildare Nationalist* (June 20) reported on assaults at work – **'Horrifying' level of assaults on staff at Naas Hospital**. "Over 260 assaults were carried out on staff at Naas General Hospital over the past three and a half years – including physical, violent and verbal attacks. A 'shocking' 77 of these incidents were on accident and emergency workers alone but it is the nurses of the A&E department who bear the brunt of most of the physical and verbal attacks." IRO, Joe Hoolan said "the figures for Naas General Hospital are 'not surprising'. Nobody should be surprised. We have consistently highlighted at a national level the dangers nurses and midwives face – not just in A&E. It's a very difficult profession and people have huge expectations on a workforce with limited resources…We would have members in Naas out of work because of assaults in the workplace. You have to have safe staffing levels. The first person to get the brunt of the public's frustration with the health service is the nurse."

May trolley statistics

The Daily Mirror (Irish) June 19 ran a headline – **It's mayhem with 8,154 patients on trolleys – Figures soar last month as nurses' union hits out at staff shortages**. "The figures provided by the Irish Nurses and Midwives Organisation, show last month was the worst May ever with 8,154 patients being treated on trolleys in our hospitals." Liam Doran, general secretary, said "the figures were disappointing, especially at this time of year when the numbers of people on trolleys usually decrease. This record level of overcrowding showing a 23% increase when compared to 2016, is very disappointing coming at this time of year and after a marginal improvement in April. The figures confirm yet again, that our health service remains far too small to cater for demand, with this difficulty exacerbated by bed closures due to nursing staff shortages. The figures reaffirm the extent of the crisis, arising from the recruitment/retention difficulties in nursing, which must be addressed, through pay related initiatives, as an absolute priority. Until the shortage of nurses is addressed, both beds and services will remain curtailed and trolley numbers will continue to grow."

Letterkenny University Hospital

LUH in crisis due to increased bed demand was a headline in the *Letterkenny Post* (June 8). "Last Wednesday the beleaguered hospital was the most overcrowded in the State, with 46 people waiting for a bed…The hospital's Full Capacity Protocol has been partially invoked almost continually over the past six weeks in order to deal with increasing bed demand." IRO Maura Hickey said: "The problem will not be solved by placing extra beds on inpatient wards. This is a tried, flawed and failed practice of the past which should never be revisited."

University Hospital Limerick

The Limerick Post (June 3) ran a story on the news **ED at Limerick University Hospital – UHL emergency department opens after last minute deal**. "A last minute deal with nursing union representatives cleared the way for the opening of the new €24m emergency department at University Hospital Limerick after concerns were raised about inadequate staffing levels and patients being left on trolleys at the new facility…Nurses said they had raised a number of serious patient concerns that, up to Friday's meeting were denied by senior management. They were particularly worried about management proposals to place a minimum of 24 patients on trolleys and recliner chairs in the new unit which they described as a move to embed, forever, the unacceptable concept of patients on trolleys. The INMO proposed that the old emergency department should be utilised as a separate area for admitted patients but this was rejected by management. The number of newly qualified staff rostered to work in the new unit was also raised at Friday's meeting with the situation further compounded by the loss of nine highly skilled emergency department nurses. However, Ms Fogarty confirmed that these issues were finally accepted by management who agreed on a range of actions to ensure safer care including the immediate appointment of a clinical skills facilitator to ensure adequate support for newly qualified nurses."

Ann Keating is INMO media relations officer
Email: ann.keating@inmo.ie

Global stage for INMO student and graduate voices

INMO student and new graduate officer, **Liam Conway**, discusses the INMO's involvement in the inaugural meeting of the Global Association of Student and Novice Nurses

SOME 50 delegates across nine member nations gathered for the Global Association of Student and Novice Nurses (GASNN) inaugural meeting, which was held recently in Barcelona, Spain.

The INMO was accepted as a founding nation member of the GASNN with full voting rights, qualifying on the grounds of the well-established student and youth structure, where the students and graduates can have autonomy in terms of decision making and campaigns within the organisation. The INMO is also the only trade union that is a nation member.

The GASNN is continuing to network and develop new contacts and connections with the aim of student and novice nurses having their voices heard and being at the table when these events and organisations are making decisions on the future of healthcare.

I was the INMO representative attending the inaugural conference on behalf of the Executive Council and student and new graduate members and was elected vice president of the GASNN by nation members. I was delighted to be appointed to this position on behalf of the organisation to represent our members' interests both at home and on the global stage. Our mission is to be the unified voice for student and novice nurses globally through partnerships and collaboration.

Topics discussed during the inaugural meeting included work-life balance, evidence-based safe staffing, workplace relations/leadership capacity, team work, transition from students to new graduates, continuing practice development, global health issues, OneHealth, mentorship, where GASNN is headed and post traumatic stress disorder.

Pictured (l-r) at the GASNN Congress in May were: *Ahmed Gamal Sallam, co-founder of the Egyptian Novice Nurses and Students Scientific Association; and Liam Conway, INMO student and new graduate officer*

For more information on the organisation, visit **www.gasnnurses.com**

ICN student assembly

The ICN student assembly took place on May 27,2017 as part of the ICN congress, with some 36 countries represented. Topics discussed included:

- Skills gap: The point was made that HR management is too far removed from nursing and HR management should have a nursing or midwifery background
- Workforce: The skills gap is broadening due the need and demand for more nurses but falling numbers globally. The world's population is increasing and people are living longer
- The concept of the 'workforce': nurses and midwives continued to be viewed as workers or workforce and not science degree students/professionals.
- Inadequate use of ICT in everyday practice: Some countries around the globe have fantastic ICT systems where note-keeping and records are done through ICT. In contrast, in most third world countries and many first world countries, including Ireland, documentation and filing are done manually.

The role of nurses in the context of leadership was discussed and how a leadership mindset can define the future of the nursing profession.

A Thai representative spoke on the dynamics and importance of leadership in their country while many speakers from Latin America spoke on the omission of holistic approaches to care from their nursing practice. Students agreed that person-centred care and holistic approaches to care can be lost due to the serious demand and caseloads placed on nurses and midwives.

The need for students and graduates from across the globe to share their knowledge and experience in order to enhance professional practice and knowledge was also discussed by Ahmed Sallam of ENNSSA.

Student and new graduate reps

We are always looking for new student and graduate reps, if you are interested in getting involved or want to find out more information please contact me (details below).

For the latest updates, visit the student and graduate section at **www.inmo.ie**

I would like to wish you all a very enjoyable and safe summer.

Liam Conway is INMO student and new graduate officer
Email: liam.conway@inmo.ie; Tel: 01 6640628

Appendicitis overview

In the latest clinical update in our continuing professional development series, **Ikwuoma Udeaja, Nina Thirlway** and **Gerry Morrow** discuss appendicitis

APPENDICITIS is an acute inflammation of the appendix. The appendix is a small, narrow tube of about 5cm to 10cm, which is connected to the caecum, part of the large intestine, just before the colon.[1] It is not believed to have a specific function in the body.

Appendicitis is thought to be caused by infection secondary to an obstruction inside of the appendix. The main causes of obstruction are hard masses of faecal matter, normal stools and lymphoid hyperplasia, secondary to viral infection. Other causes include fragments of indigestible food, mucus, parasites and/or tumours. Obstruction results in increased pressure, bacterial overgrowth (most commonly *Bacteroides fragilis* and *Escherichia coli*), ischaemia, and necrosis of the appendix, leading to perforation in some people.[1,2]

Risk factors for appendicitis include age, male gender, frequent antibiotic use and smoking. Appendicitis is most common between the ages of 10 and 20 years, but can occur at any age, although it is rare before the age of two years. It is slightly more common in men than women, with a male to female ratio of 1.4 to 1.[2,3,4]

Use of antibiotics

A balance of microbial gut flora is important for prevention of infection and digestion. Frequent use of antibiotics leads to imbalance of gut flora that may eventually cause a modified response to viral infection, thereby triggering appendicitis.[2,3,4]

Smoking

There is an increased incidence of acute appendicitis in smokers compared with non-smokers, and children exposed to passive smoking have a significantly increased incidence of acute appendicitis.[4,5,6]

Appendicitis is one of the most common causes of an acute abdomen in adults and children and is the most common non-obstetric surgical emergency in pregnancy, with an incidence of 0.15-2.10 per 1,000 pregnancies.[5]

Complications and prognosis

The most common complication of appendicitis is perforation. This is likely to occur after more than 12 hours of progressive inflammation. The average rate of perforation at presentation is 16-30%; however, this rate is significantly increased in elderly people and young children (up to 97%) and in pregnant women (up to 43%), usually because of a delay in diagnosis. Perforation can lead to abscess, life-threatening infection, sepsis and death. Complications in pregnancy include premature labour or miscarriage and, if there is a delay in diagnosis and treatment, death of both mother and child.[4,6]

Appendicitis may resolve spontaneously, but complications are more likely if the appendix is not removed. Appendicectomy, surgical removal of an appendix, is a relatively safe operation. Morbidity and mortality are related to the stage of the disease, and increase after perforation of the appendix. The mortality rate for non-perforated appendicitis is 0.8 per 1,000 people compared with 5.1 per 1,000 people after perforation. Provided there are no complications, recovery from an appendicectomy is usually straightforward. Physical activity may need to be limited for a short period after surgery, three to 14 days depending on the type of procedure used, to aid recovery. [4,6]

Diagnosis

The diagnosis of appendicitis relies on a thorough history and examination. The classic symptoms of appendicitis are abdominal pain (which is the most common presenting complaint in people with acute appendicitis), loss of appetite, nausea, constipation and vomiting. Typically, the person will describe a stomach pain that worsens during the first 24 hours – becoming constant and sharp – and migrates towards the right lower abdomen and pelvic area. The pain is worsened by movement, such as coughing and driving over speed bumps. In children, if asked to 'hop' the child will often refuse as this causes pain.[4,5,6]

On physical examination, the classic signs of appendicitis are tenderness on percussion, guarding and rebound tenderness. The person may have facial flushing, a dry tongue, halitosis, low-grade fever, not more than 38°C, and/or tachycardia. Be aware that the classic features of appendicitis may not always be present, appearing in only about 50% of people. The symptoms of appendicitis vary and can mimic other conditions that cause abdominal pain.[4,5,6]

Presentation can be influenced by the person's age. In older people, even with advanced inflammation, pain may be minimal and fever absent. The person may also present with confusion and shock. In infants and young children symptoms may include only vague abdominal pain and anorexia, and they may seem withdrawn.

In pregnancy, pain can be in an atypical area due to displacement of the appendix. Right lower quadrant pain and tenderness dominate in the first trimester. In the latter part of pregnancy, right upper quadrant or right flank pain may occur.[6]

Scoring systems have been developed

to aid the diagnosis of appendicitis by estimating the probability of the disease in a person compared with a large number of similar people, using history and examination findings along with inflammatory markers to produce a numerical score. Although there is some evidence that these scoring systems are useful tools in the diagnosis of appendicitis, they are not widely used by clinicians.[6]

Signs of complications include tachycardia and sudden relief of pain, which may be signs of a perforated appendix. An abdominal mass and fluctuating temperature may be signs of an appendix abscess. Profuse vomiting, high fever (more than 40°C), severe abdominal tenderness, and absent bowel sounds may be signs of peritonitis.[4,6]

Conditions that may be confused with appendicitis include gastroenteritis, diverticulitis, pyelonephritis, urinary tract infection, ovarian cyst and pelvic inflammatory disease.[1,6]

Investigations

There is no single investigation that can completely rule out appendicitis; however, some tests may be useful to support the diagnosis and/or rule out differential diagnoses.

Simple blood and urine tests may be useful to exclude alternative diagnoses and/or support the diagnosis of appendicitis. A pregnancy test should be taken to exclude pregnancy, including ectopic pregnancy, in women of childbearing potential.

Urine dipstick test can help exclude a urinary tract infection. Be aware that this may be abnormal in about 50% of people with acute appendicitis because of inflammation adjacent to the right-sided urinary tract and bladder.

Blood tests including full blood count and C-reactive protein (CRP) can help to rule out infection.[1,4,6]

Management

Appendicitis is a medical emergency that requires immediate hospital assessment and management. Prompt diagnosis and treatment are essential for reducing the risk of complications, which increases with duration of symptoms. Delayed diagnosis and treatment account for much of the mortality and morbidity associated with appendicitis.[1,3,4,6]

Immediate hospital admission should be arranged if appendicitis is suspected. There should be a very low threshold for admitting infants and young children, elderly people, pregnant women and people with signs of complications. People at the extremes of ages have increased mortality from appendicitis because of delayed presentation or diagnosis and/or subtle/atypical clinical features.[1,3,4,6]

Appendicectomy (surgical removal of the appendix) is the treatment of choice in secondary care for people with appendicitis. This may be done by an open incision in the lower right part of the abdomen (open appendicectomy or laparotomy) or through small incisions in the abdomen with the help of a camera (key hole surgery or laparoscopy). Provided there are no complications, recovery from an appendicectomy is usually straightforward.[1,3,4,6]

Ikwuoma Udeaja is clinical author at Clarity Informatics, Nina Thirlway is style editor at Clarity Informatics and Dr Gerry Morrow is editor and medical director at Clarity Informatics. Clarity Informatics is contracted by the National Institute for Health and Care Excellence (NICE) to provide clinical content for the Clinical Knowledge Summaries service available through the Clarity Informatics Prodigy website at: **http://prodigy.clarity.co.uk**

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CPD Quiz

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

1. Appendicitis is thought to be caused by:

A) Obstruction
B) Infection secondary to obstruction
C) Injury
D) Virus

2. Risk factors for appendicitis include:

A) Male sex
B) Female sex
C) Smoking
D) Obesity

3. Complications of appendicitis include:

A) Perforation
B) Sepsis
C) Death
D) Abscess

4. Classic symptoms of appendicitis include:

A) Increased appetite
B) Nausea
C) Pain
D) Constipation

5. Symptoms of appendicitis may mimic:

A) Pelvic inflammatory disease
B) Urinary tract infection
C) Gastroenteritis
D) Ovarian cyst

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

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

Answers: Question 1 = B; Question 2 = A, C; Question 3 = A, B, C, D; Question 4 = B, C, D; Question 5 = A, B, C, D

Preparing for a coroner's inquest

Edward Mathews outlines the coroner's inquest process and what nurses and midwives need to know, should they find themselves called to give evidence at an inquest

CORONER'S inquests are relatively common occurrences, however, they are also events which tend to instil a degree of anxiety among those who must attend. Clearly the inquest may be a traumatic experience for family members and loved ones, and so too it can be a difficult experience for nursing, midwifery or medical staff who are compelled to attend to give evidence.

While most inquests are uncontentious, in that they simply, and in a non-adversarial manner, seek out information relating to the death, this unfortunately is not always the case and a minority of cases can be adversarial with robust questioning of professionals.

The more difficult cases tend to emerge where there are conflicts of evidence between professionals as to what occurred, or where family members feel there have been deficits in care in the time leading up to death. Understanding the roles of those involved, how the process works, what you should do to prepare and what help you should expect from your employer are important parts of a nurse or midwife's knowledge base.

Role of the coroner

The coroner is a state official who must be either legally qualified or medically qualified, or both. The coroner makes legal determinations in relation to the cause of death. The central role of the coroner is the investigation and certification of death in circumstances where there is some question or lack of clarity concerning that death, in essence where there are sudden or unexplained deaths.

In many cases, the coroner needs to do little more than satisfy themselves that no further inquiry is necessary, however, where necessary they have powers to facilitate a broader investigation or inquest.

The investigation will generally take the form of a post mortem, whereas the inquest is a formal exercise where the coroner, with or without a jury, hears sworn evidence to establish the cause of death without apportioning blame. The object of an inquest, associated as it is with the role of the coroner, is to establish answers to four basic questions:

- Who is the deceased?
- How did the deceased die?
- When did the deceased die?
- Where did the death occur?

The process establishes the facts surrounding the death, places these on the public record and answers the relevant questions. While the coroner may make recommendations to prevent the re-occurrence of such deaths, neither the coroner nor inquest process may establish or apportion any blame for the death that occurred.

Reporting a death to the coroner

There are wide range of cases in which a report must be made to a coroner and these are determined in law and by local practice.

Any sudden or unexplained death and in cases of suspected natural causes, where the person has not been seen by a medical practitioner for a month prior to death, must be referred to the coroner.

When deaths are directly or indirectly the result of any surgical or medical treatment or procedure, they must be reported to the coroner. Further to this, any death suspected as arising from negligent or violent processes must be reported.

Coroner's response

As previously mentioned, the coroner need not investigate or hold an inquest in every case, and if they are satisfied following informal inquiries that nothing untoward has occurred, they may direct the issuing of death notification certificate. However, they may conduct further investigations in the form of a post mortem examination and if satisfied that the cause of death was natural causes, they may then issue a coroner's certificate. However, in other circumstances the coroner may decide to hold an inquest.

In most instances, the coroner has a discretion as to whether to convene an inquest, however, one must be convened where death is suspected to have occurred in violent or unnatural circumstances or suddenly and is of unknown cause. An inquest may sit with or without a jury, but a jury must be involved, where:

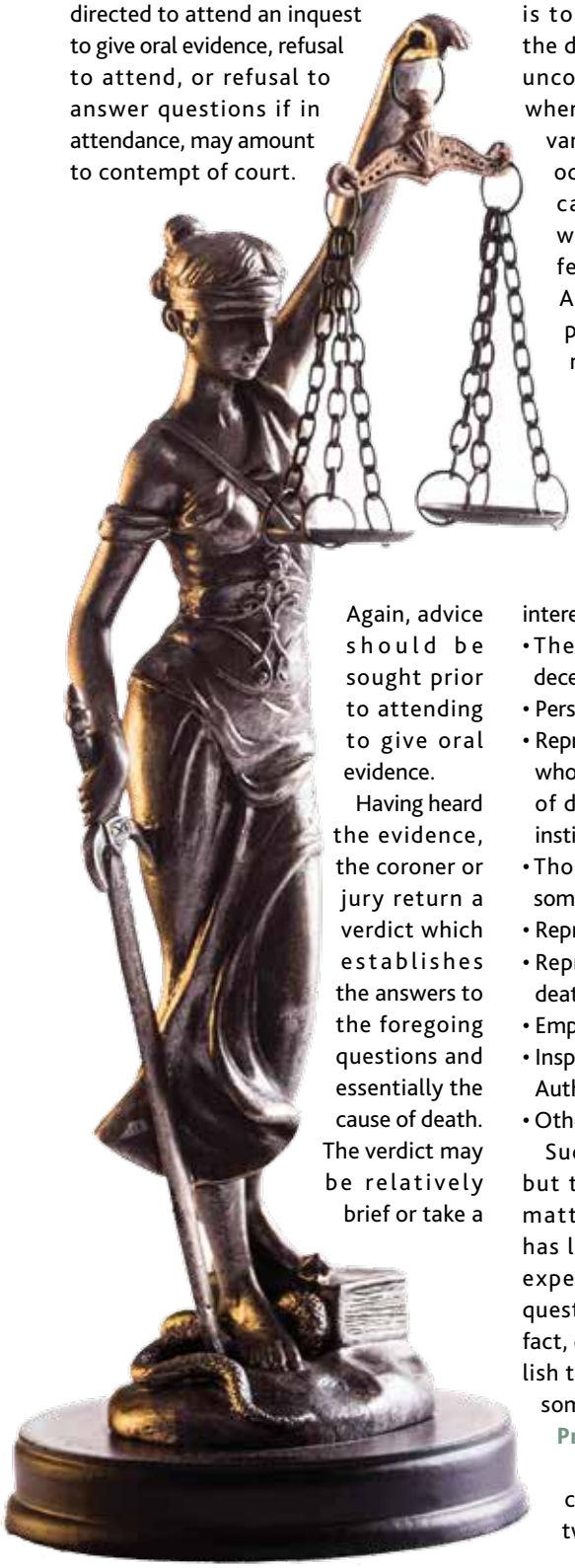
- Death may be due to homicide (or a suspicious death)
- Death occurred in prison
- Death was caused by accident, poisoning or disease requiring notification to be given to a government department or inspector
- Death resulted from a road traffic accident
- Death occurred in circumstances which may be prejudicial to the health or safety of the public
- The coroner considers it desirable to hold an inquest with a jury.

The inquest process

The inquest seeks to establish the facts surrounding the death and to answer the four questions outlined above. In theory, the inquest is an inquisitorial process, in that it is not one side versus the other but rather is an inquiry into the circumstances surrounding the death without the attribution of blame.

The inquest involves the coroner hearing evidence from witnesses and these may include those involved in the care of a person prior to and at the time of their death. The coroner is the person who determines from whom evidence may be taken.

Evidence may be given in writing or orally, or both. Written evidence normally takes the form of a deposition and advice should be sought prior to making such a submission to an inquest. If directed to attend an inquest to give oral evidence, refusal to attend, or refusal to answer questions if in attendance, may amount to contempt of court.



Again, advice should be sought prior to attending to give oral evidence.

Having heard the evidence, the coroner or jury return a verdict which establishes the answers to the foregoing questions and essentially the cause of death. The verdict may be relatively brief or take a more extensive narrative form. Common verdicts associated with cases where nurses and midwives may be called to give evidence include accidental death, death by misadventure, medical misadventure, suicide/self-inflicted death, want of attention at birth, stillbirth, death by natural causes an open verdict.

While recommendations may also be made, no blame may be attributed.

Giving evidence

The primary purpose of the inquest is to establish the circumstances of the death, and as such, it should be an uncontentious exercise for a witness whereby they give an account of relevant matters, and indeed this is what occurs in most cases. However, some cases may be more contentious where different witnesses have differing accounts of what occurred. Additionally, the facility for certain persons to ask questions can give rise to a degree of contention.

Questions may be asked of witnesses by the coroner. Also, any person who has a proper interest in the inquest (a properly interested person) may personally examine a witness or be legally represented by a solicitor or barrister. Properly interested persons include:

- The family and next-of-kin of the deceased
- Personal representatives of the deceased
- Representatives of a board or authority in whose care the deceased was at the time of death, eg. hospital, prison or other institution
- Those who may have caused death in some way, eg. driver of a motor vehicle
- Representatives of insurance companies;
- Representatives of trade unions (where death resulted from an incident at work)
- Employer of the deceased
- Inspector of the Health and Safety Authority
- Others at the discretion of the coroner.

Such persons may not call evidence but they may question witnesses on matters relevant to the death. This has led to some nurses and midwives experiencing sustained and difficult questioning where there is a conflict of fact, or where a family is trying to establish that the death was associated with some want of care.

Preparation

Preparation for an inquest is crucial and is essentially divided into two categories, personal preparation and appropriate engagement with your representative.

Personal preparation

- Read all the notes carefully
- Ensure you have a chronological account of what occurred, when it occurred, why it occurred, who was there, and what happened afterwards
- Remember look at the person asking questions, then direct your answer to the coroner
- Do not engage in any argument with the person asking questions, ask for a break if necessary and try to remain calm
- Tell the truth and remain focused on what occurred.

Preparing with your representative

Your employer is obliged to provide you with a competent and impartial legal representative at the inquest. You must have time to consult with your representative before the inquest and you must seek their advice before making any written submission. The following should be discussed during representative preparation:

- Ask your representative if there is any conflict between you and anyone else they are representing (your colleagues or the employer), if there is, seek another representative from your employer
- Ask your representative for advice on the type of questions you will face, and how to best deal with the process
- Ask your representative are they sure they can legally represent your best interests at the inquest.

If you encounter any difficulties with accessing a representative from your employer, or with the conduct of the representative, it is advisable to contact the INMO immediately, who will in turn seek an alternative representative from your employer.

Further information

The majority of inquests are uncontentious and do not give rise to any concerns. However, understanding the process, preparing well and knowing what to expect from your representative are your best protections, and if you have any concerns contact your INMO official.

The INMO recently launched a new information leaflet to advise members in relation to coroner's inquests and this can be accessed via the INMO website. Alternatively, hard copies are available from INMO offices.

Edward Mathews is INMO director of regulation and social policy

Quality & Safety

A column by Maureen Flynn

What matters to you?

I HAD the privilege of hearing Henry Mintzberg speak recently, he observed that the "field of healthcare may be appropriately supplied by businesses, but in the delivery of its most basic services, it is not a business at all, nor should it be run like one. At its best, it is a calling".[1] He spoke about reorganising our heads rather than our institutions to think differently and see the person beneath the 'patient'. This reminded me of a previous column, in December 2014, which shared experience from Magee Women's Hospital in the US introducing the 'all about me' programme. It's great to see we that have our own example of such initiatives being adopted and tested in the Irish healthcare context. This months column focuses on 'What Matters to You?' (WMTY).

What Matters to You?

WMTY? is an approach to care that promotes compassionate relationship-centred care. It involves introducing a change in practice, whereby, staff purposefully ask about what is important to the patient, rather than simply concentrating on their diagnosis and past medical history. The literature suggests that to provide compassionate care we need to know the details of care that matter to the person.[2,3] Information captured through WMTY? provides staff with a unique knowledge of the person, which then informs the plan of care for that person. It is recorded on a WMTY board, which is kept at the bedside, or as determined by the patient, for ease of access by all healthcare professionals.

Benefits

Throughout an acute hospital stay, focus of healthcare can revolve around the physical status of the person.[4] We work in a system where patient flow and lengths of stay are indicators of effective organisations. The emphasis appears to centre on 'What's the matter with you'. This fast paced environment can be dehumanising. While the presenting health issue is a concern to the person, their experience of

hospital care is measured by them on the level of dignity, compassion and respect with which they are treated.[5] The HSE National Service Plan[6] explicitly emphasises that people's experience of the health service must be safe, of high quality, but also caring and compassionate. Compassionate care involves knowing the patient as a person and developing a relationship of equals where the carer conveys an understanding of the patient's suffering in a way that alleviates some of that suffering.[7]

Irish approach

The National Clinical Programme for Older People, in collaboration with the Quality Improvement Division and the Irish Hospice Foundation (IHF), worked with St Vincent's University Hospital and Midland Regional Hospital Portlaoise to pilot the introduction of WMTY? in one ward in each hospital. The IHF 'What Matters to Me' education programme was adapted for use in the acute hospital to support this initiative. A suite of documents which include a WMTY logo, WMTY board, frequently asked questions, patient information leaflet and WMTY patient stories, were developed to provide guidance and information. The intended impact is to:

- Counter-balance a possible sense of invisibility felt by older people admitted to the two pilot wards
- Positively influence the experience of patients as they share the issues that are important to them
- Enhance potential to deliver compassionate care, which, in turn, enhances positive outcomes for patients.

Interviews with patients suggest that WMTY is positive, especially for older people with cognitive and communication issues. The learning diaries maintained on the ward captured a number of situations where WMTY was key to the provision of better outcomes for patients. Staff reported that the information captured was helpful as it enabled conversation, building rapport and establishing relationships.

Learning to date

- Education is key to the implementation of WMTY including the concept of person-centred, compassionate care at its core and a multidisciplinary team approach
- Person-centred compassionate care is not the role of one profession. All staff are encouraged to contribute to the WMTY conversations
- Focus on the WMTY conversations first and the number of boards completed can be used as an outcome measure
- WMTY works best where the lead is based within the ward involved and provided with support to ensure the continued successful implementation.

Get involved

If you would like to participate in What Matters to You and would like further information please do not hesitate to contact Deirdre Lang, director of nursing, National Clinical Programme for Older People at email: deirdrelang@rcsi.ie

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

References on request by email to nursing@medmedia.ie (Quote Flynn, M.WIN 2017; 25 (6) 50)

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To D or not to D?

Addressing the issue of Ireland's suboptimal vitamin D status in a clinical and public health context could yield a significant health dividend for the population, writes **Daniel McCartney**

VITAMIN D is a fat soluble vitamin which can be derived from food sources and sunlight. While it is most widely recognised for its role in skeletal health, epidemiological, laboratory and clinical data have emerged in recent years implicating low vitamin D status in other serious disorders such as auto-immunity, metabolic disease, type 1 and type 2 diabetes, cardiovascular disease and its antecedents, cancer and neurocognitive impairment.

Recent intake and status studies have suggested that suboptimal vitamin D status is common in Ireland and other northerly countries, raising concerns that this deficit is a contributor to Ireland's heavy chronic disease burden. If this is the case, it is important that this issue be addressed by the development and implementation of effective public health policy and clinical guidelines in this area.

Sources of vitamin D

Physiologically, vitamin D exists in several different forms, the most potent of which is vitamin D3. It occurs naturally in a small number of foods such as eggs, oily fish and liver, and is also found in fortified foods like breakfast cereals and milks.

The other primary source of vitamin D is sunlight, specifically UVB irradiation at a wavelength of 290-315nm.[1] Although it's intuitive to assume that oral intake is the main source of vitamin D, this is not really the case. While it is true that many people are now heavily reliant on the vitamin D that they consume in food and supplements, this is actually a relatively recent departure from our evolutionary past.

Sunlight and vitamin D

Historically, most people at northerly latitudes received the majority of their vitamin D from sunlight exposure during the summer months, accumulated this vitamin D in their liver and fat tissue, and then deployed this 'biological store' of the vitamin to meet their physiological requirements over the darker winter months. In this scenario, dietary intake really only provided small top-up doses of vitamin D to keep levels from dropping into functionally deficient ranges before they could be replenished the following spring.

To put the relative contributions of diet and sunlight into context, average oral intakes of vitamin D in Ireland are currently estimated at 4.2µg/d, with 72% of men and 78% of women aged 18 to 64 years reporting average daily intakes less than 5µg/d.[2] In contrast to this low provision from diet, exposure of the skin to sunlight in summertime has been estimated to generate 70-125µg/d of vitamin D endogenously.[3]

Unfortunately, recent years have witnessed a sharp decline in summer sunlight exposure and an increased use of high factor sun protection due to legitimate concerns about the increased risk of skin cancer with extended UV irradiation. This has created a situation where our main source of vitamin D has been critically diminished, precipitating a much greater reliance on oral vitamin D intake than at any time in our ancestral past. And because dietary intakes, even among people consuming fortified foods, tend to be very low,[4] the prospect of widespread vitamin D deficiency has risen substantially in recent decades.

Deficiency

The biological thresholds that define vitamin D deficiency, insufficiency and adequacy remain contentious. While some agencies have suggested that serum 25(OH)D levels of ≥ 50nmol/l define adequacy,[5] diversity of opinion persists in this area.[6] For example, others have contended that the range 50-80nmol/l should be termed 'insufficiency', and that true adequacy is only achieved at serum levels which exceed 80nmol/l or beyond.[7]

It is noteworthy in this context, that humans are the only primate whose serum 25(OH)D typically falls below 100nmol/l, with lowland gorillas, chimpanzees and other non-human primates typically having serum 25(OH)D levels of 110-130nmol/l.[8]

While parathyroid hormone (PTH) release (and hence osteoclastic bone demineralisation) is essentially minimised at serum 25(OH)D levels of 80nmol/l,[9] it has been suggested that levels above this 80nmol/l threshold are required to provide the extra vitamin D required for optimal control of cell division, cell differentiation and other important metabolic and biochemical pathways pertinent to various chronic diseases.[10,11]

Intakes

It has been recognised for some time that vitamin D intakes in Ireland are low.[12] In 2001, analysis of the NSIFCS dataset again highlighted low levels of intake across the Irish adult population.[13]

Subsequent analysis of data from the National Adult Nutrition Survey[4] revealed that while intakes had risen in the intervening years, consumption of vitamin D remained low in all population groups.

An important issue when assessing the adequacy of vitamin D intake is selecting an appropriate threshold to define the desired level of intake. Again, this is complicated by the derivation of vitamin D from sunlight, where the physiological requirement from dietary intake is essentially dependent on the adequacy or deficiency of endogenous cutaneous synthesis. This uncertainty is reflected in the recommended dietary allowance for vitamin D in Ireland, which stands at 0-10µg/d for those aged 18 to 64 years, and 10µg/d for those aged 65 years and over.[14]

While the Food Safety Authority of Ireland has since published guidance that those aged five to 50 years should take a 5µg/d vitamin D supplement, and that those aged over 50 years should take a 10µg/d supplement,[15] this provision has received little attention in terms of public health promotion and has not been universally adopted or actively endorsed in clinical practice.

Vitamin D toxicity

Part of the conservatism which surrounds the recommendation of vitamin D supplementation arises from the documented cases of vitamin D toxicity described in the literature.[16] It is important to note however, that these cases have almost exclusively arisen from very high oral intakes, usually precipitated by industrial accidents where the vitamin was added to foods at levels at least an order of magnitude higher than that intended.[17,18]

The reality is that vitamin D toxicity is very difficult to induce by high dietary intakes, or indeed by supplementation with the preparations currently available on the Irish market. In fact, while toxicity has been observed at serum levels as low as 355nmol/l,[19] such intoxication more typically occurs only at levels exceeding 600nmol/l.[20] This is much higher than the serum levels achieved through the use of even 'high-dose' supplements currently available in this country.

Further to this issue of toxicity, numerous studies have now yielded data demonstrating the safety of vitamin D supplementation at daily doses at or exceeding 100µg/d.[11,16,21,22] The safety of supplementation is further supported by the fact that blood levels of vitamin D typically rise in a proportionate 1:1 ratio with increases in oral consumption, with each 1µg/d increment in intake generally yielding a 1nmol/l increase in serum 25(OH)D levels.[7]

This suggests that toxicity will not arise from supplementation at 5-50µg/d; a point supported by the fact that vitamin D intoxication from sunlight exposure (which produces significantly more vitamin D than these supplemental doses), has not been described in the literature.[23]

Vitamin D status in Ireland

Analyses of Irish data several years ago indicated that vitamin D insufficiency was widespread in the Irish adult population, especially among older adults and women.[24,25] Subsequent analysis of data from the National Adult Nutrition Survey has shown that low serum vitamin D levels are endemic in the Irish population, with 40% of adults falling below 50nmol/l, and 76% recording 25(OH)D levels less than 75nmol/l.[26] Modelling studies in this area have estimated that the oral dose of vitamin D required to maintain year-round serum 25(OH)D concentrations of > 37.5, > 50 and > 80nmol/l in 97.5% of the Irish adult population are 19.9, 28.0 and 41.1µg/d, respectively.[25]

While early studies clearly implicated vitamin D deficiency in the pathogenesis of osteoporosis,[28] more recent work in this area has highlighted the possible role of low vitamin D status in multiple serious disorders[29] including autoimmune disease,[30] diabetes,[31] cardiovascular disease,[32] cancer[33] and neurocognitive disorders.[34] More importantly, recent studies have consistently reported an association between low vitamin D status and all-cause mortality.[35,36]

Ireland continues to have higher rates of osteoporosis, diabetes, cardiovascular disease, cancer and other chronic degenerative disorders than most other countries. These are multi-factorial conditions with complex aetiologies but the epidemiological, clinical and laboratory data implicating low vitamin D status in these disorders, as well as our high prevalence of suboptimal vitamin D status, suggest that addressing this issue in the clinical and public health context could yield a significant health dividend for the Irish population.

While the issue of food fortification remains under review,[37] there is much that can be achieved now by the strengthening, promotion and implementation of the vitamin D supplementation guidelines which already exist in this country.

Daniel McCartney is a programme director and lecturer in human nutrition and dietetics, Dublin Institute of Technology

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HPV testing as primary cervical screening method

HIQA has recommended that CervicalCheck changes its primary screening method to HPV testing. **Tara Horan** reports

A CHANGE to the primary screening method for prevention of cervical cancer is likely following recommendations issued by HIQA in May, which state that primary screening with HPV testing would be more effective than the current liquid-based cytology method.

This recommendation was the outcome of a health technology assessment (HTA) carried out by HIQA at the request of CervicalCheck, Ireland's National Cervical Screening Programme.

The HTA of human papillomavirus (HPV) testing as the primary screening method for prevention of cervical cancer found that changing to primary HPV testing would reduce the number of screenings each woman has in her lifetime, while providing better accuracy in detecting precancerous abnormalities and early stage invasive cervical cancer.

There would be no change to the way the cervical screening sample is collected, so the screening experience would be the same for the woman.

Given that HPV infection is associated with almost all cervical precancerous abnormalities and invasive cervical cancers, Dr Máirín Ryan, HIQA director of HTA and deputy chief executive, said: "Compared with the current screening strategy, primary HPV screening is a better test which allows all women who participate in cervical screening to become aware of their current HPV status and those who are at higher risk of cervical cancer to be picked up earlier."

Follow-up test for cellular abnormalities

The HTA recommends that where a woman is found to be HPV-positive following primary HPV screening, a follow-up test using liquid-based cytology would then be carried out on the same sample to inspect for cellular abnormalities. If any abnormalities are detected, a colposcopy will be needed for a more detailed examination of the cervix.

"Women with a negative HPV test can be reassured that they are at very low risk of developing precancerous abnormalities in the next five years. For this reason, we advise that the interval between screenings can be increased to every five years for those currently being screened three-yearly. A change to primary HPV screening means the same benefit is provided to women in fewer screenings," Dr Ryan said.

Fewer lifetime screening tests

Implementing primary HPV screening five-yearly from age 25 to age 60 would lead to two fewer screening tests over a woman's lifetime. According to HIQA 20% more precancerous abnormalities would be detected and 30% more cervical cancer cases and deaths would be avoided for every screening test carried out compared with the current screening strategy.

However, as HPV infection is more common in younger women, HIQA recommends that women aged between 25 and 30 years who have not been vaccinated against HPV should continue to be offered three-yearly screening to ensure they are protected.

Uptake of screening

CervicalCheck began in 2008 and there has been good uptake with four in five of the estimated 1.2 million eligible women currently up to date with their smear tests. However, compliance decreases with age and for this reason, HIQA advises that cervical screening may be extended up to 65 years of age for women who have only had the benefit of routine cervical screening from age 50. "While this would come with an increased cost, it would provide additional clinical benefit for these women," said Dr Ryan.

HPV immunisation programme

The first women vaccinated against HPV 16 and HPV 18 as part of the national school-based immunisation programme will become eligible for CervicalCheck in 2018. These women are at lower risk of developing cervical cancer.

However, as the current vaccine does not protect against all virus types that can lead to cervical cancer, vaccinated women should still attend for regular cervical screening every five years with HPV

Main points of HIQA recommendation on HPV testing as the primary screening method for prevention of cervical cancer

- The sequence of screening tests should be changed to primary HPV screening with liquid-based cytology follow-up testing
- All eligible women aged 25-60 years should be screened every five years, including those vaccinated against HPV 16 and HPV 18
- However, women aged under 30 years who have not been vaccinated against HPV could be provided with three-yearly primary HPV screening, as HPV infection is more common in this age group
- Screening coverage could be extended up to age 65 years for women who have only had access to CervicalCheck from age 50. Given the lower uptake of screening in older women, this should occur alongside a targeted campaign to maximise uptake of screening in those over 60

testing, which HIQA believes is the best strategy in this group.

Cervical cancer

Cervical cancer is the eighth most commonly diagnosed cancer (excluding nonmelanoma skin cancer) in women in Ireland. Although year-on-year variation occurs, invasive cervical cancer in Ireland has increased in the past decade. There are, on average, 88 deaths from cervical cancer each year. Data from the National Cancer Registry Ireland (NCRI) from 2012 to 2014 indicate that, on average, 2,873 women were diagnosed with cervical carcinoma in situ and 277 women were diagnosed with invasive cervical cancer each year.

NCRI data from this period indicate that:

- One in 13 women will be diagnosed with pre-invasive cervical cancer (cervical carcinoma in situ) in their lifetime (up to age 74)
- One in 112 will be diagnosed with invasive cervical cancer
- One in 333 will die from cervical cancer.

On average, CervicalCheck processed approximately 281,000 smear tests per annum in 2015 and 2016, declining from a peak of almost 367,000 tests in 2013. Between 2012 and 2015, on average 7.7% of smear tests each year showed low-grade abnormalities and 1.6% showed high-grade abnormalities.

Between September 2008 and August 2015, it reported 1,082 biopsy-confirmed invasive cervical cancers, 41,417 high-grade abnormalities (CIN 2 and CIN 3) and 29,505 low-grade abnormalities (CIN 1).

Certain oncogenic strains of HPV (denoted high-risk HPV or hrHPV) are associated with an increased risk of developing precancerous abnormalities and invasive cervical cancer. Preliminary Irish data indicate a crude hrHPV prevalence of 14.6%. Prevalence of HPV is highest in women under 30 years of age and decreases with advancing age. The data indicate that 32% of women who test positive for HPV are positive for HPV 16 and 18, the particular genotypes of HPV that are associated with 70% of cervical cancers.

Given the association of cervical cancer with persistent HPV infection, there are two complementary approaches to preventing cervical cancer:

- Primary prevention through vaccination to prevent HPV infection
- Secondary prevention through screening to detect and treat precancerous abnormalities and early stage invasive cervical cancer.

Evidence base

Over the past 10 years, increasing evidence has become available that, when used as a primary screening test, HPV testing can improve the accuracy of cervical screening compared with cytology-based testing for the prevention of cervical cancer.

The recommendation to switch from primary cytology screening to primary HPV screening is in keeping with developments in other high-income countries. Australia, Italy, the Netherlands, New Zealand, Sweden and the UK have all recommended the implementation of primary HPV screening. The Netherlands began using primary HPV cervical screening in January 2017. Extending the screening interval to every five years is also consistent with recent recommendations in Australia and New Zealand.

When requesting HIQA to undertake the HTA, CervicalCheck highlighted emerging evidence of an opportunity to increase both the clinical and cost effectiveness of its screening programme.

Primary HPV screening with liquid-based cytology triage testing at five-yearly intervals from age 25-60 years was identified as the best possible strategy in the context of a willingness-to-pay threshold of €20,000 to €45,000 per quality-adjusted life year (QALY), with an incremental cost-effectiveness ratio (ICER) of €29,788 per QALY.

Changing to primary HPV screening followed by liquid-based cytology testing at five-yearly intervals from age 25-60 would result in a net saving of up to €3 million for the cohort of women vaccinated against HPV 16 and HPV 18, €32m for the unvaccinated cohort, and up to €35m for the whole CervicalCheck population over an eight-year period from 2018 to 2025.

Infection progression

Human papillomavirus (HPV) is a sexually transmitted infection, with skin-to-skin genital contact sufficient for transmission. Cervical cancer results from persistent infection with certain strains of the HPV virus (hrHPV strains). The majority of women clear the infection spontaneously. Cervical cancer arises when HPV is transmitted, the virus persists, and persistently infected cervical cells progress to precancerous abnormalities and finally to invasive cervical cancer.

Prognosis is linked with stage at diagnosis of invasive cervical cancer. In Ireland, between 2008 and 2012 the net five-year age-standardised survival probability for those diagnosed at stage II was 63.6% compared with 21.6% for those diagnosed at stage IV.

Five-year survival probability (not age-standardised) for those diagnosed with stage I was 93.9%. Treatment for invasive cervical cancer is stage dependent. On average each year, 162 women undergo surgery for invasive cervical cancer, 102 receive chemotherapy/immunotherapy and 141 are treated with radiotherapy.

Changing to HPV testing

HIQA noted that primary HPV screening may result in worry and anxiety for some women. Potential issues relate to the fear of testing positive for HPV because of the possible implications for their health, their relationships and the inability to treat HPV infection.

The informed consent process would have to be carefully managed to ensure that women are given sufficient information about the new testing process and its potential risks and benefits in a way they could understand. Women who test positive for HPV should be reassured about HPV infection and their concerns about transmission allayed as far as possible.

The HTA report has been approved by the Board of HIQA and has now been submitted to CervicalCheck and the Minister for Health to inform decision-making about the screening programme.

Dr Ryan concluded: "Implementation of our advice to CervicalCheck has the potential to increase benefits for all women and lower costs compared with the current screening programme, freeing resources for use elsewhere in the healthcare system."

The full HTA of HPV testing as the primary screening method for prevention of cervical cancer can be accessed at **www.hiqa.ie**

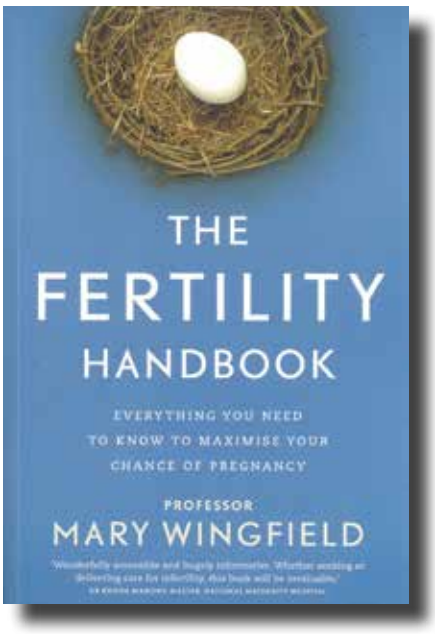
Understanding fertility

PROF Mary Wingfield, one of Ireland's foremost fertility experts, has helped hundreds of women to conceive over the past 30 years and she has now made her knowledge and expertise available to all in her new book *The Fertility Handbook*.

Prof Wingfield is a consultant obstetrician gynaecologist at the National Maternity Hospital in Dublin, clinical director of the Merrion Fertility Clinic and an associate professor at University College Dublin. She is regarded as a leading expert in her field, is widely published and is actively involved in research and teaching in the area of fertility.

In this book Prof Wingfield has created an authoritative guide for anyone who wants to maximise their chance of pregnancy. It provides a clear and holistic approach to the subject of fertility, including:

- Understanding your body and maximising your chances of conceiving naturally
- A pre-conception plan with sections on lifestyle, nutrition and the role of stress
- The common (and uncommon) causes of fertility problems in both men and women
- Demystifying complex treatments such as IVF, IUI and egg freezing
- Up-to-date information on ethics, funding and the law both nationally and internationally
- Options for single people and same-sex couples from a modern perspective
- Insightful testimonials from patients dealing with fertility problems and the emotional impact of treatment.



The thorny issues of national legislation and state funding are also tackled by Prof Wingfield and in a chapter devoted to ethical and legal issues in fertility she looks at why Ireland is one of only three EU countries that does not have public funding for IVF. She believes that it is unacceptable for such treatments to be preferentially available to only those who can afford them. She also finds the lack of legislation to govern this area to be problematic, stating that the complexity of assisted reproduction demands legislation that protects all of those involved.

The Fertility Handbook is a must-read for anyone planning a pregnancy now or in the future. It offers a wealth of information to those at the planning stage as well as those who face fertility issues. The book offers a direct and honest appraisal of fertility by age, straightforward advice on topics ranging from the treatments available, to lifestyle changes that both men and women can make.

All royalties from the sale of this book will be donated to the Merrion Fertility Foundation, which funds fertility treatment for those unable to afford it.

– Alison Moore

The Fertility Handbook by Prof Mary Wingfield is published by Gill Books. ISBN 9780717172740 RRP €16.99

Crossword Competition

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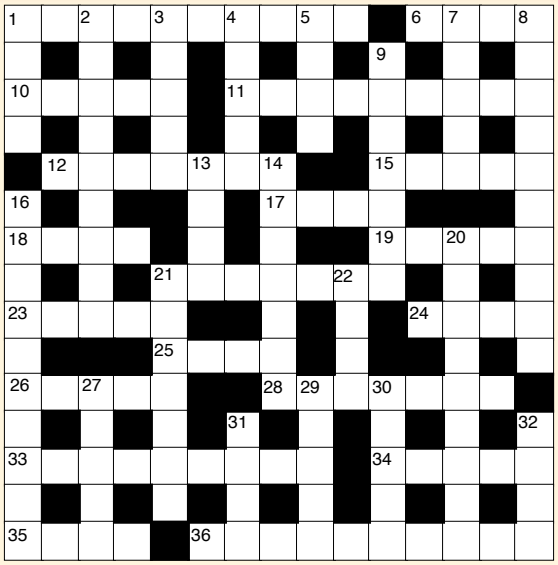

Across

1 So stir cans thus to make what the French have for breakfast (10)
6 Fifty percent (4)
10 La Cosa Nostra, the criminal organization originating in Sicily (5)
11 Somehow, one lands more of this fish (3,6)
12 Far away (7)
15 Prompt someone with your elbow (5)
17 Chemical extracted from Carolina lumber (4)
18 Part of a ladder (4)
19 Herr Hitler (5)
21 He delivers the mail (7)
23 Panorama, view (5)
24 In Faro, one may arrange for a hair stylist to give you this (4)
25 Perform - or create - once again (4)
26 Adjust slightly (5)
28 & 2d Coyote sins differ, somehow, for the Quakers! (7,2,7)
33 South American country, capital Buenos Aires (9)
34 Mr Tribbiani's baby kangaroos? (5)
35 Ms Barnacle married James Joyce (4)
36 Inflammation that disturbed a mining site (10)

Down

1 Stay in a tent (4)
2 See 28 across
3 & 22d How chic Mr Baldwin is! Clever and conceited too (5-4)
4 In the Bible, Moses' brother (5)
5 Neat (4)
7 Pointed a weapon at a target (5)
8 Snacks that don't require cutlery (6,4)
9 Dustin Hoffman won the second of his Best Actor oscars in this 1988 movie (4,3)
13 The highest male voice (4)
14 Examples of skin adornment; 'ink' (7)
16 Should one make tracks saucily for this source of perks? (5,5)
20 & 21 Ron fears gift kept changing in this facility in which to leave the car (3-6,7)
22 See 3 down
27 Keen (5)
29 Creature related to the giraffe (5)
30 & 31 Get the popular Irish dance tempo almost immediately! (2,3,4)
32 Avails of (4)

Name: .....
Address: .....
.....
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The prize will go to the first all correct entry opened.
Closing date: Friday, August 18, 2017
Post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin

Solutions to June crossword:

Across:
1 Timber wolf 6 Step 10 Error
11 Funny bone 12 Disturb
15 Alpha 17 Omen 18 Amin
19 Nadal 21 Torquay
23 Manor 24 Grin 25 Able
26 Tying 28 Thought
33 Melodrama 35 Sits
36 Condescend

Down
1 Twee 2 Mortician 3 Egret
4 Wafer 5 Lane 6 Troop
8 Prevailing wind 9 Tyranny
13 Undo 14 Bouquet garni
16 Haematomas 20 Dark horse
21 Tragedy 22 Ambo 27 Inlet
29 Hoard 30 Urges 31 Faro

The winner of the June crossword is:

Pauline Dunne, Monasterevin, Co Kildare

Inheritance planning

Ivan Ahern discusses the importance of thinking ahead when it comes to inheritance

IRELAND has one of the highest inheritance tax rates in the world. Major 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 acquired 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, ie. the 'group threshold'
- The net/taxable value of the inheritance
- Any previous gifts or inheritance received.

What many people don't realise is that the tax bill needs to be paid soon after inheritance. Indeed, 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 their 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.

Thresholds and capital acquisitions tax (CAT)?

Inheritances can be received free from capital acquisitions tax (CAT) 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've received, in that group. The current rate of CAT is 33%.

Options to protect your family against inheritance tax

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

Table 1: Capital acquisitions tax group thresholds after October 14, 2015

Group	Beneficiary	Tax free amount[1]
A	Son or daughter	€310,000
B	A parent[2], brother, sister, niece, nephew or grandchild of the person giving the gift	€32,500
C	All other relationships, other than those mentioned in A or B	€16,250

Table 2: Example of how Inheritance tax works

Net/taxable value of inheritance	€750,000	
Number and type of beneficiaries: two – one son and one daughter		
Breakdown of inheritance due	Jamie	Deirdre
Gross inheritance to each beneficiary	€400,000	€350,000
Less tax free amount threshold Relationship: Child, ie. Group A	€310,000	€310,000
Gross taxable inheritance per child	€90,000	€40,000
Less personal capital gains tax exemption	€1,270	€1,270
Net taxable inheritance per child	€88,730	€38,730
Tax payable at 33% per child	€29,281	€12,781
Overall inheritance tax due	€45,362	

- A 'Section 72 life assurance policy' – this policy can fund the capital acquisitions tax (CAT) liability which arises on the benefits inherited from your estate and the proceeds of this are exempt from inheritance tax. This policy is relatively straight forward to set up. However, it is subject to medical underwriting so the earlier this is done, the better
- Giving a gift of 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.

Ivan Ahern, Director, Cornmarket Group Financial Services Ltd. For information on Cornmarket's Inheritance Planning Service, Tel: 01 408 6275. Cornmarket Group Financial Services Ltd. is regulated by the Central Bank of Ireland. A member of the Irish Life Group Ltd. Telephone calls may be recorded for quality control and training purposes.

1. *CAT only applies to amounts over the relevant group threshold*
2. *In certain circumstances a parent taking an inheritance from a child can qualify for Group A threshold*

A volunteering journey to Lourdes

INMO staff and members travel to France with sick on pilgrimage

EACH year, volunteers from Ireland accompany the sick who set out on a pilgrimage to Lourdes, a small town in the southwest area of France. The Lourdes pilgrimage from Ireland was initiated and instituted by Archbishop John Charles McQuaid in 1949 and the Dublin diocese has been facilitating sick or ill people who are interested in travelling to Lourdes for spiritual healing and renewal of their faith.

Nurses, doctors, pharmacists, speech and language therapists and students are among some of the volunteers who travel to Lourdes under the diocese with a team of chaplains led by the archbishop.

The pilgrimage programme commenced on September 8, 2016 with an opening mass at the grotto led by archbishop Diarmuid Martin.

Nurse's role

The nurse's role as a volunteer at Lourdes starts before even travelling to France, with home visits to the sick for medical assessment weeks or months before the journey. This continues by accompanying and assisting them (with other volunteers) from Dublin Airport through the flight and settling them in their rooms at Accueil Notre Dame, which is within the Basilica and close to the grotto.

During the five-night stay, volunteers attend to the needs of the sick – physically, medically, socially and spiritually. This is done by assisting them with activities of daily living, mobilising them to the grotto, churches, torchlight processions, baths, picnics (in Lourdes and Bartres), thereby making their stay in Lourdes as comfortable, meaningful and enjoyable as possible.

The volunteers are appreciated and rewarded during a service award night where bronze, silver and gold medals are presented for third, fifth and 25 years' service respectively.

Ibukun Oyedele of the INMO International Nurses Section, who travelled to Lourdes as a volunteer this year, was awarded the silver medal as a volunteer nurse in the Dublin Diocese. Edward Matthews, INMO director of social policy and regulation, has also been part of the volunteering team for a couple of years.

The pilgrimage also provided an avenue to meet and make friends and socialise together, whereby some volunteers went on a cable car ride to Pic du Jer, which is a mountain within the town.

The pilgrimage was rounded up with a departure mass at St Benedict Church, led by Archbishop of Dublin diocese and a farewell party for the sick.

The volunteers flew back to Dublin with all the sick pilgrims and assisted them in identifying and collecting their luggage, which includes holy water and souvenirs brought from Lourdes. They also ensured the sick got home safely.

Edward Mathews, INMO director of regulation and social policy, and Ibukun Oyedele, INMO International Nurses Section, travelled to Lourdes in September 2016 along with other volunteers from Ireland to assist the sick who were travelling as part of a pilgrimage

Special Olympics call for volunteers

SPECIAL Olympics Ireland is calling for nursing volunteers for the summer games, which are due to take place in 2018.

As a volunteer with Special Olympics Ireland, you enable athletes to achieve and win not only in sport but in life too.

If you are interested in volunteering with Special Olympics Ireland, please visit **www.community.specialolympics.ie/volunteer-registration** to complete an online volunteer application form.

Further information about volunteering can be found online at **www.specialolympics.ie**

Pictured (l-r) at a presentation of money raised by the Health Voices Choir for Pieta House were: *Grace Oduwole, INMO and choir member; Ibukun Oyedele, INMO and choir member; Dave Hughes, INMO deputy general secretary; Leonie Weekes, Health Voices Choir organiser and INMO member; Rosarii Mannion, HSE national HR director; and Cindy O'Connor, Pieta House chief clinical officer. The choir raised €17,000 for Pieta House. The Health Voices Choir is made up of 200 people representing all areas of healthcare provision. They recorded two songs; Carol of the Bells and He Ain't Heavy, which briefly made number one in the iTunes charts in Ireland. The cheque was received by Cindy O'Connor, Chief Clinical Officer of Pieta House*

International award for Irish nurses

TWO nurses at University Hospital Waterford (UHW) received a prestigious international Award for Excellence in Cardiovascular Care for their case study on the risks of using protein supplements.

Shortlisted from over 250 entries from hospitals around the world, UHW cardiology nurses, Norma Caples and Edel Cronin, travelled to Jonkoping,Sweden where they presented their case study on a 32-year-old body builder to a panel of cardiovascular experts. The nurses were then selected as the ultimate winners of the award, presented at the international EuroHeartCare conference in Sweden by the European Society of Cardiology Council on Cardiovascular Nursing and Allied Professions.

The case study examined the effects of protein supplements on the cardiovascular system by observing a patient who initially presented to the cardiac unit of University Hospital Waterford for an ECG.

A comprehensive health history of the 32-year-old body builder was carried out, which revealed his daily habitual usage of protein supplements. Despite education and consequently deteriorating health, it took over 12 months for the patient to accept the dangers of protein supplements. This patient now has end-stage renal disease and requires dialysis four times a week.

Pictured (l-r): *Claire Tully, director of nursing, University Hospital Waterford; Norma Caples, clinical nurse specialist and registered nurse prescriber, University Hospital Waterford; Edel Cronin, CNM2 and registered nurse prescriber, University Hospital Waterford; and Richard Dooley, general manager, University Hospital Waterford*

The award recognises nurses who have demonstrated excellence and innovation in providing heart and cardiovascular treatments. It is the first time that UHW has received an international award for this speciality. The international judging panel was appointed by the Council on Cardiovascular Nursing and Allied Professions and the European Society of Cardiology.

Winner Norma Caples, clinical nurse specialist and registered nurse prescriber, at the UHW heart failure unit, said: "It was such a privilege to be chosen as the overall winner of excellence in practice in cardiovascular care. Both myself and Edel have always put a lot of work in to improving our practice in cardiovascular care to ensure patients receive high standards of treatment so it means a lot to be awarded for that."

Edel Cronin, who received the award alongside Norma Caples, CNM2 and registered nurse prescriber at UHW cardiac catheterisation laboratory said: "I was so delighted that we were invited to present our abstract as one of the eight finalists but to be awarded the overall winner was overwhelming. This is such a prestigious award and to be the recipient reflects our hard work and dedication."

Cancer of unknown primary research

THE Sarah Jennifer Knott Foundation, which was launched to create awareness, research and education into cancer of unknown primary, was officially launched recently in Dublin. The objective of the foundation is to raise information and support for patients, families and healthcare practitioners and to promote improved medical research into this condition.

The foundation was inspired by Sarah Knott, who died from cancer of unknown primary in April 2015 at just 31 years of age.

The SJK Foundation is the only organisation in Ireland where the sole focus will be on awareness, research and education into cancer of unknown primary.

For more information about the Sarah Jennifer Knott Foundation, please visit **www.sjkfoundation.org** or follow the foundation on Facebook at **www.facebook.com/SJKFoundation**

INMO members and staff support Pride 2017: *Pictured (l-r) at the Pride festival, which took place in Dublin city centre on Saturday, June 24, were: Mags O'Brien, SIPTU; Clare Treacy, INMO IRO; and Edward Mathews, INMO director of regulation and social policy*

SMA Nutrition new product launch

Effective from May 2017, SMA Nutrition has changed the SMA High Energy formulation. SMA Pro High Energy 90ml will replace the SMA High Energy 100ml, while SMA Pro High Energy 200ml will replace SMA High Energy 250ml. The new SMA Pro High Energy range is designed for use from birth to 18 months.

Call to double number of IBD nurses

Lack of specialist IBD nurses in Ireland greatest barrier to patient care

THE Irish Society for Crohn's Disease and Ulcerative Colitis has launched the #DoubleUp campaign, which calls for the number of specialist inflammatory bowel disease (IBD) nurses to double from just 14 to at least 28, bringing Ireland in line with international best practice.

A survey of service providers treating patients with IBD, conducted by the Irish Society of Gastroenterology (ISG), found that the lack of dedicated specialist nurses in Ireland is the greatest barrier to delivering patient care, and that 45% of hospitals across the country have no specialist nurse treating IBD patients.

A report in 2015 entitled, *Gut Decisions*, put forward numerous recommendations-for the government to improve services for IBD patients in Ireland, including:

- Develop and implement a national strategy for Crohn's and colitis to deliver the highest standards of care for people living with these conditions
- Ensure every patient with Crohn's and colitis has ready access to the care of a multidisciplinary team
- Develop specific measures to help patients and their families deal with the financial burden of Crohn's and colitis.

Pictured at the launch of the #DoubleUp campaign were Mary Forry, IBD specialist nurse at Beaumont Hospital and Todd Manning, Abbvie Ireland general manager with campaign models Colin Whyte and Joseph Whyte

The Irish Society for Crohn's Disease and Ulcerative Colitis (ISCC) is calling on the public to get behind the initiative by signing its online petition, available at **www.change.org/p/doubleup-for-ibd**

COMPETITION

WIN a pair of shoes from the SKECHERS Work collection

SKECHERS WORK FOOTWEAR

To be in with a chance to win a pair of shoes from the Skechers Work collection *(see page 11)*, just answer the simple multiple choice question below:

- From the list below, what is the name of the popular and super comfortable type of insole used in many Skechers Work shoes:

  a) Air cooled memory foam
  b) Wood insole
  c) Cardboard insole

To enter send this form to: SKECHERS Work Collection Competition, MedMedia Ltd, 17 Adelaide St, Dun Laoghaire, Co Dublin.
Closing Date: August 18, 2017. Winner will be announced in next issue.

Answer: .....

Name: ..... Tel no: .....

Address: .....

.....

July

Thursday 13
Retired Nurses and Midwives Section outing. Meet at EPIC, The Irish Emigration Museum, Custom House Quay, Dublin 1. Red Luas line stop at George's Dock. Contact geraldinesweeney@gmail.com for further information

Saturday 22
International Nurses Section family day in Farmleigh, Phoenix Park, Dublin. Email: cres415@yahoo.com for further details

September

Wednesday 6
Registered Nurses in Intellectual Disability Section meeting. INMO HQ. 1pm. The meeting will take place following an education programme for RNIDs. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Thursday 7
Retired Nurses and Midwives Section day trip. Newbridge Estate, Hearse Road, Donabate. Train departs Connolly Station at 11.17 and 11.45. It is a 10-minute walk to Newbridge House or a taxi is available at Tel: 01 8460869. Lunch is available onsite. Admission to house/farm costs €6.

Thursday 14
Retired Nurses and Midwives Section meeting. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Thursday 14
PHN Section meeting. INMO HQ. 2.30pm. The meeting will take place following an education programme for PHNs. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 16
CRGN Section meeting. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 16
CNM/CMM Section meeting. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Thursday 21
Assistant Directors of Nursing Section meeting. Limerick. Venue TBC. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Thursday 21
Legal and Professional Issues Workshop organised by the Nursing and Midwifery Education Section. Tel: 01 6640641 for further details or log on to **www.inmoprofessional.ie**

Saturday 23
School Nurses Section meeting. Midlands Park Hotel, Portlaoise, Laois. From 10am. Education session on Documentation. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Thursday 27
ED Section meeting. Venue TBC. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

October

Saturday 7
ODN Section meeting. Mater Hospital Dublin. 11.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 7
Radiology Nurses Section meeting. Venue TBC. Contact jean.carroll@inmo.ie or Tel: 01 6640648

Thursday 12
All Ireland Midwifery Conference Armagh City Hotel. Contact jean.carroll@inmo.ie or Tel: 01 6640648

Monday 16
Retired Nurses and Midwives Section autumn break to Tower Hotel, Co Waterford. Cost: Three-night stay, dinner bed and breakfast per person sharing €159. Single rate €219. Tel: 051 862300

Wednesday 18
Care of the Older Person Section meeting. INMO Cork Office. 11am-1pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Reunion

- A reunion of past Meath Hospital nurses will take place in the Clayton Hotel (Burlington) on Saturday, October 7, 2017 at 5pm. Cost €50 per person. Please contact Mary Kelly at Tel: 0879393801

INMO Membership Fees 2017

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

Education programmes for Sections in the INMO PDC

- An education programme specifically for registered nurses in intellectual disability will take place in INMO HQ on Wednesday, September 6 from 10am-1pm. Social media – your responsibilities and aging and care services for people with intellectual disabilities will be discussed. An RNID Section meeting will be held following this programme
- An education programme on risk assessment and documentation, specifically for public health nurses, will take place on Thursday, September 14, 2017 from 11am-2pm in INMO HQ. The PHN Section meeting will take place at 2.30pm following this programme.

Members of these sections are advised to book early (three weeks prior) to avail of the early bird rate. Tel: 01 6640641/18 or go to **www.inmoprofessional.ie**

Condolences

- The Staff of CLD, St James's Hospital, wish to acknowledge the passing of our dear friend and colleague, Catherine Deegan, head of learning and development. We extend our sincere condolences to Catherine's partner Art and her family and friends. RIP
- The INMO extend its sincere condolences to Phyllis Foody on the death of her mother, Margaret Foody. May she rest in peace
- The INMO extends its deepest sympathies to the family of Mary Teresa Coughlan, retired INMO member who worked in St Luke's Rathgar. RIP