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INMO
Journal of the
Irish Nurses and
Midwives Organisation

World of Irish Nursing & Midwifery

Latest INMO CPD education programme

See page 33

Stark warning against return of ED overcrowding
page 9

PTSD: A consequence of caring
page 22

Covid-19: Nutrition in care homes
page 55

The case for vitamin D in Covid-19
page 61

Coping with Covid

Meet the heroes behind the masks

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NEWS & VIEWS

5 **Editorial**
Covid-19 and overcrowding just don't mix, writes INMO general secretary Phil Ní Sheaghdha

7 **From the President**
Your priorities with INMO president Martina Harkin-Kelly

8 **News**
Workable childcare scheme essential... Extra college places vital to meet staffing shortfall... Deliveries continue despite unsafe midwifery levels... Stark warning issued against any return to hospital overcrowding... Limerick overcrowding demands national action... PHN sponsorship programme extended... Implementation of strike settlement Clonakilty faced extreme difficulties... Members' risk assessment ensures early mask usage... INMO renews claims for enhanced practice payment... New contract rollout in Cork acute hospitals...
Plus: Opinion by Dave Hughes, *page 14*
Plus: Section news, *page 15*

47 **Students & new graduates**
Catherine O'Connor updates readers on news for students and new graduates

FEATURES

16 **Cover story**
Messages from the Covid-19 frontline. Freda Hughes and Lisa Moyles report

22 **Mental health focus**
Steve Pitman looks at the mental health consequences of caring for Covid-19 patients

25 **Messages of support**
Members of the public show their support for frontline healthcare workers

27 **Workers memorial day**
President Higgins remembers those who lost their lives in the practice of their work

29 **International days**
Celebration of the international days of the Midwife and the Nurse

31 **Pride focus**
Steve Pitman underlines the INMO's solidarity with its LGBT+ members

41 **Legal focus**
Edward Mathews discusses new guidance on pronouncement of death during Covid-19

43 **Branch focus**
Freda Hughes meets the Cork HSE Branch

44 **Questions and answers**
Your industrial relations queries answered

45 **Nursing Now**
This month the spotlight is on ED nurse Neil Perry

46 **Midwifery focus**
A new module from RCM i-learn focuses on recognising maternal sepsis

49 **Quality and safety**
This month Maureen Flynn looks at open disclosure during a pandemic

50 **Behaviour focus**
When it comes to challenging behaviours, respect is key, writes Brian McDonald

67 **Update**
Round up of healthcare news items

CLINICAL

52 **Covid-19**
A hospital team looks at the benefits of conscious proning of Covid-19 patients

55 **Nutrition**
The HSE has issued nutritional guidance to directors of nursing in residential care

59 **HPV**
Mary Short explains the change from cytology to HPV testing for cervical cancer

61 **Vitamin D**
Tara Horan reports on the importance of vitamin D in the Covid-19 context

65 **Diabetes**
Catherine Dolan looks at the potential neurological complications of diabetes

LIVING

66 **Book review**
Niall Hunter reviews *The Narrow Land* by Christine Dwyer Hickey
Plus: Monthly crossword competition

JOBS & TRAINING

33 **Professional Development**
Pull-out section from INMO Professional

68 **Diary**
Listing of meetings and events

69 **Recruitment & Training**
Latest job and training opportunities

On the cover this month:
Nurse Siobhan Devine

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Breastfeeding: The best start

Health benefits for infants

Breast milk is the ideal food for newborns and infants. It gives them all the nutrients they need for healthy development. It is safe and contains antibodies that help protect infants from common childhood illnesses such as diarrhoea and pneumonia, the two primary causes of child mortality worldwide. Breast milk is readily available and affordable, which helps to ensure that infants get adequate nutrition.

Long-term benefits for children

Beyond the immediate benefits for children, breastfeeding contributes to a lifetime of good health. Adolescents and adults who were breastfed as babies are less likely to be overweight or obese. They are less likely to develop type 2 diabetes and perform better in intelligence tests.

Benefits for mothers

Breastfeeding also benefits mothers. It reduces risks of breast and ovarian cancer later in life, helps women return to their pre-pregnancy weight faster, and lowers rates of obesity.

Support for mothers is essential

Breastfeeding has to be learned and many women encounter difficulties at the beginning. Nipple pain, and fear that there is not enough milk to sustain the baby are common. Health facilities that support breastfeeding – by making trained breast-feeding counsellors available to new mothers – encourage higher rates of breastfeeding. To provide this support and improve care for mothers and newborns, there are 'baby-friendly' facilities in about 152 countries thanks to the WHO-UNICEF Baby-friendly Hospital initiative.

Work and breastfeeding

Many mothers who return to work abandon breastfeeding partially or completely because they do not have sufficient time, or a place to breastfeed, express and store their milk. Mothers need a safe, clean and private place in or near their workplace to continue breastfeeding. Enabling conditions at work, such as paid maternity leave, part-time work arrangements, on-site crèches, facilities for expressing and storing breast milk, and breastfeeding breaks, can help.

The Irish Nurses and Midwives Organisation supports breastfeeding

For more information log onto www.breastfeeding.ie

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Covid-19 and overcrowding just don't mix

NURSES and midwives have always had to contend with infectious diseases, but Covid-19 has put contagion at the heart of our work. Preventing the spread of the virus requires a different type of care provision to protect ourselves, our colleagues, our families and those under our care.

This is creating unprecedented requirements to divide patient care areas to reduce the risk of cross contamination. This relocation and quarantining of patients in hospitals, nursing homes and in the community has been a major challenge. Nursing's clinical eye has been to the fore: developing pathways of care to ensure protections for patients and staff.

This is not new to our professions. We have become sadly all too used to overcrowding in unsuitable locations. A return to overcrowding mixed with the risk of a deadly virus would be a dangerous combination. This is why we have developed a set of demands and proposals with the doctors of the Irish Association for Emergency Medicine this week. Pointing to the rising trend of patients on trolleys, we set out the steps needed to avoid a return to overcrowding *(see page 9)*.

In responding to Covid-19, we must also learn the lessons from other countries. A key step in the Taiwanese response to the pandemic was to reduce work group sizes. This sees infected patients treated by fewer staff, with a constant staff-to-patient ratio. This reduces the risk of a community spread within the hospital. Combined with stricter regulations for cleaning and disinfecting medical areas, Taiwan's hospitals have been able to effectively lockdown the virus treatment environment. This is a lesson we must learn and implement immediately.

This has been key to keeping infection rates low among healthcare workers, something which needs urgent scrutiny in Ireland. We have sought greater clarity on the infection rates among healthcare workers, but at the time of writing, we know that 7,400 of them have tested positive; 34 have been admitted to ICU – 14 of them nurses.

The INMO has requested the intervention of the Health and Safety Authority and sought stronger legal regulations to protect frontline healthcare workers. A part of this must also be very strict quality control on all PPE provided to staff – including that donated by those outside of the health service.

We must also look at the length of time spent caring for Covid-positive patients. Screening of all staff must be mandatory, especially for those staff working for long shifts on Covid-positive wards. This approach must become routine in the fight to suppress this virus.

Responses to Covid-19 have rightly focused on physical health, but in this month's *WIN* you will also see steps we are taking to highlight the mental health consequences that you face as a result of battling this virus.

Calls to our helpline and to officials clearly show a growing concern among members. They are citing problems in being able to switch off, and in dealing with high levels of stress and anguish associated with the virus. In many cases this will require specific intervention, but we know from members that the comradeship, mutual support and encouragement of colleagues and fellow INMO members is crucial.

We know this virus has not gone away. It's a tide that has ebbed, but it is likely to flood back again. Nurses and midwives have proven that they can and do provide interventions that save lives. The recovery figures are due to your expert interventions. Our professionals have the education, skills and dedication to deliver.

Even in these dark times, be proud of your contribution in all aspects of care: from birth to death you have been with the patients, advocating and supporting them.

We continue to advocate on behalf of the professions and together we will face the challenges ahead.

Phil Ní Sheaghdha
General Secretary, INMO

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

Working Together

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Your priorities with the president

Martina Harkin-Kelly, INMO president

Looking forward to better times

NORMALLY, the June issue of *WIN* would have included all the highlights for our annual delegate conference and indeed it would have been a great reward to spend those days together after the eventful year we have had, given the many pressing issues of healthcare provision in Ireland that continue to demand our attention.

Nevertheless, I look forward to meeting with you all later this year, for a conference that will be all the more significant, not only for our achievements and hard work, but also for its being held in the WHO Year of the Nurse and Midwife.

This year we find ourselves firmly at the centre of global events, with the demands of the ongoing Covid-19 emergency highlighting the vital nature of our work. Looking ahead to our conference in October, and beyond, it is important that we consider our position in society, and how we can utilise the current focus on healthcare to best serve our patients and our professions.

Landmark days in nursing and midwifery

I FELT both privileged and proud to speak with our members via video and social media to acknowledge the International Day of the Midwife on May 5 and International Nurses Day on May 12.

In my three-minute address, I considered the unwavering dedication of nurses and midwives, and their vital role in ensuring the delivery of safe care to people of all ages and across all sectors of society.

Ireland's President, Michael D Higgins also addressed the nurses and midwives of Ireland and it is noted and welcomed that he referenced how nursing is a fundamental and critical role that we have come to appreciate in more recent times. He stated and acknowledged that this was all hard won wisdom and that: "It would be so regrettable, egregious even, if, through some form of collective amnesia, we as a society were ever to disregard or forget the heroic efforts and revert to where we were before the pandemic – a society that sometimes failed to value you fully."

ICTU Women's Committee

ON TUESDAY, May 12 INMO second-vice president Eilish Fitzgerald and I attended a remote meeting of the ICTU Women's Committee. Among the agenda items were issues surrounding the impact of Covid-19 on women in society and the challenges of home working for women and people with caring responsibilities. This included a discussion of potential health and safety issues arising from home working.

The committee also considered the issue of maternity leave and returning to work, particularly the payment of the temporary wage subsidy scheme, which is currently unavailable to women in this situation. The committee was informed that the NWCI and trade unions are seeking to remove the inequitable sexist and discriminatory nature of this anomaly, highlighting its illegality in relation to the Maternity Protection and Employment Equality Acts. The committee awaits further developments on this matter.

The committee also heard from Sarah Benson, Women's Aid CEO, who spoke regarding the increase in domestic violence during the Covid-19 emergency, in particular the challenges involved in accessing and providing support. Sadly, the current crisis and the necessary restrictions on movement pose an additional difficulty to women in dangerous living situations, both in Ireland and around the world. The committee will continue to consider the unique ways that women are impacted at work and at home by the Covid-19 emergency over the coming months.

The contact details for Women's Aid are Tel: 1800 341900 and **www.womensaid.ie**

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

Quote of the month

"Accept the challenges so that you can feel the exhilaration of victory."
- George S Patton

Report from the Executive Council

THE Executive Council continues to convene for weekly updates by teleconference. Full monthly meetings are expected to resume in June 2020. The Executive Council weekly updates continue to discuss the matters relating to the Covid-19 emergency as well as other ongoing issues.

The INMO has been pushing forward the issue of childcare arrangements for healthcare workers since schools and crèches first closed on March 13. We will continue to seek adequate childcare solutions over the coming months. In the meantime, we have advised members to maintain records of leave taken and costs incurred as a result of their childcare responsibilities.

Cornmarket has donated €30,000 towards the INMO's benevolent fund. We expressed thanks on behalf of members to Ivan Ahern and his team in Cornmarket. The Communications Workers Union has also recently donated a large quantity of handcare products to INMO members. Your reps will be contacted next week regarding the distribution of this very kind and practical donation.

The Executive Council has joined international colleagues and condemned unreservedly the bombing and shooting of mothers and babies in Kabul's Maternity Hospital on May 12. Our solidarity and sympathy are extended to those who lost their lives or were injured and to the staff helping them to overcome this tragedy.

We ask all our members to stay up to date by visiting the Covid-19 page on our website and paying careful attention to all members updates issued by email.

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

Workable childcare scheme essential

Government must go back to drawing board on childcare scheme

THE INMO called on the government to go back to the drawing board on childcare following the cancellation of a proposed childcare scheme for frontline healthcare workers.

The failed scheme had aimed to provide in-home childcare for frontline healthcare workers who were facing difficulty. The government pointed to a low take-up of the scheme as the reason for cancellation.

The INMO has been calling for childcare provision since before the Covid-19 restrictions took effect. The union was not consulted on the proposals for the now-cancelled scheme, and sought constructive engagement with government on the issue.

Over 94% of nurses and midwives are women, with childcare a major practical issue during the Covid-19 epidemic. At a time when the health service needs as many frontline nurses and midwives as possible at work, a workable childcare scheme is essential, the union said.

INMO general secretary Phil Ní Sheaghdha said: "The government must go back to the drawing board. Everyone wants to see a successful scheme, so we will be engaging constructively with the government to get this sorted.

"A key lesson from this process is that there should be constant engagement with unions and stakeholders in the design of these schemes.

"Until then, nurses and midwives with childcare difficulties can expect maximum flexibility to allow them to attend work. Should that fail, they can remain home, awaiting remote work, with full pay. This was negotiated between unions and employers in the past weeks.

"If the government wants as many frontline nurses and midwives as possible at work, they will have to offer an additional scheme to make it practical."

Extra college places vital to meet staffing shortfall

IRELAND'S health service will face even more severe staffing pressures without increasing the number of undergraduate nursing and midwifery places, the INMO has warned.

The call for more places came on the International Day of the Nurse, May 12, 2020.

Of the 3,700 nurses and midwives who joined the nursing and midwifery register in Ireland last year, 13% (183) had trained elsewhere in the EU, with nearly half (49%, 1,189) having trained in countries outside the EU. The INMO warns that the global pandemic means a likely drop in overseas recruitment, resulting in even further pressures in nursing and midwifery staffing in coming years.

To combat this, the Organisation is calling for an urgent increase in the number of undergraduate nursing and midwifery places in Irish universities and colleges. It is also sending a clear message that a moratorium, pause or any other measure to slow down recruitment cannot be countenanced.

There are roughly 1,800 spaces on nursing and midwifery courses available each year. In 2019, 5,324 students put nursing or midwifery as their first-preference choice on their CAO form.

INMO general secretary Phil Ní Sheaghdha said: "We must ensure that frontline staff are given the support and resources they need to do their job. To provide safe care, we need to build up our staffing levels. Ireland must continue to recruit staff from around the world, but also to train more ourselves. We train far fewer nurses and midwives than we need, but we know that thousands more want to join the nursing family.

"Over 5,000 motivated students put nursing or midwifery as their first preference in the CAO last year. We should ensure that more places are available to accommodate them, as the health service needs them."

Deliveries continue despite unsafe midwifery levels

OVER 11,000 babies were born in Ireland's understaffed hospitals between the arrival of Covid-19 in late February and the International Day of the Midwife on May 5, analysis from the INMO showed.

The figures were released to mark the International Day of the Midwife, in recognition of the role of midwives in delivering expert care and supporting women and babies. 2020 is also the WHO's Year of the Nurse and Midwife.

There are 1,479 staff midwives working in the public health service. This is significantly below the scientifically recommended ratio of one midwife to every 29.5 births.

The INMO is calling on the HSE, the government and all parties to not only recognise the work done by midwives but to ensure that staffing levels are set scientifically.

The INMO estimated projection of 11,000+ births is based on an analysis of CSO birth figures from 2007 to 2017 (latest data), looking at the period of February 27 (when Covid-19 first arrived in Ireland) to May 5 in each year. Over those years, the figure has varied between 11,181 and 13,938.

INMO general secretary Phil Ní Sheaghdha, said: "As Covid-19 puts pressure on our health service, midwives are there for mothers and babies, providing care, comfort, advocacy and advice.

"While much has been put on hold during the pandemic, childbirth has continued as normal. On a daily basis, midwives in Ireland welcome over 150 new people into the world.

"The skill and dedication of midwives not only deserves recognition but support. Consistent understaffing has put midwifery under pressure, leaving overworked staff to pick up the slack.

"The next government must ensure that the promise of safe staffing in the National Maternity Strategy is upheld, and that staffing numbers are set by scientific safe levels."

Stark warning issued against any return to hospital overcrowding

EMERGENCY departments and hospitals must not return to overcrowding in the coming weeks, emergency nurses and doctors have said.

This warning came as part of the first-ever joint statement from the INMO and the Irish Association for Emergency Medicine, which represents frontline doctors and nurses in emergency departments across the country.

The statement cautions that the "problems of the past" may emerge again as the health service gradually ramps up non-Covid activities.

A return to overcrowding and understaffing will lead to increased infection risk, poor patient outcomes, and unsafe workplaces, the emergency nurses and doctors warned.

The joint statement calls for measures to counteract this, including:

- A permanent increase in bed capacity, initially by retention of access to private hospitals until a vaccine against Covid-19 is secured, with a maximum occupancy rate of 85% across hospitals in order to maintain patient safety
- Adequate staffing to ensure good patient care despite staff sickness and the reduced productivity related to use of PPE. This should include a commitment that no future recruitment embargoes will apply to nurses or doctors and priority immigration and travel arrangements for health professionals recruited from abroad
- Extra priority and decision-making powers in the community to avoid unnecessary referrals to ED
- A high-level working group to urgently examine staffing issues in the health service over the coming year.

Dr Emily O'Conor, president of the Irish Association for Emergency Medicine, said: "We need to reset care in Ireland's emergency departments and allow us to continue to care for those patients that need emergency medicine expertise in a way that is safe for patients and staff."

INMO general secretary Phil Ní Sheaghdha: "Overcrowding, understaffing and Covid-19 pose a triple threat to patients and staff alike"

INMO general secretary Phil Ní Sheaghdha said: "Overcrowding, understaffing and Covid-19 pose a triple threat to patients and staff alike.

"ED and hospital overcrowding is always unacceptable, but it is exceptionally dangerous with the added risk of Covid-19 infection.

"We have never seen trolley overcrowding figures as low as over the past few weeks. We must build on that and resist any return to the problems of the past. In the short term, that means keeping the extra capacity of the private sector, prioritising immigration of migrant health professionals, and no more recruitment embargoes. We cannot repeat the mistakes of the past."

The full statement, sent to the HSE and the Minister for Health, can be read at: **https://inmo.ie/attachment.aspx?doc=5356**

Limerick overcrowding demands national action

A RETURN to major overcrowding at University Hospital Limerick must be stopped, the INMO has warned.

Throughout the Covid-19 pandemic, as previously, UHL has consistently been the hospital with the highest number of patients on trolleys in Ireland. On May 14, for example, this rose to 42 admitted patients on trolleys in UHL, with 22 in the emergency department and a further 20 placed on wards elsewhere in the hospital. This was more than half of all patients on trolleys across the country on that day (57% of 74 nationally).

The INMO called for direct national oversight and investigation as to what is causing this overcrowding. The Organisation said that national intervention was and still is absolutely necessary to avoid catastrophic outcomes for patients and frontline staff.

INMO assistant director of IR Mary Fogarty: *"UHL has more patients on trolleys most days than all other hospitals in Ireland put together"*

Overcrowding in hospitals in the current Covid-19 pandemic is dangerous as it increases risk of infection and transmission of the virus. This also poses a health and safety risk for critical frontline staff.

University Hospital Limerick has, in recent years, been consistently the most overcrowded hospital in Ireland, with nearly 14,000 admitted patients left on trolleys in the hospital in 2019.

INMO assistant director of industrial relations for the region, Mary Fogarty, said: "Trolley numbers are rightly at record lows nationally, as health service capacity is increased and many services pared down.

"Yet what we are seeing in Limerick is beyond belief. UHL has more patients on trolleys most days than all other hospitals in Ireland put together.

"Any overcrowding is unacceptable at the best of times. But with Covid-19, this presents a serious danger of infection and transmission of the virus to staff and vulnerable patients. Hospitals should be limiting occupancy to safety limits, not going beyond 80% capacity in times of such high infection risk.

"We need immediate national oversight action to ensure this level of overcrowding is halted, with direct national intervention if necessary."

Tony Fitzpatrick, INMO director of industrial relations, reports on national IR issues in the context of Covid-19

PHN sponsorship programme extended

AS a result of the Covid-19 lockdown period, the conclusion of the 2019-2020 academic year has brought a level of concern to many nurses and midwives who are completing the PHN sponsorship programme throughout Ireland this year.

In May 2020, I met with the HSE programme directors who in turn have discussed the issue with the Higher Education Institutes and NMBI with regards to extending the PHN Sponsorship Programme by six weeks.

This is due to the impact of Covid-19 on the ability of student PHNs to complete their Maternal and Child Health competency. It is understood that the student PHNs will successfully achieve competency sign off on or before the end of the extension period.

In this regard, it was agreed that student PHNs should proceed as normal onto the RN salary scale from May 29, 2020 as this had been the scheduled completion date. They will remain on the RN salary scale for the extension period and up to receiving their registration from NMBI. As per the normal process, once registration is received, they will be placed on the PHN salary scale.

The INMO has requested the HSE to ensure that the NMBI would fast-track PHN registration on the completion of the six week extension.

The INMO is satisfied that the above agreement will bring certainty to the student PHNs around the country.

PHN Sponsorship Programme 2020-2021

Meanwhile, the INMO also met with HSE management on the PHN Sponsorship Programme for the next academic year. The union is anxious to ensure that the largest cohort of sponsored PHNs can be accommodated in the 2020-2021 programme. This is necessary as under Sláintecare there is again a requirement to increase the number of nurses working within primary care services.

The INMO welcomed the fact that HSE Health Business Services and Community Operations are currently shortlisting candidates and making arrangements to conduct interviews remotely. Details have been sought on the numbers by location of developmental PHN posts that may to be added to the intake in 2019-2020.

PHN Section

The PHN Section met via Zoom on April 25 to discuss the provision of the service during the pandemic. Issues discussed included:

- Guidelines on pregnancy and Covid-19
- Issues regarding Covid-19 pay and annual leave
- Provision of PPE, especially for PHN/CRGN visits to homes where there is a known case of Covid-19.

To attend the next PHN Section meeting scheduled for July, email jean.carroll@inmo.ie *(see also page 15)*.

ED overcrowding must not be allowed to return

AS the Covid-19 government restrictions begin to ease, the INMO is keeping in close contact with the HSE to ensure that there is no return to overcrowding in emergency departments.

To that end, a teleconference between myself and the officers of the ED Section took place in May 2020 to discuss the management of ED departments, as we move from pandemic to endemic state.

The HIQA Tallaght report of 2012 clearly outlined that patients should not be cared for in an inappropriate space. This is even more important considering the infection risk that will arise due to Covid-19.

The INMO has written to Anne O'Connor, deputy director general of the HSE who is also the co-chair of the ED Taskforce, regarding the requirement for engagement around the management of EDs going forward and a teleconference is due to take place in the coming weeks. However, I believe it is necessary that we become extremely organised in each ED, to enforce a zero tolerance policy with regards to overcrowding.

Furthermore, the INMO joined with the doctors and consultants of the Irish Association for Emergency Medicine to issue a joint call to stop overcrowding once again becoming a feature of our emergency departments, hospitals and wider health service *(see page 9)*.

Unifying with other professions and groups adds strength to our calls, and we will seek to work with other health professionals over the coming months.

Implementation of strike settlement payments

THE INMO continues to meet with hospital groups regarding the payment of the strike settlement agreed in February/March 2019.

While many nurses and midwives have received their retrospection and full payment on their new point of scale and allowances due, some work locations are slow to implement these changes and resulting payments due to staff.

The INMO is working to ensure that all members receive their entitlement in as short a time as possible. I urge all who have not applied for the enhanced practice contract to do so, to ensure payment and retrospection due.

ID sector

Negotiations are concluding with HSE management and representatives of the Section 38 providers in regard to implementation of the strike settlement in this sector. In the coming weeks applications for the enhanced salary scale, enhanced senior staff nurse scale and the CNM1 regrading will take place. A full update will be included in the next issue of *WIN*.

Clonakilty faced extreme difficulties

INMO members show of strength in united demands for PPE supplies

PATIENTS and staff in Clonakilty Community Hospital have experienced an extremely difficult time during the Covid- 19 pandemic, with a serious outbreak in the facility and a number of deaths related to the virus. Our members and the INMO wish to take this opportunity to extend our sympathies to those residents and families affected.

The INMO has been providing ongoing support and representation to members in Clonakilty since the outbreak. A number of disputes arose in relation to PPE usage, stock levels and, as in Fermoy Community Hospital, the widespread usage of surgical masks. Agreement was reached ahead of the recommendation from the HSE on the widespread usage of masks in Clonakilty with management following the strength and unity of our members and reps in demanding this necessary introduction.

We spoke to some of the staff there for our Courage to Care section *(see pages 16-21)*, but they also gave us their commentary on the support they received from the union and the local community.

Mary Nagal, an INMO rep in the hospital, told us: "The staff redeployed to Clonakilty were of great support to us and we can't thank them enough. We would like to thank the public, local clubs and all the other community hospitals who were so kind and supportive to us by donating hampers and cakes. Tablets were donated to our residents to communicate with their families and our local station Red FM raised money.

"Our INMO industrial relations officer Liam Conway has been with us throughout this Covid-19 pandemic, providing regular updates and representation. It was a huge comfort to be able to make contact with him directly regarding issues with PPE as we had such a limited supply and needed it urgently.

"The Covid-19 crisis in our hospital is the toughest challenge we have ever faced as nurses. The support from the general public was amazing and helped us get through it."

Fellow INMO rep Colette O'Regan added: "Without the support of the INMO, we believe our situation would have been even more traumatic in Clonakilty Community Hospital. We think about our colleagues who are sick and we hope they get better soon."

Protection on the frontline:
INMO reps Belen Morales and Colette O'Regan

Another INMO rep, Mary-Joan Salalima, reinforced the absolute necessity of redeployed staff joining their team so that the hospital could cope with the crisis.

She said: "Without the additional staff who were redeployed to help us from Mallow, Dunmanway, Kanturk, Bandon, Kinsale and Bantry we would not have been able to cope. All of the solidarity we received has given strength to the extremely hard-working staff of Clonakilty Community Hospital."

As well as the local radio station raising funds for PPE, the local Ballinascarthy GAA club set up a Go Fund Me page and local businesses and individuals donated food and hampers to staff to help them through such difficult times. Cairde Group which raises money for the hospital were also a great support.

Members' risk assessment ensures early mask usage

FERMOY CNU was among the first community hospitals across the country to commence wearing surgical masks as a result of a clinical risk assessment carried out by INMO members utilising their clinical judgement.

This measure was taken ahead of the HSE's policy change recommending the widespread usage of masks.

INMO members on the ground, particularly the reps, must be commended for taking this preventive step within the hospital. The INMO sought that the HSE would not prohibit such a use of PPE given that the European Centre for Disease Prevention and Control had already recommended surgical mask usage in early March. The INMO also called for widespread usage of surgical masks across all community hospitals and ID services ahead of the HSE's policy change.

Safety first:
INMO members at Fermoy CNU identified the need for surgical masks for all staff early in the Covid-19 outbreak. Pictured (l-r) were: Leona Roche, Mohamad Badeiki, Nina Hynes

Following engagement with management, the INMO successfully secured that this practice would continue prior to the issuing of HSE guidelines. This was prior to local media coverage of the issue and a number of local disputes which erupted prior to this agreement due to the position of the HSE nationally.

– Liam Conway, INMO IRO

Irish **Nurses** and **Midwives** Organisation
Working Together

Covid-19

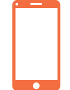
BEFORE LEAVING WORK
Shower if possible and change out of work clothes

ARRIVING HOME
Wipe steering wheel, controls and door handles

AT FRONT DOOR
Pause, Breathe, Reset, Take your time

KNOCK ON DOOR
Open from inside - Step in

PLASTIC BOX AT DOOR
Doff your work/commute shoes, outer clothes/ coat/bag, keys, pens and glasses. Wipe down with damp soapy cloth



PHONE
Kept at work in clear zip lock bag. Empty out of bag into box - wipe phone clean and throw the bag away

WORK BAG
Has to be machine washable - keep in a locker at work and a box by the front door at home

WALK STRAIGHT TO SINK/SHOWER
Don't touch doors, get someone else to open them for you. Wash or shower especially hands, arms and face with soap and hot water

YOU ARE CLEAN
Relax and enjoy your evening

Take care of yourself at this time

Your employer has a responsibility to protect your health, safety and wellbeing at work. Given the extraordinary situation in dealing with the COVID-19 emergency, below are some tips for looking after your own self-care during these times.

Tips

Maintaining your energy levels and personal reserves is a major factor in helping you cope and preventing exhaustion during the current crisis.

Physical Wellbeing

- Maintain a healthy lifestyle: keep hydrated, eat and sleep well, and exercise
- It is important that you take 'at work' breaks
- Don't feel guilty about taking your days off
- Avoid negative coping strategies - excess alcohol, tobacco or other drugs.
- If you are coming off a long shift and do feel too exhausted to drive take a rest before driving and follow the advice of the RSA: pull over in a safe place, sip coffee and sleep for 15 minutes.

Emotional and Psychological Wellbeing

- Your stress levels and psychosocial wellbeing are as important as your physical health
- Remember it is normal to feel sad, stressed, anxious or overwhelmed during a crisis. These feelings are no reflection on your ability to do your job.
- Watch out for signs of stress
- Use strategies that have worked for you in the past to manage stress rather than learning new ones.
- Minimize watching, reading or listening to news about COVID-19 that causes you to feel anxious or distressed.
- Seek information updates, from trusted sources, at certain times of the day rather than a constant stream: www.inmo.ie/Covid19, www.gov.ie/, www.hse.ie

Social Wellbeing

- The support and contact with family, friends and colleagues at this time is vital.
- Some nurses and midwives may have to minimise direct contact with family and friends. If possible, staying connected with your loved ones, for example using video messaging.
- Remember to plan and enjoy contact with family and friends (even if it is virtual).

Support

- Talk to someone you trust or seek assistance from a counsellor
- If you feel you require further support. You can contact the INMO Members 24 Hour Counselling Helpline 1850 670407 or 01 8818047.
- Support is also available from the HSE Employee Assistance and Counselling Services https://www.hse.ie/eng/staff/workplace-health-and-wellbeing-unit/

PPE

- Staff should have the protective and medical equipment they require to do their jobs safely and professionally. If you are experiencing any issues around PPE, **please contact the INMO's PPE freephone hotline on 1800 320 087, or text 087 719 7188.**

Sources: WHO, 2020; RCN, 2020, www.hse.ie

The INMO Representing and Advocating for Nurses & Midwives during the COVID-19 Emergency

INMO renews claims for enhanced practice payment

Private hospitals called on to recommence talks

THE INMO has served claims for payment of the enhanced practice scale on a number of private hospitals, including the Mater Private Hospital and the Bon Secours Hospital Group, and had commenced engagement prior to the outbreak of the Covid-19 crisis.

The INMO has recently written to both hospitals seeking to recommence these discussions, since the roll out of the enhanced practice salary is now being paid in the public system. Both the Mater Private and the Bon Secours have a long-standing pay relationship with the public system.

Albert Murphy, INMO assistant director of industrial relations, said it is vital that these negotiations recommence and are implemented as a matter of urgency.

"Our members in the private hospitals have played their part in the nation's effort to combat Covid-19 and deserve to be treated on an equal footing. The members working in these hospitals have also been fighting to keep patients safe and have been brought under government control for the duration of the pandemic. There is no justification for delays in implementing the new enhanced practice scale for these nurses and also for the extension of the medical and surgical allowances and the application of the enhanced practice scale for senior nurses", he said.

Mater nurses social distancing with style

NURSES from the Mater University Hospital took interesting steps to show people how to maintain social distance recently. A video clip of a group of nurses from the hospital who had previously been involved in a Strictly Come Dancing competition went viral recently. They sang and choreographed a routine in a church green near the hospital to the sounds of the Village People's YMCA. The clip was also played on Virgin Media News.

New contract rollout in Cork acute hospitals

IN MARCH and April 2020, Bantry and Mallow General Hospital saw the rollout of the enhanced contract along with payment of same. Members received their contacts, signed and returned them to HR and were placed on payroll with arrears in the next pay period. This process continued in May for members in Cork University Hospital and Cork University Maternity Hospital.

There has been a huge uptake of the enhanced practice contract by nurses and midwives in all four sites. Members are receiving arrears of monies backdated to their increment date post March 1, 2019. This follows payment of the medical and surgical allowance which was also backdated to March 1, 2019. In addition, staff nurses and direct entry midwives saw the extension of the maternity allowance paid and backdated to March 1, 2019.

CUH members are to receive the medical/surgical allowance in the upcoming payroll periods.

– Liam Conway, INMO IRO

INMO activist Mary Ranahan retires

INMO activist Mary Ranahan from the Brothers of Charity Services in Bawnmore, Limerick recently announced her retirement and will be sorely missed by INMO members in Limerick.

Ms Ranahan joined the INMO over 36 years ago, spending the majority of those years as an INMO rep where it was always her goal to serve the best interests of RNIDs and that of the service users.

Many newly qualified nurses were recruited to join the INMO and Ms Ranahan always put her nursing colleagues on a clear path when they came to her seeking advice from the union. It was reassuring for the many INMO officials who worked alongside Ms Ranahan over the years that there was always a good turnout for local union meetings and ballots. None of this work is easy, it takes time and effort.

In later years, Ailish Bredin joined Ms Ranahan as a rep in Bawnmore as the INMO took members on a road for better pay and conditions. We wish Mary every happiness with her family in retirement and hope to celebrate her work on behalf of INMO members at the annual delegate conference in October.

– Mary Fogarty, INMO

Nurses and midwives in action around the world

Australia
- Covid-19 workers compensation loophole closed for nurses, paramedics and other essential workers
- NSW nurses angry over proposed pay freeze

Brazil
- Brazilian nurses mourn colleagues killed on the Covid-19 frontline
- Research shows that only 56% of nurses in São Paulo receive enough PPE to change and only 11% have adequate work shoes

Canada
- Ontario nurses say Covid-19 pandemic highlights need for sweeping reforms
- Nurses being told to reuse masks at Manitoba hospitals, says union

El Salvador
- Nursing Day: "Saying 'they are our heroes or heroines' is not a true recognition"

India
- We don't need empty praise: Nurses' unions demand better protection, rights

New Zealand
- Nurses add to proposed law which imposes minimum prison sentences for assaults against healthcare workers

Spain
- SATSE demands that, after the pandemic, more investment be made in nurses

UK
- RCN: Fix PPE and testing before relaxing lockdown further

US
- Duelling protests besiege the nation: nurses and retail workers versus anti-lockdown activists

Post Covid-19, the government must steer Ireland clear of austerity policies and travel an expansionist road, writes **Dave Hughes**

Life and the economy after Covid-19

FUTURE generations might talk about life before Covid-19 (BC) and life after (AC). The changes already experienced trying to control the virus have not only altered temporarily how we live but may well have changed how we think and act in the future.

Without doubt, there is a new awareness and sense of community, as well as a realisation that our lifestyles up to now have impacted on the natural world. People talk of their joy in seeing renewed beauty in plants and animals and even daylight from a different perspective. On the other hand, old habits die hard so society may quickly forget this.

How our society and others, come out of this pandemic will depend on political decisions. In Ireland, the struggle to form a government after an inconclusive general election has pulled together political parties previously bitterly divided. It has also placed others in powerful bargaining positions, while taking monumental gambles on their political future.

Economists voice opinions based on previous recessions and, depending on their perspective, either promote a return to austerity or a reflation of the economy.

What Ireland will do is not entirely down to our government. As members of the EU the fiscal policy adopted for Ireland is influenced as much by German politicians as it is by our own. That international response has yet to be determined and will be heavily influenced by the impact of the virus on the most influential of the EU nations.

In this era, we are all at the mercy of both fiscal and monetary policies.

Fiscal policies are decided by governments whose job it is to control the economic growth and prosperity of the nation. In fiscal policy they have two mechanisms – taxation and public spending.

Monetary policy is set by central banks setting interest rates and by influencing the supply of money in the economy. They do this by quantitative easing, for example, which essentially means printing money. For an individual currency this would lead to devaluation, however recent experience has shown that its impact in a global recession is not as dramatic as one might think.

From the outset of this pandemic, the European Central Bank (ECB) said it would do whatever it took to save economies in the face of a lockdown. These were not mere words as the ECB committed that a massive €750 billion monetary package would be available to EU governments interest free.

It is that commitment which has allowed the Irish government, following considerable lobbying by the Irish Congress of Trade Unions, to provide special higher-level unemployment benefits, supplements to employers to keep employees on their payroll and Covid-19 sick pay arrangements. It is that money which has seen the temporary realisation of a single-tiered health service and the expansion of ICU and recovery beds. Yes, this is borrowed money but it is interest free.

Given the scale of the ECB commitment, the arguments about how it is used have now moved from monetary policy to fiscal policy. Therein lies the real arguments about whether society changes or not.

Governments have two possible roads to travel:
- Return to austerity with cuts in public spending, or
- Increase borrowing and spend more on infrastructure.

With a return to austerity with cuts in public spending and reduction in taxation, the hope is that the money saved by companies and individuals will refloat the economy. Ireland has experienced this approach and its consequences in social terms.

On the other hand, expansionists argue that in a recession, the government may decide to increase borrowing and spend more on infrastructure. The idea is that increased government spending injects money into the economy and helps to create jobs. There may also be a multiplier effect, where the initial injection into the economy causes a further round of higher spending. This increase in aggregate demand can help the economy to get out of recession.

The scale of the recession, its impact globally, its unpredictability and the availability of interest free money make it imperative that the expansionist minded politicians win the European argument.

Our health service, our housing crisis and our future environment requires that there is no going back. In the worst of times we have made progress toward a fairer society – we must not squander this opportunity.

Dave Hughes is deputy general secretary of the INMO

ANNUAL DELEGATE CONFERENCE 2020

Rescheduled

RADISSON BLU HOTEL, CO SLIGO

Wednesday to Friday, October 7-9, 2020

The INMO Annual Delegate Conference 2020 will take place from Wednesday, October 7 to Friday, October 9 in the Radisson Blu Hotel, Sligo. The gala dinner will take place on Friday, October 9, when conference has ended.

For any enquiries regarding the ADC, please contact Michaela Ruane, INMO HQ at **Tel: 01 6640665** or email: **necactivities@inmo.ie**

Section update

Public Health Nurses Section

THE Public Health Nurses (PHN) Section held a successful virtual meeting in April.

More than 70 members attended the meeting and Tony Fitzpatrick, INMO director of industrial relations, and Edward Mathews, INMO director of professional and regulatory services, were both available for discussion and to answer questions.

The meeting was expertly chaired by Eilish Fitzgerald, INMO second-vice president, who fielded members' questions following the meeting.

The feedback was positive, and this virtual platform may become the 'new normal' for the section for the timebeing.

The PHN Section is also busy organising its inaugural conference for Saturday, November 28, for which there is an interesting variety of speakers lined up.

Topics for the conference will include:

- The nursing and midwifery response to the Covid-19 pandemic
- Perinatal mental health
- Working with marginalised groups
- Caring for people in direct provision
- Workshops on wound care
- Breastfeeding
- Mindfulness
- Children's nursing strategy.

There will also be a panel discussion on the future of public health and community nursing in Ireland.

The PHN Section has a very active WhatsApp group. If you wish to join, send a text message to Jean Carroll at Tel: 087 4108011, stating your name and the words 'PHN Please Add Me', and you will be added to the group.

SECTIONS IN FOCUS:

INMO School Nurses Section

SCHOOL nursing is a career that many nurses had previously not thought possible but it is a career path that has been developing in Ireland.

The role of the school nurse is exceptionally diverse and challenging. School nurses tend to be lone practitioners, often working in isolated settings. They provide care for the physical, mental and emotional health needs of pupils while supporting them during their academic journey.

The role is varied – from the management of children with chronic health conditions, to dealing with sports injuries and, in recent years, dealing with an increasing volume of mental health issues. The role of the school nurse is constantly evolving and becoming more challenging.

INMO School Nurses Section

The School Nurses Section currently represents 55 nurses working in secondary-level day and boarding schools, also including special educational needs schools.

The section meets approximately four times a year and as a result of these meetings and the increased collaboration between school nurses, a hugely supportive network has grown.

Education

Just before the Covid-19 outbreak, the section invited Jane Graham, nurse advisor from the Boarding Schools Association (BSA), to facilitate a three-day intensive course from February 17-19 entitled 'Nursing Certificate in School Nursing' for section members.

Hosted by the INMO at the Richmond Education and Event Centre, this was the first time this particular course had been run in Ireland.

Members of the INMO School Nurses Section pictured at the recent educational course at the Richmond Education and Event Centre, which took place from February 17-19

The section's members are grateful for the Organisation's support in helping them to achieve this qualification while also contributing to their professional development.

The course was attended by 20 school nurses from across Ireland. Guest speakers included Edward Mathews, INMO director of professional and regulatory services, who covered legal issues, and Greg McGovern, Garda youth liaison officer, who gave an insightful presentation on drug misuse and screening.

The course has proven to be an important and relevant support for members. It has resulted in enhanced knowledge and has promoted best practice, two much-appreciated outcomes for attendees.

The unprecedented times in which we find ourselves have resulted in the closure of schools across the country. The challenge will be how best to manage a safe return for pupils, staff, visitors and nurses.

The School Nurses Section is continuing to host meetings via Zoom to discuss the potential challenges and solutions that can be implemented to limit risk to school communities.

Zoom meetings are divided to facilitate both boarding/day schools and special education schools.

The School Nurses Section is delighted to have recruited many new members over the past year but always welcomes more.

If you are a school nurse and are interested in joining this proactive and focused group of nurses, please send an email to: lauracrowley00@hotmail.com or the section's secretary at: sinrio146@icloud.com

Message for frontline members

The School Nurses Section would like to take this opportunity to applaud everyone on the Covid-19 frontline, working hard for the nation during this pandemic, including those school nurses, of which there are many, who were willing to answer 'Ireland's call' and support their nursing colleagues on the frontline.

Thank you and stay safe.

– Laura Crowley, chair, School Nurses Section

If you would like to join an INMO section or an existing section WhatsApp group, contact Jean Carroll, INMO section development officer by email: jean.carroll@inmo.ie

Meet the heroes behind the

INMO members from across the country send messages from the Covid-19 frontline. Reporting by **Freda Hughes** and **Lisa Moyles**

'Nurses have once again answered the call'

Nipuna Thamanam, clinical skills nurse, DCU School of Nursing

"NURSES have once again answered the call, showing their dedication, ability and willingness to work.

"With the opening of contact tracing centres across the country to fight the pandemic, I had the privilege to volunteer in the call centre run by DCU. This involved contacting people by phone. We were able to reach people of different age groups with various symptoms, treated at home, in hospitals and in nursing homes. I was involved in informing people of their Covid-19 diagnosis, providing information and advice. An assessment was also carried out on positive patients and data put into a computer system called the 'Covid-19 tracker'.

"We aim to flatten the curve by interrupting the chain of transmission and getting people to self-isolate, thus preventing the spread of the disease. Informing people over the phone of their positive test results is often not so easy. When the person on the other end sheds a tear, our hearts too are saddened. Empathy, care and compassion, although not shown physically, were expressed through the tone of our voice. Along with good communication skills, we also practised good listening, which is vital to nursing. Listening to their stories as they shared their fears and anxieties was saddening.

"On the bright side, it was heart-warming to hear stories of recovery. Although the nursing landscape has changed, the nature of the work we do has not changed. We are still working on the promotion of health and prevention of disease.

"Covid-19 has raised the status and profile of modern-day nursing. Along with the devastation the virus has brought, it has also given perspective and awareness about nurses and the work we do. The applause for frontline workers on March 26, along with the Taoiseach's remarks that 'not all superheroes wear capes; some wear scrubs and gowns' meant a lot to me.

"The masks, visors and gowns worn in hospitals are lifesaving and necessary; however, they can be uncomfortable. Masks pinch noses and irritate ears. Sweat pours from the gowns, and feet are often sore due to standing, hands dry due to frequent washing, eyes watery and misty beneath the visors and hearts burdened by patients saying goodbye to this world. Broken hearts and sadness are often what we see around us, but we must stand strong."

'We have really become closer as a team'

Thelma Halpin, CNM2, Our Lady of Lourdes Hospital, Drogheda

"We've transformed overnight from a 31-bed orthopaedic ward to a Covid-19 ward, so our focus is completely different. Things have evolved and will continue to evolve rapidly, and it is all about trying to keep up with that and update staff in the clinical environment.

"The patient's condition has to be monitored so closely as they can be relatively well for the first few days but between day five and day 10 of disease progression their condition can deteriorate really rapidly. We are so mindful, watchful, and cautious.

"There was understandably an anxious mood in our unit initially, but once we educated ourselves and prepared as much as we could things settled. The nursing team looks out for each other, especially when putting on and taking off PPE. It's not about correcting anyone; it's about minding each other. We have really become closer as a team (while staying two metres apart!).

"I'm in a leadership role with management responsibilities, so I feel more mentally tired at the end of the day. I always try to do my best and then I return home to be a mammy and do the home schooling, which I find far harder than any day at work.

"My family are anxious and concerned for me, but I reassure them that I am protected and I am following all the policies and protocols. My father lives with us and he minds our two kids, so I follow the advice on living with vulnerable adults and I'm always reassuring him that I'm safe and careful.

"When all of this started there was never a part of me that wondered what I was going to do. This is where I'm supposed to be. This is what I do. I face what is in front of me and try and overcome it as best I can."

masks during Covid-19

'We are always watching out for each other'

Jean Morrissey, theatre nurse, Royal Victoria Eye and Ear Hospital

"IN THE beginning putting on the PPE was scary but it's becoming more familiar the more I do it. The face mask and visor are the hardest things to get used to as they are tight and it's very hard to talk or hear.

"Being a nurse these days is made much harder because of all these obstacles to communication. You're so confined and you feel like you're not talking to anybody. It's quiet and even though we're all pulling together, there's no chatter.

"If you need to talk, you make certain that you shout and make sure the person hears you. After a while you find that something like a warm smile goes a long way.

"The theatre team are great and we are always watching out for each other. I find it hard that I'm not working with my usual team as the Covid-19 roster has us divided up between all the theatres. My usual gang are like my extended family as I used to see them every day, but my new colleagues are great too.

"My friends and family are worried for me. Even my neighbours are concerned for me and ask me regularly how I'm feeling after a shift. It's quite humorous, I think they'd take my temperature if they could. Initially I feared bringing it home, but I am so strict in the way I work that I don't fear it as much anymore.

"I am mentally exhausted at the end of the day as I'm thinking all day long if I've done things right – even on the way home that feeling stays with me. It's difficult to switch off from it. One feeling that's great is removing the PPE and face mask and breathing. It's so freeing."

'In work, the whole team keeps me going'

Danielle Keating, ICU nurse, Our Lady of Lourdes Hospital, Drogheda

"MOST patients are very nervous when they arrive in ICU, and these days when our patients see us all gowned up it can naturally be extremely unsettling for them. We manage this fear together with them and with each other in new ways. The preparedness and planning that has gone into our work has made things possible that we would never have done before.

One of the biggest challenges at the moment is having no families present. Before all this you'd have families in and you could build up a relationship with them, but now all that interaction happens over the phone. Some of the ICU nurses have been using Facetime to help families see their loved ones in ICU. Trying to bring families into patients' end-of-life care over the phone is very emotional and difficult, but it's so important to give them that experience.

"Some of the staff have started making 'memory boxes' for patients' families – knitting little hearts, getting hair locks and handprints so families have some sort of memory. While this is heartening it is also so sad.

"My family are afraid for me as they are aware how closely I work with Covid-19 patients. I know I have the appropriate PPE and my cleaning routine is excellent, so I remind myself and them that I'm protected and careful. Everyone at work is aware that everyone else is nervous, but my ICU nursing family are such a great support.

"What drives me to keep on going in this situation is the hope that this will all eventually come to an end and that by using all my critical care nursing skills and expertise I am making a real positive difference.

"Hopefully I will be able to see my family and friends again soon. At the moment I can only see my mam from the end of the garden and I haven't seen my 86-year-old nana in five weeks so that's been really hard.

"In work, the whole team keeps me going. There's great support across the ICU team, and I feel like my work colleagues are my family at the moment as I see them more often. The public support is also great.

"At the end of the day I know I've done everything I can, but I find I'm more mentally exhausted than my job has ever made me before.

"My new favourite feeling is when I'm out of my PPE, out of the shower in work and going across to the carpark, taking a breath of fresh air and feeling it on my face."

'We've all had to learn about the unknown'

Anne-Marie O'Reilly, ADON, St Michael's Intellectual Disability Services

"I WORK as part of a team that provides out-of-hours nursing and management services at St Michael's House, a large community-based organisation with more than 80 intellectual disability facilities across Leinster.

"We are all in this together as a team and hoping for the best outcomes for service-users, their families and our staff.

"We've all had to learn to know about the unknown, so to speak. I think at this stage we're a bit more confident than we were at the onset of the pandemic in early March, but like everyone we floundered a little bit until we found our feet.

"We have an excellent director of nursing here, Gráinne Burke, who has led the nursing teams. We also have a clinical nurse specialist in infection control and that has been a huge asset to this organisation. She has linked with public health and has been able to disseminate the most up-to-date information to everyone working in the service.

"We have a multidisciplinary testing team of which I am part. We did a lot of training and set up the programme within the service. We are a rights-based organisation so people can refuse testing and we must be clued in to implied consent from service-users. There is a support person from each house on the team to put service-users at ease.

"We had to be prudent in our use of PPE at the beginning, but we all wear masks now. Wearing PPE affects our communication with service-users, so our speech and language team have worked on developing communication tools to help with this. We have all had our photograph taken in our PPE and in our normal clothes to help service-users know who is who.

"We have been very lucky that our positive cases have all been cared for within the facility and have made full recoveries. All houses are equipped with smartphones so that people can keep in touch with their families and with their friends from day services. The phones are also used for staff training through video and WhatsApp.

"At the beginning everybody was exhausted; it is mentally draining trying to keep on top of everything. We are thankful at the end of each week that everyone has made it through and is safe. We have become more confident in our abilities as time goes on.

"I have been nursing for 40 years. I really like my job. It's in my essence to be a nurse – I cannot not be a nurse. I am also on the RNID Section committee and the peer support we provide each other here has been of great benefit to me."

'I really respect how my colleagues have adapted to the situation'

Carol Cronin, emergency department nurse, University Hospital Galway

"AS THE emergency department is all Covid-19 we are now streaming our patients differently to other departments which is a huge adjustment. We're used to a fast-paced day where you have that 'go, go, go' mindset. This is such a different environment now, not to mention the extra precautions these days when treating a patient. You take your time because you're worried for the patient in front of you and you're also worried for yourself. There's just so much to be concerned about.

"There was a feeling of apprehension when all this first started. A lot of colleagues were going home to elderly parents and young kids and you'd see the uneasiness in them. It's the job and they knew they had to come to work and they did.

"There's been a lot of great bravery and I really respect how my colleagues have adapted to the situation. Everyone involved in the ED at the hospital have been fantastic in playing their part, including everyone from the healthcare assistants and cleaners to the administration staff and paramedics.

"Our management team have also been outstanding in providing a safe workplace for staff, and it's not a daunting thought to come into work.

"I love being a nurse and caring for people. That has never changed. Patients need care and that's what I do. An essential part of success in the ED is having a good team and we really have the best. I value that.

"My brother is also a frontline worker so that's daunting for my parents. They worry about us and miss us, but they are also very supportive. They respect us for what we do, and I know they are extremely proud of us both.

"We were all so used to being physically tired from all of the running around but now I notice I'm more mentally tired at the end of the day. I even feel it emotionally. I still think about my patients once I've left for the day and I wonder how they're doing.

"So long as I've given 100% that settles my mind. I just have to keep reminding myself of that."

'This is what I signed up to when I became a nurse'

Allison Kennedy, CNM2 in post-acute services, Mater Misericordiae University Hospital

"WE FEEL very strained and upset for our patients at this time. The atmosphere has changed in the unit and so has the whole model of care we provide. We are our patients support system and we're kind of restrained now.

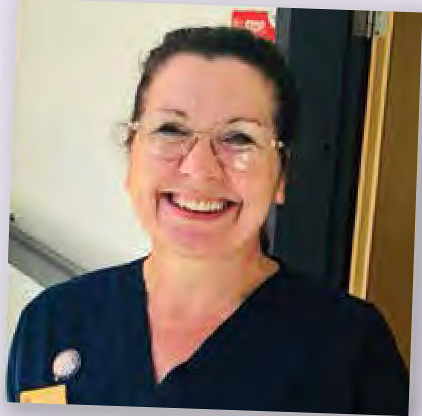
"Our service is a step-down facility mainly for older adults and others with complex discharge needs. Depending on complexity people can end up staying longer with us but the average length of stay is six weeks. We try to re-integrate people into the community and give them back their independence. This involves a lot of social interaction and family involvement is a big part of our model of care. It is difficult to do that now.

"From a visitor or family point of view the pandemic has brought great difficulties. We can still maintain some activities through social distancing, but patients are missing out on the social and family aspects we can normally provide, and of course some of our cognitively impaired patients find it harder to understand. We also have palliative care patients. It has been really hard when family can't visit.

"The biggest challenge is trying to keep the patients motivated and involved. Our focus is always person-centred and we feel we can't deliver on that anymore. We have always been about getting out of that hospital mode and preparing people for getting back to their lives.

"We have been lucky in that we haven't had a case of Covid-19 yet, but we have had patients who were symptomatic and had to be tested. All the staff are following the HSE guidelines to the letter. Being conscious of infection control, as well as dealing with all the anxiety the pandemic brings, can be exhausting. We have to always be self-aware. We're constantly washing down the nurses' station and stepping back from patients to maintain distance. There is still a risk factor for us so we're taking our temperatures all the time.

"At the end of each day I feel really sad. Sadness is the only way to describe it. I feel sad that so much has changed and I feel sad that colleagues are fearful. Although we're not in the thick of it or working on a Covid-19 ward, that anxiety is still there. You walk in the door when you get home and the first thing you hear on the news is how many people died from Covid-19 that day. You don't get a break from it. Staff are



coming in saying their partners have lost their jobs or they're worrying about vulnerable parents or children. I worry about my own elderly parents who are cocooning.

"I'm quite a positive person, but now I feel I have to try to maintain everyone's spirits and keep morale up. It is a lot of pressure. I'm trying to study too, and I'm just exhausted physically and mentally all the time. You have to just take it day by day and try to get plenty of fresh air.

"The patients are central to what I do. That's what drives me. I've worked through MRSA and other infections. My attitude is that this is what I signed up to do when I became a nurse. I feel like I'm contributing by doing my job regardless of the fact that my patients are non-Covid-19 patients.

'I decided the right thing to do was to sign up and re-join the health service'

Kellie Sweeney, staff nurse, Cherry Orchard Hospital, Dublin

"I haven't worked as a nurse for the past three and a half years due to the cost of childcare. However, when the crisis hit in an already short-staffed and underfunded health service and the 'Be On Call for Ireland' campaign was launched, I decided the right thing to do was to sign up and try to help out where I could. Little did I know, just as I was about to re-join the health service, my life would become much more complicated.

"The day before I was due to go back to nursing, I received a phone call from the hospital my mum was in. She was being treated for pneumonia following a Covid-19 infection. I knew it was bad news when they rang – no one gets asked to come to the hospital unless it's bad news, particularly during a global pandemic. But nothing could have prepared me for the absolute heartache of being told my mum had lung cancer. I just didn't see it coming. At 9am that morning I was preparing to go back nursing to play my part during the crisis and by 11am my whole world was falling apart right in front of my eyes.

"After my three-year absence, it turned out that when I went back to working in the health service, I was suddenly both a nurse and a patient's family member at the same time. I saw how difficult it is to care for people and how difficult it is to not be able to be with them when they are sick. The visiting restrictions during the pandemic add another layer of pain to my mum's already heart-wrenching diagnosis. I was lucky that I got the opportunity to comfort her for a short while following her diagnosis but with restrictions as they are, I don't know when I will have that opportunity again.

"As difficult as it is, I am very grateful that I have nursing during this time. I take great comfort in the fact that even though I can't be with my own mother in her time of need, at least I can give comfort to someone else's family member in their time of need.

"I would like to thank all the staff who have been caring for my mother – I will be forever grateful. To everyone else – please adhere to the public health guidelines so we can all hold our loved ones close again soon."

'There's a great sense of pulling together'

Mick Schnackenberg, emergency department nurse, Midland Regional Hospital, Tullamore

"It's a new environment and a new way of working. Nobody knows what's going to happen or what a surge might look like. Every day we are preparing and deep down we are hoping that day doesn't come. Everything is manageable at the moment, but we are waiting for it to get unmanageable and that is a frightening prospect. My family and friends feel very concerned for me and they worry about my health and the stress this situation brings.

"It's my job to look after sick people regardless of the situation. I also work with top-class people and there's nothing they can't do.

"There's a great sense of pulling together, open communication and support amongst our team. There's a sharing and caring attitude and it changes the barometer of your day for the better. Knowing we are all in this together and have each other's backs means the world to me and my family.

"The people of this country also give me hope. They are self-isolating and abiding by the social distancing guidelines. If we can keep the curve right down that would be an amazing achievement and one that I would be so proud of. I'm already proud of the effort everyone is making to flatten the curve.

"At the end of a day I feel tired, the emotional and mental exhaustion gets me. I try to leave it behind but it's impossible not to take it with you. Switching off apprehension is not that simple. Going into work I'm always reassured that I have a great bunch of colleagues, and you can't beat that."

'It's hard to comfort people when your smile is covered'

Anonymous, nurse

"A typical day starts off at 6.40am. I wash my uniform at 60 degrees while packing a bag with what seems to be a whole season's worth of clothes: scrubs, a spare uniform and the clothes to wear on the way home. I also pack a towel, shower gel, shampoo and a packed lunch and dinner. Sometimes I'm too tired on days off to plan my meals for the next two days of work.

"Work begins at 7.30am and progresses as one would expect, checking up on patients and delivering the best care we possibly can with new challenges.

"Some of the new-found challenges that came with Covid-19 include the use of PPE, which is very time-consuming and difficult. We wear gowns, masks, eye shields and gloves, and must put them on quickly and efficiently to avoid touching the fabric. Hand washing is as important as ever, especially for medical staff. I wash my hands so often that they are now raw and sore. It's hard to comfort people when your smile is covered by a mask and the warmth of your hand is covered by a rubber glove. The gowns can be difficult to work in considering the thick and scratchy material that leaves little room for ventilation, making them extremely warm and, by the end of the day, very sweaty.

"The hardest part of our job is trying to ease the minds of patients who are exposed to frightening information about an unknown disease. Waiting for swab results is nerve-racking and it's hard to comfort someone when you are wearing full protective gear."

'We are 100% there for one another'

Noeleen Kangley, intellectual disability nurse, An Driseoga Respite Centre, Navan

"Social distancing is a very difficult concept for the service-users where I work. They may understand there's a virus and that they need to wash their hands, but maintaining a safe social distance can prove difficult for them and for us due to the nature of our work.

"Lockdown has had a major impact, because it means a lack of family visits and changes to routines and services, which can be distressing. Our day and respite services have also had to stop, leaving many families at home providing 24-hour care. Knowing the toll this takes on people and how important support and regular breaks can be to families, it is very sad.

"When day and respite services closed many staff were redeployed, meaning new faces for the residents. New staff may not know the routine and everyone's likes and dislikes. As much familiarity as possible is key, and seeing routines and services stripped back is heartbreaking, even though I know it's crucial.

"Knowing that we're like extended family for the service-users keeps me going. My colleagues also keep me going with little chats and lighthearted moments. We are a team and we support and respect one another. We are also conscious of the obstacles outside of work such as childcare. We work together to be flexible and that really boosts morale within the team. We are 100% there for one another.

"Initially my family were concerned about me getting the virus but having changed my routine going to and from work, I have left those concerns behind for myself and my family. I think more about the service-users' families and how they

must be feeling. I have come to realise how important seeing people really is and we ensure regular contact is kept up through phone calls. We're in the process of introducing video calls for visual interaction.

"We are all grateful and proud as a team that we have managed to remain Covid-19-free for our service-users to date. We go above and beyond for them and we wouldn't have it any other way."

'There is nowhere else I would possibly want to be'

Siobhan Kenny, emergency department nurse, Mater Misericordiae University Hospital

"I have been a proud nurse for the past 16 years. For most of my career I have practised in the emergency department (ED) and in more recent years I have branched out into dermatology.

"Two months ago I was redeployed back to the ED as Covid-19 took hold. I was happy to return to help, to do what I could to not only help the community but to help alleviate the stresses this virus has put on my former department and my friends who work there. I was worried that I may have forgotten how to be an ED nurse given my time away from the department, but in true ED fashion I was assisted with my updating and upskilling from all disciplines and grades.

"The first thing that struck me on returning to the ED was the vital changes that have been made practically overnight. New pathways for patients to prevent cross-contamination, updated equipment, even adapted nursing and medical roles. I have always been inspired by the people who choose to work in the ED. They are a special breed of people: fearless, practical, warriors. They are the type of people who in the face of huge adversity, roll up their sleeves and dive in to get the job done without complaint.

"During this crisis I am acutely aware of how scary coming to hospital is for some of our elderly population. We know Covid-19 is incredibly dangerous for our older loved ones, and during this time no family members are allowed visit the hospital. Since I have returned to the ED, I have often worked in the resuscitation area and I see the fear in my older patients' eyes. They are afraid they will die and that they will never see their families again.

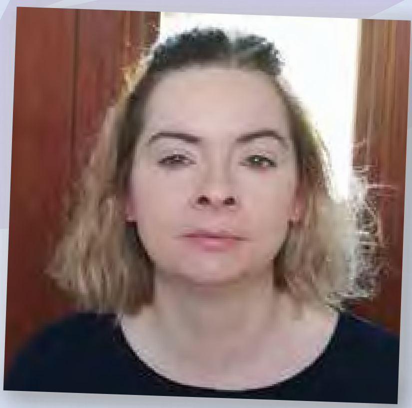
"I know that on a regular day, the nurse can be the only source of comfort for a patient; sharing a smile, a joke or a kind look. These days we are unrecognisable in our PPE, often looking alien to our patients. These days I hold hands with my patients and talk openly about their fears. I call their family members more often than I normally would with any little updates that are available, as I can imagine how I would feel if it were my parents.

"These are strange times but I feel

privileged to be in a position to help patients. I love being part of such an amazing, adaptable and dynamic team whose primary focus is always on holistic patient care.

"I am extremely proud to be an ED nurse and I am proud of my hospital. They have moved mountains to enable us to provide the best possible care to our community and I am proud of all my colleagues, clinical and non-clinical.

"I am also proud of my family, who constantly worry about my health and safety but also understand there is nowhere else I would possibly want to be during this pandemic but shoulder-to-shoulder with the Mater ED team."



'As an RNID I felt I needed to use my nursing skills and do my bit'

Pauline Miller, intellectual disability nurse, Muiríosa Foundation

"Prior to the May 13 I worked in a special school and in respite as a staff nurse. Both services closed so I have been redeployed. There was a period of time prior to redeployment when I was involved in converting the respite building into an isolation unit.

"At this time, I was not working directly with people who use the services, which afforded me time to identify what skills may be required for redeployment such as palliative care, administration of subcutaneous medications, donning and doffing. I began completing these courses online or in small groups to maintain social distancing.

"There was a lot of uncertainty at this time and plans changed regularly as we tried to apply directives from public health and HSE. Initially I was redeployed to a residential unit. From there I went to work in a facility that was created specifically to assist in providing isolation nursing for people with intellectual disabilities that contracted Covid-19. The work environments were completely different from what I normally did, but I felt my time spent attending courses had helped me to adapt.

"Unfortunately I contracted Covid-19. I isolated in a bedroom within my home. This was difficult as I have two children, but my husband kept the house going and luckily nobody else in my home became symptomatic. I'm still recovering as I now have a chest infection secondary to the virus.

"At the beginning of this national crisis I felt, as an RNID, I needed to use my nursing skills and do my bit. The people I work with are particularly vulnerable to the virus and I wanted to help alleviate their discomfort by providing nursing care and supporting their families.

"Nursing a person with an intellectual disability in isolation can be further complicated by their understanding of their illness, behaviours of concern, complex physical and sensory disabilities and inability to understand or follow social distancing guidelines.

"My family were very worried when I contracted the virus. My children were upset but it helped when they saw me every day, albeit through a window or on the patio. I still feel a little daunted about returning to work. I still feel that need to do my bit and provide nursing care, but I'm worried about contracting the coronavirus again.

"I'm proud to be an RNID and I'm proud to play my part in the work that is being done in the disability sector."

We can and we must protect healthcare workers from the effects of caring in a pandemic, writes **Steve Pitman**

PTSD and Covid-19: A consequence of caring

THE Covid-19 pandemic is unprecedented in modern healthcare and has placed extraordinary pressure on nurses and their healthcare colleagues. Nurses have been traumatised and emotionally affected by the Covid-19 pandemic. Many are at risk of psychological distress, burnout, anxiety, depression and post-traumatic stress disorder (PTSD).[1] PTSD is an issue of increasing concern which had been heightened by the current crisis.[2] This article will focus on the nature of PTSD, its presentation and impact, and the need to recognise and treat the condition.

Background

During the crisis, the need for nurses to balance their professional duty of care with their responsibility to look after and care for their family and loved ones had placed a huge burden on nurses. This can often evoke feelings of uncertainty, dilemma and helplessness. Due to the sheer number of infections, nurses and other healthcare workers have been working, and continue to work, in extremely challenging and traumatic situations, often for weeks, combating the virus.

This increasing demand is unsustainable as it drains physical and mental resources, which takes a toll on each person. The strategy to flatten the curve has had the positive impact of safeguarding the health service. However, we will see the continuation of the emergency for the remainder of this year and probably into 2021.

At the time of publication, more than 1,600 people had died in Ireland from Covid-19 (**www.doh.gov.ie**). In the region of 40% of people died in the hospital setting, but the largest number of deaths (over 60%) occurred in the community residential care setting. The experience of caring for this number of residents, patients and their families and the associated deaths over such a short period creates a highly stressful caring environment. This is further exacerbated by the necessity to wear, often uncomfortable but vital, personal protective equipment and the barrier that it creates between the nurse and the patient.

Figure 1: ICD-11 characteristics of post-traumatic stress disorder *(https://icd.who.int)*

- The re-experiencing of the traumatic event or events can present as vivid intrusive memories, flashbacks or nightmares. These are often accompanied by strong or overwhelming emotions, particularly fear or horror, and strong physical sensations
- The avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event or events
- Persistent perceptions of heightened current threat, for example as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises

A student nurse in Northern Ireland made an essential point that as nurses "we may be perceived as superhuman, but we're not". She said: "It's tough out there. We're human." This is important because nurses are vulnerable, just like every other member of society, and they need protection and support.[3]

What is PTSD?

PTSD is a psychiatric disorder that results from exposure to an extremely threatening or horrific event or series of events (**ICD-11 http://icd.who.int**). The symptoms associated with PTSD[4] include:

- Re-experiencing
- Avoidance
- Hyperarousal (including hypervigilance, anger and irritability)
- Negative alterations in mood and thinking
- Emotional numbing
- Dissociation
- Emotional dysregulation
- Interpersonal difficulties or problems in relationships
- Negative self-perception, including feeling diminished, defeated or worthless (see *Figure 2* for further details on this).

PTSD in the workplace can result as a consequence of a single, repeated or multiple events associated with work-related exposure to trauma and suffering.

Nurses are at particular risk due to direct or indirect exposure to traumatic events while providing care. It is essential to recognise that it is normal to experience upsetting memories and feelings following a traumatic event. However, it is crucial to understand the need to seek help when symptoms persist for more than several weeks and when they have had a negative impact on personal, family, social, educational, occupational or other important areas of a person's life.[5]

The lifetime prevalence of PTSD in the general population is reported as 5.6% in Europe[6] and 10.1% in the US.[7] The reported prevalence of PTSD in nurses varies significantly, ranging from 6.7% to 95.7%.[2] The inconsistency of measurement largely explains the difference in the reported prevalence of PTSD. Schuster and Dwyer[2] found that some studies measured prevalence based on symptomatology while others used diagnostic criteria.

However, prevalence rates do highlight PTSD as a problem. Following a SARS outbreak in 2003 some 20% of nurses and doctors experienced PTSD.[8] In the current Covid-19 pandemic it has been estimated that the risk of PTSD for frontline staff in this pandemic could be greater than 10%.[9]

Factors that contribute to workplace

Figure 2: Factors that contribute to the development of work-related PTSD among nurses

Workplace matters	This factor includes five sub-themes: the nurse's role, exposure, workplace frustrations, perceptions of care and organisational support. There is some evidence to indicate that years of practice and type of specialty are important factors that can influence the development of PTSD. Exposure to violent and aggressive behaviour and other similar disconcerting events have been linked to the development of PTSD symptoms. Frustration in the workplace is a sub-theme that is associated with dealing with non-nursing issues, feeling overextended, inadequate safe staffing and lack of resources. The perception of 'poor' or substandard patient care has also been identified as a contributing factor. The most crucial component of organisational support is the availability of organisational debriefing following a traumatic event
Relationships	The sub-themes related to relationships at work and at home. A supportive work environment is seen to have a protective effect due to the availability of social support. Conversely unsupportive workplaces contribute to PTSD in nurses. Outside of work, family and friends play a significant role in providing social support which limits the development of PTSD symptoms
It hurts to care	The two sub-themes are dealing with the death of a child or adolescence and witnessing suffering. The exposure to neonatal and paediatric death is a heightened toll on nurses. Exposure to the death of a child is seen as unnatural and is one of the most frequently reported traumatic events. Similarly, witnessing suffering regardless of age when working with a patient following trauma or as a result of chronic illness. This is particularly the case when the nurse identifies or build a close relationship with the patient
Interpersonal strengths	The three sub-themes for this factor are coping, personality and resilience. Coping strategies play a crucial role and can be both effective and ineffective. An active and problem-solving approach along with access to social support has been shown to be beneficial in reducing psychological distress and fatigue, while avoidance and emotional coping approaches are seen to have a negative effect. Personality traits such as extraversion are negatively related to PTSD symptoms. In contrast neuroticism and type D personality ('distressed') are positively associated with PTSD symptoms. Nurses who have high levels of resilience ('personal competence' and perseverance) are less likely to experience PTSD

PTSD

Schuster and Dwyer identified four key factors that they believe contribute to the development of work-related PTSD among nurses. These are workplace matter, relationships, 'it hurts to care' and interpersonal strengths *(see Figure 2)*.[2]

Now what?

An approach to prevent, identify and care for nurses with PTSD must include governmental and organisational action. Personal emotional and psychological self-care and relationships are also important. The four characteristics identified by Schuster and Dwyer[2] provides a framework to help understand PTSD among nurses. This framework can be useful to help develop organisational, personal and relationship strategies to prevent and to care for nurses who experience PTSD.

Individual nurses react and cope with psychological distress in different ways and draw upon many different coping mechanisms. Nurses need to look after themselves to enable them to look after others. An understanding of the signs and symptoms of PTSD is important to ensure that help is sought at the earliest possible opportunity.

Prevention by reducing stress through eating well, taking exercise, ensuring good sleep and connecting with family and friends are important. Social connectivity is vital as it enables any burden to be shared and support to be accessed from others.

There is a range of psychological and pharmacological interventions available to prevent and manage PTSD. Further information about effective and evidence-based treatments is provided by the National Institute for Health and Care Excellence (NICE) in the UK.[4]

> **Actively monitoring**
>
> "This means regularly monitoring a person who has some symptoms but who is not currently having clinical intervention for the condition" – NICE 2018

In the clinical environment, nurse managers play a critical role in leading their team through this arduous period. They are central to supporting nurses to ensure they are well and able to care into the future beyond the current troubling times.

A minority of health services workers will need support and treatment for PTSD once Covid-19 has peaked and is eventually controlled. The role of healthcare managers in proactively taking steps to protect the mental wellbeing of staff is of critical importance.[10] Their role includes preparing for the psychological impact on individuals once the crisis recedes.

This can be achieved by actively monitoring and supporting staff and by employers providing access to evidence-based treatments. Employers in both the public and private sectors must support nurses suffering the mental health consequence of the Covid-19 pandemic. This will be particularly important within the community residential setting which has seen (to date) the highest percentage of Covid-19 deaths in Ireland. Employers must ensure that appropriate and funded employee assistance programmes are in place to support nurses.

Further research is required into the causes and signs of PTSD in nurses and the intervention that can be put in place to mitigate the problem and to treat PTSD when it presents. This pandemic is a new experience for the health service in Ireland, and we must care for healthcare workers injured as a consequence of caring. The lessons must be learned to enable us to ensure that we are prepared, and we can protect nurses and other healthcare workers from the physical and psychological consequences of the pandemic.

Steve Pitman is INMO head of education

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

RNID Section
Tuesday, 15 September 2020
The Richmond Education and Event Centre

Telephone Triage Nurses Section
Tuesday, 13 October 2020
Midland Park Hotel, Portlaoise, Co Laois

All Ireland Annual Midwifery Conference
Thursday, 5 November 2020
The Richmond Education and Event Centre

Public Health Nurse Section
Saturday, 28 November 2020
The Richmond Education and Event Centre

Occupational Health Nurses Section
Date to be confirmed
Venue to be confirmed

Operating Department Nurses Section
Date to be confirmed
Venue to be confirmed

For information contact
Jean Carroll,
Section Development Officer,
by email: jean.carroll@inmo.ie
www.inmoprofessional.ie

Messages of support

Many members of the public want to show support to local frontline workers but that can be difficult when we have to observe social distancing measures. People have come up with different ways to share the message and we want to give you a flavour of some these tributes to our brave frontline workers. This is a selection of some of the images we have been sent from around the country. Artist Emma Blake from Tallaght designed a number of Covid-19 themed murals to encourage people to stay home and observe social distancing. She also created a wonderful piece inspired by the iconic World War II image of Rosie the Riveter but featuring a nurse instead. Her work on walls in her local area inspired local children to send her their artwork. She then reproduced their work on a wall in Kingswood including depictions of the children who sent them to her – some of these are pictured here. If you would like to send us photos of artwork in your area please email high resolution photos to: Freda.hughes@inmo.ie

A REMINDER

If you have qualified since 2019 and have **completed 16 weeks of work post internship** (including pre-reg experience), under the strike settlement you get to skip the 2nd point of the salary scale and **progress straight to the 3rd point, worth €32,734** in basic salary. **If you qualified in 2018** and are still on the 2nd point, you get to **skip the 3rd point, go straight to point 4, and can apply for the Enhanced Practice contract.** You may also be entitled to the **new medical/surgical ward allowance.** Many of you will have moved up the scale and had the location allowance applied automatically, but be sure to check with your payroll/HR department.

If you have any questions, please contact;

Catherine O'Connor,
INMO Student/New Graduate Officer
Email: **catherine.oconnor@inmo.ie**

If you are not a new graduate but have questions about your pay, please contact INMO Information Department.

INMO
Irish Nurses and Midwives Organisation
Working Together

Recruit a Friend

And We Will Give You a €20 One4all Gift Card*

One4all Gift Cards

Please recruit your friend/colleague and ask them to complete an INMO new member Application Form (*please contact any INMO office for a supply of Application Forms*). Insert <u>your</u> name and INMO membership number on the 'Recruited By' portion of the application form at the end of Section 1.

*For every new member or re-joining member recruited, you receive a €20 One4all Gift Card.

Workers' memorial day

President Higgins pays tribute to health workers and remembers those who lost their lives in the practice of their work. **Freda Hughes** reports

WORKERS' Memorial Day, on April 28, is an international day of remembrance of workers who lost their lives in the workplace. It is recognised by the International Labour Organisation and the International Trade Union Confederation as International Workers Memorial Day. This year it was a particularly poignant day falling in the midst of the Covid-19 pandemic and at a time when social distancing and lockdown measures greatly impact the sort of events and memorials that can be held.

President Michael D Higgins laid a wreath at 'The Plough and Stars' monument on the grounds of Áras an Uachtaráin in memory of all those who lost their lives in the practice of their work, while fighting for the right to organise or for the right to decent working conditions. He paid special tribute to health workers who make up more than one-quarter of all Covid-19 cases and to all those who selflessly responded to the needs of others and put their own health at risk for the health and safety of all.

He said: "This year is a time of unprecedented risk for those working in the health service and in essential services... We owe them an enormous debt of gratitude. However, gratitude is no substitute for dignity, well-being and security of employment. That is the right of all workers in any fair and inclusive society... Praise alone will not adequately protect the lives of vulnerable workers nor safeguard them from subordination to economic efficiency. It is only by closing the gap between words and action in relation to conditions, safety and provision that we can sufficiently and ethically commemorate those workers we honour here today."

A nurse, a postal worker, a firefighter, a cleaner and a retail worker were asked to take part in the socially distanced ceremony in the grounds of the Áras. President Higgins commented on the "wisdom that has been unearthed during the Covid-19 pandemic with regard to the value we place on frontline workers and those providing essential services across the economy."

Karen McGowan, an advanced nurse practitioner at Beaumont Hospital, represented nurses and midwives on behalf of the INMO. Ms McGowan said: "I was very proud to represent the nurses and midwives of Ireland on this special occasion. Considering the times we are in, it was even more important to be represented. I was truly humbled to be there."

In Ireland and the UK, the ICTU and the TUC organised a 'Light a Candle to Remember them' event in memory of all workers who have died from Covid-19. People were encouraged to photograph their candle and share it on social media as a way of coming together in this time of social distance. ICTU, IBEC, the Health and Safety Authority and the Construction Industry Federation have also pledged to work together in the aftermath of the pandemic to ensure health and safety in the workplace are given precedence.

The INMO wrote to the Department of Health's chief clinical officer in early April calling for new measures to be put in place with regard to the use of PPE in healthcare facilities. On April 22 the INMO welcomed a change in national policy, which now mandates facemasks in all settings for any healthcare workers who provide care within two metres of a patient. It also applies to any of their colleagues who come within two metres for more than 15 minutes. In practice this will mean nearly all frontline healthcare workers will wear facemasks. This will not only benefit frontline healthcare workers but will reduce the risk of transmission to patients.

On May 7, Dr Tony Holohan, chief medical officer at the Department of Health, stated that 6,473 healthcare workers had contracted Covid-19 by that date, making up 28.7% of all cases. He gave a further breakdown of that figure, stating that 27% of those healthcare workers were male and 73% were female. Of the 239 healthcare workers who were hospitalised, 38 had been admitted to an intensive care unit (ICU) at some point. He also acknowledged the five tragic deaths of healthcare workers in Ireland since the beginning of the pandemic. These stark figures bring the need for protection in the workplace into sharp focus.

President Higgins ended his speech with a strong call for workers' rights and union recognition across all sectors.

"Let us recall the battle cry of Cork-born activist Mother Jones and the motto that lies at the heart of this important day: 'Remember the dead. Fight like hell for the living.' Today as we remember those workers in our shared history, some who lost their lives on the right to decent work, some on the right to organise, some in the practice of their work. Let us ensure their legacy will be an enduring one. Let us commit to continuing our appreciation by being in solidarity with all those whose contribution is so vital. During this difficult time recognising and enabling their right to protection, to be represented, to participate, to job security and decent working conditions now and into the future where work will, in an enduring way, be recognised for the defining human activity that it is."

Pictured above on April 28 were President Michael D Higgins with his wife Sabina Higgins and representatives of key workers who have lost their lives while at work, including Karen McGowan representing nurses and midwives

Enhanced Salary Scale

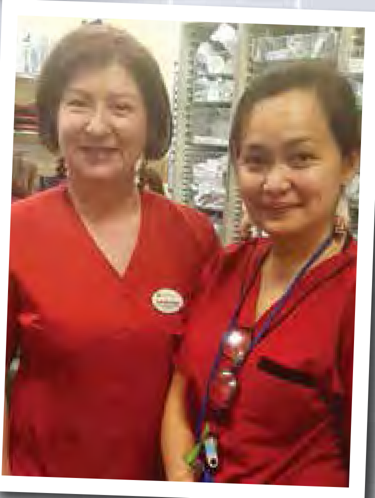
Have you applied for the Enhanced nurse/midwife salary scale?

Do it now!	The enhanced scale has higher pay at every single point of your career! All staff nurses and midwives with 1 year and 16 weeks experience (or more) can apply. You can apply to join now and it will mean higher pay from any increment date you have after 1st of March 2019. If that date has already passed – you'll get back pay! Full details are available from the INMO, with some common questions below.
What do I have to do?	1. Complete the verification form and return it to your Director of Nursing/Midwifery 2. Tick the 6 boxes, sign and date. It is important that you do this IMMEDIATELY as delaying puts at risk the monies due to you. Please ensure that you retain a copy/photo of your application. 3. You will be asked to sign the contract.
New Contract	The new scale comes with a new contract. But there are no negative consequences of signing the new contract. Below are answers to some of the common questions the INMO has received.
Will this affect my pension?	Only in a good way. There are no negative effects upon your pension as a result of signing the new contract. Your service is maintained. You remain on your present pension scheme. There is no break in service and the enhanced scale is not a promotional post. There are no negative consequences for your pension, there are only benefits, as you will be earning a higher salary and your pension will be based on this higher salary.
Do I have to serve a new probationary period?	No. If you've completed your probation as a staff nurse/midwife, you won't have to serve probation again. Section 3.3 of the new contract clearly states that "where you have already completed a probationary period with the employer, or completed 12 months temporary employment, no period of probationary employment applies to this contract of employment."
Can I be redeployed to a new location?	The present protections around redeployment still exist within the new contract so therefore there is no greater risk of redeployment than what currently exists.

If you have any queries, with regards to the contract of employment, please contact your local INMO Official.

We recommend completing the verification form and submitting it to your Director of Nursing/Midwifery as soon as possible. A delay runs the risk of missing out on back pay, should your next incremental date come up.

Celebrating nurses and midwives in 2020



LAST month saw the marking of both the International Day of the Midwife (May 5) and International Nurses' Day (May 12) as people around the world shared their appreciation for both professions. This year the celebrations took on a different tone as they took place in a global pandemic. During this time nurses and midwives on the frontline have been working harder than ever to care for their patients.

Speaking on the International Day of the Midwife INMO general secretary Phil Ní Sheaghdha said: "As Covid-19 puts pressure on our health service, midwives are there for mothers and babies, providing care, comfort, advocacy and advice. While much has been put on hold during the pandemic, childbirth has continued as normal. The skill and dedication of midwives not only deserves recognition but support."

The public demonstration of gratitude towards nurses throughout the pandemic and especially on International Nurses' Day has been humbling. Ms Ní Sheaghdha said: "During Covid-19, International Nurses' Day has taken on an even stronger meaning for the public and our members. We must ensure that frontline staff are given the support and resources they need. To provide safe care, we need to build up our staffing levels. Ireland must continue to recruit staff from around the world, but also to train more here in Ireland."

This is just a small selection of the images that were sent in to us from around the country to celebrate the International Day of the Midwife and International Nurses' Day 2020. For more please see: **www.facebook.com/irishnursesandmidwivesorganisation/ www.instagram.com/inmo_irl/** and **twitter.com/INMO_IRL**

Celebrating the Past, Present and Future of Public Health and Community Nursing in the International Year of the Nurse and Midwife

Saturday, 28 November 2020

The Richmond Education and Event Centre, North Brunswick Street, Dublin 7

Topics will include, amongst others:

- **Nursing and Midwifery Response to the Covid-19 Pandemic**
- **Perinatal Mental Health**
- **Caring for People in Direct Provision**
- **Working with Marginalised Groups**
- **Concurrent workshops:**
  1. Wound Care
  2. Breast Feeding
  3. Mindfulness (Self Care)
  4. Childrens Nursing Strategy
- **Panel Discussion on the Future of Public Health and Community Nursing in Ireland**

To book a place please contact the INMO
Tel: **01 6640641/18 or visit www.inmoprofessional.ie**

INMO: celebrating Pride

As Pride approaches, the INMO underlines its solidarity with its LGBT+ members and patients, writes **Steve Pitman**

THE INMO stands in solidarity with LGBT+ members, patients and the broader community in the fight for equality and the fight against discrimination and hate crimes.

The Covid-19 pandemic has severely disrupted health services in Ireland. This disruption has caused anxiety and difficulties for many people with health needs, including LGBT+ people. The problem of loneliness and isolation has increased the risk of mental health and general wellbeing difficulties across the country.

For the transgender community, access to services for injecting hormone replacement therapy has been a particular issue. The importance of healthcare and the ability to access services has been brought into sharp focus as never before.

Amid the current crisis, it is essential to connect and celebrate. The INMO wishes its members and the LGBT+ community an enjoyable Pride 2020. Pride is a time to celebrate diversity, but the parade is only one day. The fight against discrimination and for equality takes places every day in the workplace, at home and in society.

Pride 2020

In common with all aspects of society, the Covid-19 pandemic has disrupted Pride 2020. However, the celebrations have been changed, not cancelled. This year will see the launch of the first Digital Dublin Pride Festival with a fully interactive virtual Pride Parade and a Pride Concert. Buildings will still light up for Pride, and flags will be flying high across the city. In keeping with these troubled times, the theme for this year is 'In This Together'. The virtual festival takes place between June 18-28.

LGBT Ireland

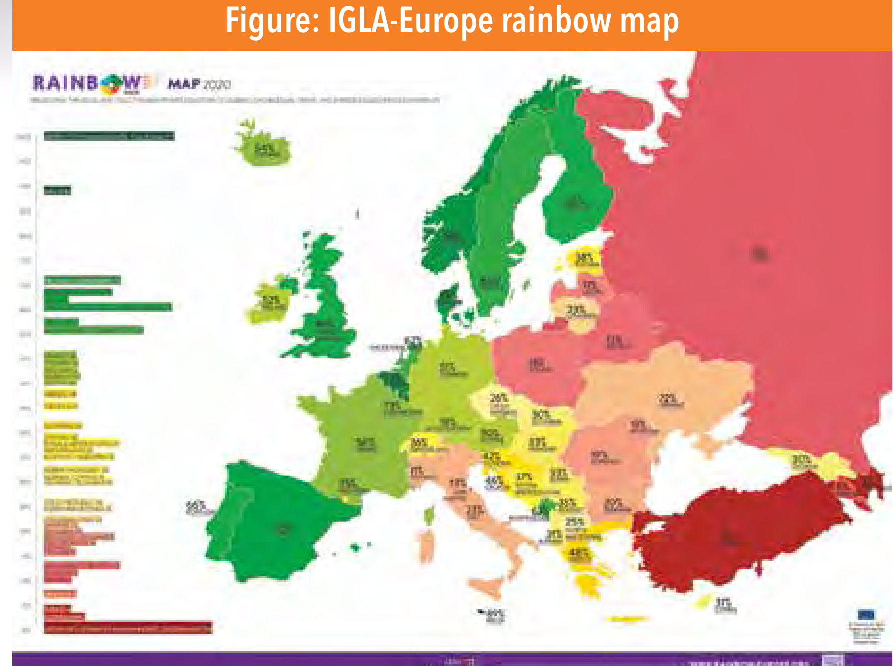
In May, LGBT Ireland launched its annual report: *For Equality, For Inclusion, For Everyone*. The report was launched in advance of the International Day Against Homophobia, Transphobia and Biphobia (IDAHOT), on May 17, 2020.

The statistics from LGBT Ireland highlight that overcoming stigma and discrimination remains the most significant challenge for those who contact their service. The report also outlines legislative, policy and practice gaps which must be addressed for all LGBT+ people living in Ireland to be able to live free from discrimination.

Additionally, in May, ILGA-Europe launched its 2020 Rainbow Europe Map *(see Figure)*. This occurred on the same day the EU Fundamental Rights Agency launched the second LGBT survey. Across Europe for the second consecutive year, countries are moving backwards on the Rainbow Index, as existing protections are disappearing.

The index shines a spotlight on the continuing struggles facing LGBT+ people to have their rights recognised and protected, providing a broader context to position LGBT Ireland's report and the vital role the Irish government has in protecting and advancing LGBT+ rights at home and globally.

Figure: IGLA-Europe rainbow map



To view the interactive map online go to: https://bit.ly/ILGArainbowmap

Key messages from LGBT Ireland

Ireland has made huge strides in progressing LGBT+ rights and inclusion over the past decade as shown by the outpouring of support towards LGBT+ citizens during the marriage equality referendum, by the tens of thousands of people who turn out each summer to celebrate Pride and through the development of two government strategies that commit to progressing LGBT+ equality.

Yet, despite all this progress, Ireland ranks 18th in Europe on LGBT+ law and policy, according to ILGA-Europe. This signifies the work that is left to be done in law and policy reform, particularly in combating incitement to hatred and hate crimes against LGBT+ people, by developing robust hate crime and hate speech legislation. More work is also needed in many other policy areas, including in protecting LGBT+ people seeking international protection here in Ireland and in progressing legislation that will enable all LGBT+ families to be legally recognised.

KEY DATES

01 Jun 2020	Online submission of abstracts opens
31 Jul 2020	Online submission of abstracts closes
October 2020	Applicants notified of acceptance
01 Oct 2020	Online registration opens
12 Feb 2021	Deadline for registration of abstract presenters
12 Feb 2021	Early bird registration deadline ends
05 Jun 2021	ICN 2021 opens

5-9 June 2021
ADNEC - Abu Dhabi
United Arab Emirates

#ICN2021 #ICNCONGRESS

Congress Secretariat: icn2021@icn.ch

www.icn.ch/events/icn-congress-abu-dhabi

CALL FOR ABSTRACTS

INTERNATIONAL COUNCIL OF NURSES 2021

Congress and Exhibition

Nursing the World Together

INMO EDUCATION PROGRAMMES

INMO Professional

Continuing professional development for nurses and midwives

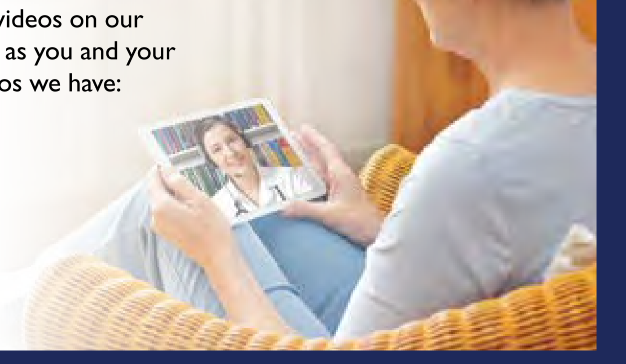
INMO cancels/ postpones training due to Covid-19 – latest updates

Online Covid-19 Resources for Nurses

With so much beyond our control, INMO Professional has a number of videos on our website providing you with advice and support in or out your workplace as you and your colleagues tackle Covid-19. The following is a sample of some of the videos we have:

- Debriefing and Wellbeing
- Practising Mindfulness during Covid-19
- Checklist for Covid-19
- HIQA Inspections in care of the older person setting (three videos)
- Yoga, breathing and relaxation exercises
- Interview techniques (three videos).

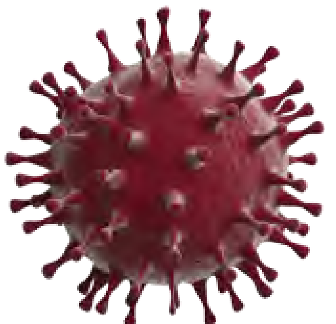
To find out more visit **www.inmoprofessional.ie**



Programmes Cancelled or postponed

Please note:

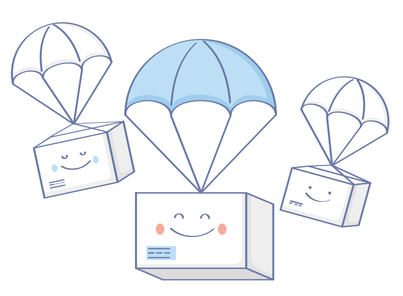
All courses, events and study days up to mid July are now cancelled or postponed to a later date. However, we will continue to monitor developments and provide regular updates on our website. If a date has to be cancelled, staff will make contact with everyone booked on the event by email to advise them of alternative arrangements. If you need to contact us please email: education@inmo.ie or call 01 6640641/18



On-site Education

In these unprecedented times we would like to let you know that INMO Professional is here to support you. If you would like to discuss or provisionally book any on-site training please call Marian Godley, course co-ordinator at Tel: 01 6640642 or email marian.godley@inmo.ie

Our on-site programmes feature the same high-quality content you have come to expect from us. We will continue to monitor the ongoing situation and we very much hope that we can return to classroom training soon which of course is subject to public health advice.

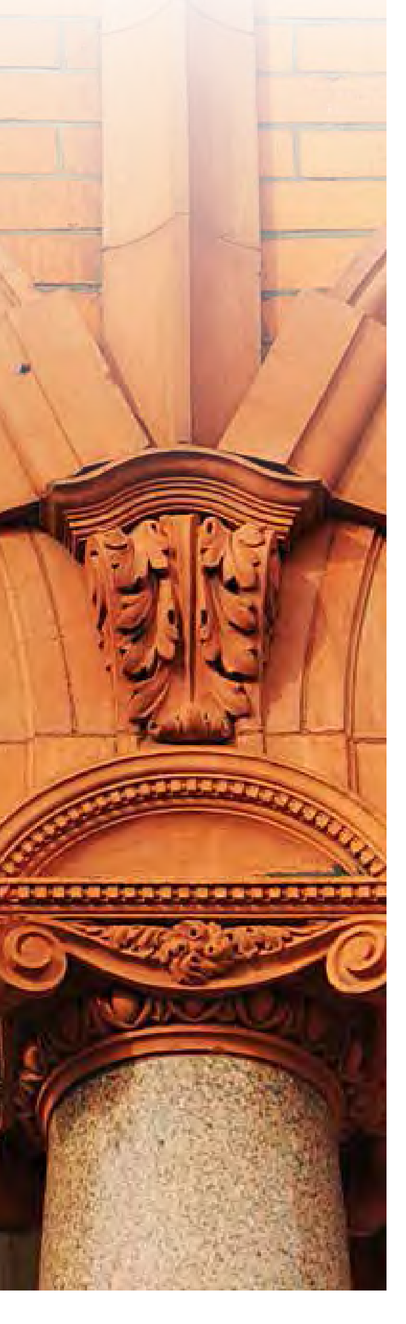


Maintaining your competency, Maintaining your registration

June 2020

PULL OUT

Steve Pitman
Head of Education and Professional Development



AS THE lockdown restrictions are eased and the government starts to open the country, the threat of Covid-19 remains ever-present. The phased approach to reopening the economy and society is designed to monitor and reduce the impact of a second wave of infection. Covid-19 will continue to be a major problem until a vaccine and other treatments are found. In addition to the risk of infection, the crisis has created a backlog in the delivery of planned and scheduled care. This will become one of the main challenges facing the health system into the future and will also have implications for education and training.

Education and Covid-19

Social distancing requirements place significant restrictions on the ability of organisations to offer face-to-face education and training. Significant changes will be seen in the approach taken by universities and colleges to ensure the safety of students and staff. These changes will require all organisations to adapt to the 'new norm' in society, at least until Covid-19 can be prevented and treated.

While this does pose a challenge, it is also an opportunity to explore new ways of delivering professional education; online and blended learning functions have been slowly integrated into many undergraduate and postgraduate programmes over the past decade, resulting in a significant shift in the approach to teaching – with varying degrees of success.

During any crisis, there is a necessity for individuals, organisations and society to evolve to ensure their survival. Over the past few months, most of us have been challenged to become familiar with new technological methods of communication; the use of Zoom and Microsoft Teams has helped to keep us connected with work and with our families. It is now commonplace for work team meetings and social activities to be carried out online. Webinars and online conferences have replaced many of the traditional approaches, at least in the short-term.

These approaches to communication and learning will become a key feature of how we interact, even after the Covid-19 pandemic is over. However we do need to be cautious about losing the importance of direct human interaction, which is at the heart of learning. Learning is more than the consumption of knowledge and is deeply rooted in the ability to question and explore ideas in an environment that stretches and challenges individuals and groups.

The social psychologist and learning theorist Lev Vygotsky argued that "social interaction is the origin and engine of learning". Nursing and midwifery are practice-based professions that involve interacting and communicating with people. New approaches to learning that are introduced in response to the current crisis must reflect the social and cultural norms of the nursing and midwifery professions.

Education and training courses

INMO Professional education and training courses have been curtailed due to the Covid-19 crisis. We will recommence courses based on public health advice and the lifting of restrictions. In the meantime, to assist members, we have developed a number of short information videos related to the care of the older person setting and 'caring for oneself'.

Other resources are currently being developed and will be available on the INMO Professional website, **www.inmoprofessional.ie**

A number of webinars have also been scheduled, including the recent Covid-19 care of the older person webinar. Planning is also underway to host online section conferences in the autumn, about which further information will be available in future issues of this journal, on the INMO Professional website and via your section.

If you have any suggested topics for sessions that you feel would be of use at this time, please get in touch and let us know at education@inmo.ie.

RCM resources available to INMO members

Don't forget to sign up for free access to the full range of updated Royal College of Midwives (RCM) professional development resources. If you are a midwife – including public health nurses, practice nurses and students – to register for free access to the RCM online resources, visit **www.inmoprofessional.com/RCMAccess**

On-site education

INMO Professional offers an extensive range of on-site quality programmes facilitated by expert practitioners. If you are interested in booking continuing professional development courses for your organisation, please contact Marian Godley by email: marian.godley@inmo.ie or at Tel: 01 6640642

Delivering courses and writing for WIN

If you are an advanced nurse/midwife practitioner or a clinical nurse/midwife specialist with expertise in clinical/management practice, get in touch about delivering a course.

We are also interested in hearing from members who are interested in writing professional or clinical articles for *WIN*. Please email me at steve.pitman@inmo.ie

Education Programmes

All programmes have Category I approval from the Nursing and Midwifery Board of Ireland (NMBI) with Continuing Education Units (CEUs).

Venue: INMO Professional,
The Richmond Education and Event Centre,
North Brunswick Street, DO7 TH76
Dublin 7

Tel: 01 664 0618

Email: education@inmo.ie

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

Date	Programme	Fee	CEUs
Aug 13	**Getting the Most out of your Library: Advanced Searching Techniques** This programme is aimed at nurses and midwives who would like to develop their information-seeking skills in order to avail of the most up-to-date information for clinical practice, reflection and policy development. This programme will assist participants who are undertaking academic programmes and will provide them with valuable lifelong skills in information literacy. Guidance will be provided on the use of keywords, Boolean logic and limiting and broadening of results. The programme involves a practical element whereby participants will have the opportunity to develop a search strategy and use it to search a database. Strategies for the evaluation and critique of online resources will be discussed.	€90 members; €145 non-members	5.5
Aug 27	**Phlebotomy** This programme provides participants with the skill and theory to perform phlebotomy in a competent and safe manner. It will cover: sites used for phlebotomy, criteria for evaluating a vein, principles of an aseptic technique as well as complications that may arise during and after the procedure. Guidance will be given on how to reassure the individual in relation to the procedure and on gaining their consent. While this course will provide the necessary skills to undertake phlebotomy, it will be necessary for each participant to ensure they abide by their workplace policy on phlebotomy and hold an up-to-date hand hygiene training certificate (within the last two years).	€90 members; €145 non-members	4
Sep 9	**Wound Care Management** This programme will allow participants to ensure professional competency in the area of wound care as per the NMBI Code of Professional Conduct and Scope of Practice for Nursing and Midwifery, which states that nurses must work within their competence. Furthermore, it will provide participants with the knowledge to ensure that their practice is founded in the latest research and guidance.	€90 members; €145 non-members	5
Sep 9	**Tools for Safe Practice** This programme provides safe practice tools to protect the nurse and midwife and patient within current health care settings. This is an awareness session to ensure all staff have an understanding of the process involved regarding patient alerts, clinical incidents and thorough assessment, while remaining focused on patients and individual staff. The programme addresses patient safety and staff safety and provides five key tools on areas of documentation, clinical incident reporting, safety statements, best practice guidelines regarding assessment and communication practices in a complex multifaceted healthcare arena.	Free for members; €150 non-members	4
Sep 10	**Introduction to Leadership for Nurses and Midwives** The aim of this course is to introduce participants to leadership concepts, approaches and skills that can be applied to their managerial and leadership practice. At the end of the course participants should be able to identify and understand key leadership concepts, approaches, understand the role of leadership within the healthcare setting, appreciate the relationship between leadership and management, link leadership concepts with their clinical and managerial practice and reflect on their own preferred leadership approach.	€90 members; €145 non-members	5.5
Sep 15	**Best Practice in Medication Management** This programme supports nurses and midwives in providing safe, evidence-based practice in the area of medication management. It will cover topics such as: the key principles of medication management, the medication management cycle, management of controlled drugs and medication safety. It will explore relevant policy and legislation and will present scenarios in order to illustrate the various principles. Participants will have the opportunity to update their knowledge in line with NMBI and HIQA requirements for medication management.	€90 members; €145 non-members	5

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Date	Programme	Fee	CEUs
Sep 15	**Intravenous Administration of Drugs** This course educates participants on how to administer drugs by the intravenous route. It will promote awareness of accountability in undertaking this role. The task of undertaking drug calculations will be outlined and demonstrated. Principles of aseptic technique, giving the patient information on the procedure, gaining consent, and complications that may arise before, during and after the procedure will also be explored. While this course will provide the necessary knowledge and skills to undertake intravenous administration of drugs, it will be necessary for each nurse and midwife attending to ensure that they abide by their local policy on intravenous administration of drugs in their place of work. Students are required of have undertaken a course in the management of anaphylaxis.	€90 members; €145 non-members	5
Sep 16	**Introduction to Change Management for Nurses and Midwives** At the end of this programme participants should be able to: identify and understand key change management approaches; understand the nature and process of change within the healthcare setting; appreciate the importance of managing stakeholders as part of the change process and apply change concepts with their clinical and managerial practice and reflect on their previous experience of change.	€90 members; €145 non-members	5
Sep 16	**Competency-based Interview Skills** This programme is designed to assist participants to prepare for a competency-based interview, based on the premise that past experience can predict future behaviour. This is an increasingly common style of interviewing that enables candidates to show how they would demonstrate certain behaviours and skills in the workplace by answering questions about how they have reacted to and dealt with previous workplace situations. The programme will provide an overview of CV development and outline the steps in the interview process. Role play will be used to ensure that participants are able to communicate their knowledge and experiences effectively for any future interviews.	€90 members; €145 non-members	6
Sep 17	**Delegation and Clinical Supervision** This programme is aimed at all nurses, midwives and clinical nurse and midwife managers who work with healthcare assistants. It explores the issues surrounding delegation and decision-making, including appropriate clinical supervision for delegated functions. Participants will learn the difference between clinical and managerial delegation and how delegation differs from assignment of a task. Guidance will be provided on the assessment of a delegate's experience and role, and how best to match appropriate clinical supervision to a specific delegated function. The professional, legal and quality of care issues involved when deciding to delegate a function will also be explored.	€90 members; €145 non-members	5
Sep 22	**Strategies for Managing Conflict** This programme presents a practical approach for dealing with conflict. Using group work, self-evaluation and case-study based discussion, it will demonstrate the knowledge, skills and confidence needed to intervene at an early stage to resolve conflict situations before they escalate. Real and perceived differences between people can spiral out of control. Conflict is not necessarily destructive; managing conflict effectively may result in positive outcomes such as new ideas and the development of positive communication, active listening and problem-solving skills.	€90 members; €145 non-members	6
Sep 23 & 24	**Management in Practice** *(two-day workshop)* This two-day programme is an intense, comprehensive and participative workshop developed to improve effectiveness in managing people and processes. The programme is focused on the changing role of management, as well as coaching, motivating and developing participants. It will stimulate participants' thinking and guide them through a review and assessment of how to put managerial skills into practice. Respected well-trained managers boost morale, and improved morale boosts staff retention. The programme will guide nurses and midwives in how best to encourage colleagues to realise their potential so that standards, competency, skills and exceptional care is provided at all times.	€230 members; €350 non-members	11
Sep 29	**Mindfulness and Meditation in Holistic Nursing and Midwifery Care** Mindfulness and meditation practice can bring positive change both personally and professionally. This programme aims to harness the nurse or midwife's ability to provide holistic care with compassion and to bring positive change in the lives of their patients. Participants will learn techniques for incorporating mindfulness and meditation into their work and daily routine, which will facilitate them to promote stress management and relaxation in their patients. Topics explored during this programme include: the role of mindfulness in holistic care, self-awareness, compassion, holistic communication and the power of stillness of mind.	€90 members; €145 non-members	5.5
Sep 30	**Diabetes management for healthcare professionals** The increased prevalence of diabetes presents significant challenges for healthcare planners and providers in terms of resource allocation and appropriately skilled staff. This course aims to prepare nurses/midwives with the theoretical knowledge and clinical skills required to facilitate diabetes care consistent with best practice recommendations and meet care participant expectations.	€90 members; €145 non-members	5

Date	Programme	Fee	CEUs
Oct 6	**Introduction to Clinical Audit**	€90 members; €145 non-members	5.5
Oct 13	**Management Skills for Clinical Nurse Managers and Staff Nurses**	€90 members; €145 non-members	6
Oct 13	**Epilepsy – It's Presentation and Management**	€90 members; €145 non-members	6
Oct 14	**Academic Writing and Research Appraisal Simplified**	€90 members; €145 non-members	5.5
Oct 15	**Incident Reporting and Investigation in Residential Care Facilities for Older People**	€90 members; €145 non-members	6.5
Oct 19	**Caring for Patients with Renal Impairment**	€90 members; €145 non-members	7
Oct 21	**Decision Making and the Use of Restrictive Practice in Residential Care Settings for Older People**	€90 members; €145 non-members	6

Oct 6 – Introduction to Clinical Audit

This programme equips participants with the necessary skills to implement clinical audit in their practice and enable them to deliver evidence of improved performance for safer and better care for patients. Participants will be provided with an overview of clinical audit and be informed about each stage in the clinical audit cycle: topic selection, standards development, data collection, data analysis, reporting, implementing changes and re-audit. A detailed overview will be given on the characteristics and dimensions of quality as well as how best to measure and monitor quality in the workplace. There will be a specific emphasis on continuous quality and safety improvement in healthcare.

Oct 13 – Management Skills for Clinical Nurse Managers and Staff Nurses

This programme outlines the key competencies required for ward managers to be effective in their roles as leaders and managers in healthcare delivery. Clinical managers perform both managerial and leadership functions in order to provide effective healthcare delivery to patients. The programme will explore both management and leadership functions and how these are applied in practice to promote quality and safety of care. Key topics covered include: management principles and competencies, team building, delegation and clinical supervision. Participants will gain effective management competencies that can be applied in the workplace to promote quality and safety in healthcare delivery

Oct 13 – Epilepsy – It's Presentation and Management

This education programme will educate participants on the presentation and management of people with epilepsy. The course will cover topics such as awareness of the nurse/midwife's accountability, understanding of epilepsy, patient safety, pharmaceutical and non-pharmaceutical interventions, lifestyle changes and specific issue for women with epilepsy and people with epilepsy and intellectual disability. Epilepsy is a chronic disease that affects 1% of the population and can be associated with significant physical and psychosocial sequelae. The management of patients with complex medical conditions, including epilepsy, is increasingly been overseen by nurses. Nurses who are not specialists in epilepsy can play a central role in providing optimal care, education, and support to their patients with epilepsy, given the proper tools. This course will provide a foundation on which to build increasing knowledge epilepsy and care of the patient.

Oct 14 – Academic Writing and Research Appraisal Simplified

This programme will introduce participants to skills that are essential when completing academic studies. It will explore evidence-based practice, which provides nurses and midwives with a method to use critically appraised and scientifically proven evidence, thus ensuring that practice is based on the most up-to-date appraised evidence. An overview will be provided on information resources, such as journals and databases. Guidance will be provided on methods for critically appraising both qualitative and quantitative studies. Skills for incorporating analysis and critique in written assignments will also be illustrated and various referencing styles will be presented and demonstrated.

Oct 15 – Incident Reporting and Investigation in Residential Care Facilities for Older People

This programme enables participants to implement an effective system of incident reporting and investigation. Participants will be shown how to complete accurate incident reports and investigations using tools such as the 5 Whys and Root Cause Analysis. The programme will also cover how to analyse incidents on a scheduled basis as part of a continuous improvement approach. Professional and legal requirements for incident reporting and investigation based on regulations and best practice guidance will be outlined in detail. The programme will include a group exercise whereby participants can practise completing an incident report.

Oct 19 – Caring for Patients with Renal Impairment

This programme is aimed at all registered nurses and focuses on developing competency in the assessment and management of patients presenting with impaired renal function. The course will assist nurses in implementing evidence-based practice while caring for this cohort of patients in clinical practice. Common causes of acute kidney injury and chronic renal failure are sepsis, diabetes and hypertension, all of which are extremely prevalent in the acute, older person and community patient populations.

Oct 21 – Decision Making and the Use of Restrictive Practice in Residential Care Settings for Older People

This programme outlines the requirements of the national policy, national standards and professional requirements for the use of restraint in residential care settings for older people. Against this backdrop, the workshop outlines the decision-making process for consideration of the use of restraint as a therapeutic intervention for individual residents. Older people have the right to live as independently as possible without unnecessary restriction. Nurses often struggle to balance residents' rights to autonomy and liberty with the need to ensure the health and safety of their residents. This study day encourages participants to take a positive and proactive approach in reducing and eliminating the use of restrictive practices in their residential care facility. It also explores the use of alternatives and encourages participants to take a person centred rather than blanket approach to the use of appropriate alternatives.

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Date	Programme	Fee	CEUs
Oct 22	**Nursing and Midwifery Documentation** This programme will provide an opportunity for nurses and midwives to avail of the most up-to-date approach to appropriate documentation and record keeping. The programme will explore a wide range of topics pertinent to documentation, such as accountability and duty of care, and will offer guidance on best practice in documentation. The programme will illustrate the importance of documentation as a basis for assessment, planning and evaluation of care, and its role as credible evidence in the event of legal proceedings. There will also be a practical session where participants will be given the opportunity to apply what they have learned by working through some examples.	€90 members; €145 non-members	5
Oct 22	**Pressure Ulcer Prevention and Management** This programme broadens participants' knowledge and understanding of pressure ulcer assessment and management, and ensures professional competency in pressure ulcer care. Topics covered include assessment and classification of pressure ulcers, causes and pathophysiology of pressure ulcers, nursing management and dressing selection. The programme will provide participants with an opportunity for continuing professional development to ensure that their practice is founded on the latest research and guidance as per the HSE's best practice and evidence-based guidelines for wound management.	€90 members; €145 non-members	5.5
Oct 23	**Management of Adult Patients with Tracheostomy** This programme introduces a holistic and inter-disciplinary approach to the management of the adult patient with a tracheostomy. Participants will be given the necessary knowledge, skills and confidence to assess, manage and evaluate the nursing care of a patient with tracheostomy. The indications, advantages and disadvantages of tracheostomies will be explored. An overview will be given on both surgical tracheostomy and percutaneous dilatational tracheostomy, as well as the various types of tracheostomy tubes. Topics also covered include tube security, tube changing, suction therapy, humidification, wound care, swallowing, communication, weaning, decannulation, management of complications and emergency care.	€90 members; €145 non-members	6
Nov 4	**Understanding and Managing Burnout** This new programme is designed especially for nurses and midwives to explore the nature of burnout and work engagement. Maslach (2011) argues that the prevention of burnout can be achieved by focusing on engagement, organisational assessment and the early detection of burnout. The key focus of the programme will be on the causes, definitions, measurement and interventions that can help create a more positive, fulfilling and engaging workplace. It also aims to introduce participants to the key concepts related to burnout and work engagement and for participants to develop an understanding of approaches to promoting engagement and creating a more fulfilling workplace. The aim of this workshop is to introduce nurses and midwives to key concepts related to burnout and work engagement and for participants to also develop an understanding of approaches to promoting engagement and creating a more fulfilling workplace.	€90 members; €145 non-members	5

Retirement Planning Webinar for INMO Members

Wednesday, July 8, 2020, 10am-11.15am

Unfortunately, due to Covid-19 and the need for social distancing, all retirement seminars have been cancelled or rescheduled. INMO Professional, in partnership with Cornmarket Financial Services, has developed an online webinar to support members planning for retirement.

To join the next webinar visit **www.inmoprofessional.ie** or call 01 6640618 to book your place. Following registration you will receive instructions on how to join so you can save the date and time in your diary and join us on the day. These sessions will briefly cover the following:

- Superannuation and your entitlements
- Options for drawing down your AVC at retirement
- Should you consider a lump sum AVC before retirement?
- Protecting your lump sum against inflation
- Key steps to long term investing
- Top tax tips for retirement
- Covid-19 Q&A: Retirement planning in uncertain times.

Following the training you will be given an opportunity to make an appointment with a financial expert, with whom you can discuss your own situation in more detail.

Cornmarket   INMO Professional

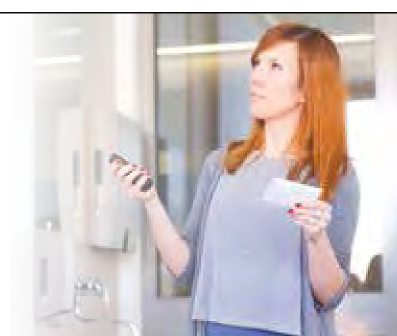
Education programmes coming to our Cork office

Date	Programme	Fee	CEUs
Oct 6	**Wound Care Management** This programme will allow participants to ensure professional competency in the area of wound care as per the NMBI Code of Professional Conduct and Scope of Practice for Nursing and Midwifery, which states that nurses must work within their competence. Furthermore, it will provide participants with the knowledge to ensure that their practice is founded in the latest research and guidance.	€90 members; €145 non-members	5
Oct 7	**Phlebotomy** This programme provides participants with the skill and theory to perform phlebotomy in a competent and safe manner. It will cover: sites used for phlebotomy, criteria for evaluating a vein, principles of an aseptic technique as well as complications that may arise during and after the procedure. Guidance will be given on how to reassure the individual in relation to the procedure and on gaining their consent. While this course will provide the necessary skills to undertake phlebotomy, it will be necessary for each participant to ensure they abide by their workplace policy on phlebotomy and hold an up-to-date hand hygiene training certificate (within the last two years).	€90 members; €145 non-members	4
Oct 20	**Management Skills for Clinical Nurse Managers and Staff Nurses** This programme outlines the key competencies required for ward managers to be effective in their roles as leaders and managers in healthcare delivery. Clinical managers perform both managerial and leadership functions in order to provide effective healthcare delivery to patients. The programme will explore both management and leadership functions and how these are applied in practice so as to promote quality and safety of care. Key topics covered include: management principles and competencies, team building, delegation and clinical supervision. Participants will gain effective management competencies that can be applied in the workplace to promote quality and safety in healthcare delivery.	€90 members; €145 non-members	6
Nov 3	**Best Practice in Medication Management** This programme supports participants in providing safe, evidence-based practice in medication management. It will cover topics such as: the key principles of medication management, the medication management cycle, management of controlled drugs and medication safety. It will also explore relevant policy and legislation and will present scenarios in order to illustrate the various principles. Participants will have the opportunity to update their knowledge in line with the most up-to-date NMBI and HIQA requirements for medication management.	€90 members; €145 non-members	5

Training Delivery and Evaluation

Module 6N3326 – QQI Level 6, Category 1 approved by NMBI and awarded 30 CEUs

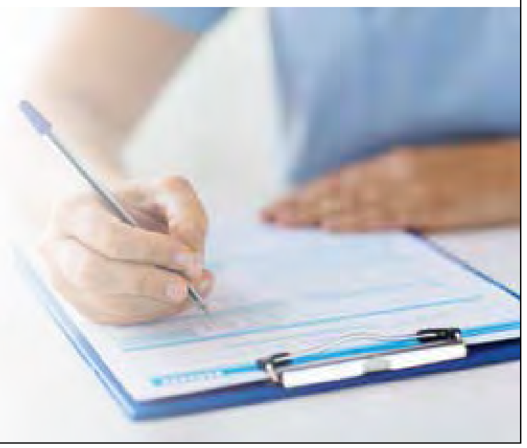
In keeping with government Covid-19 requirements, INMO Professional is closely monitoring the ongoing situation. All participants who were due to commence this module in September will be contacted in the next two weeks to be notified if the training is going ahead. If it has to be postponed it will be rescheduled for early 2021. If you wish to contact the course co-ordinator please email marian.godley@inmo.ie



Checklist for Covid-19 HIQA Inspections

Resources for members in a care of the older person setting

The Health Information and Quality Authority (HIQA) recently published the Regulatory Assessment Framework of the preparedness of designated centres for older people for a Covid-19 outbreak. INMO Professional has developed three videos which we hope will be of benefit to members. They provide an overview of the proposed inspection process, suggested documentary evidence to have ready for inspectors as well as key elements of contingency planning. These videos can be viewed at **www.inmoprofessional.ie** INMO Professional remains committed in doing everything we can to support you through this difficult time and we wish you well. If you have any queries, do not hesitate to contact us at education@inmo.ie



Book online at inmoprofessional.ie or Tel: 01 01 6640618

Focus on recent Covid-19 literature

This month the library team identifies some recent articles, evidence and commentary on the Covid-19 pandemic. For an extensive list visit www.nurse2nurse.ie

FOLLOWING last month's insight into resources available on the topic of Covid-19, this month the library team have identified some recent articles, evidence and commentary on the pandemic, as well as recent literature on non-Covid-19 related topics including leadership, dementia and advanced nurse practitioners (ANPs). A complete list of available resources can be found at **www.nurse2nurse.ie**

Covid-19 articles

Midwifery

- Zaigham M et al. Maternal and perinatal outcomes with Covid-19: A systematic review of 108 pregnancies. Acta Obstet Gynecol Scand. 2020. 10.1111/aogs.13867

Public health nursing/community nursing

- NICE guideline [NG163]. Covid-19 rapid guideline: managing symptoms (including at the end of life) in the community
- Edmonds J et al. A call to action for public health nurses during the Covid-19 pandemic. Public Health Nursing. https://doi.org/10.1111/phn.12733

Children's nursing

- NICE guideline [NG174] Covid-19 rapid guideline: children and young people who are immunocompromised

Care of the older person

- Kai I. Respiratory rehabilitation in elderly patients with Covid-19: A randomized controlled study, Complementary Therapies in Clinical Practice. https://doi.org/10.1016/j.ctcp.2020.101166

Resilience

- Walton M el al. Mental health care for medical staff and affiliated health care workers during the Covid-19 pandemic. European Heart Journal: Acute Cardiovascular Care. 2020. https://doi.org/10.1177/2048872620922795

Hand hygiene

- Hillier MD. Using effective hand hygiene practice to prevent and control infection. Nursing Standard 2020. doi: 10.7748/ns.2020.e11552

Personal protective equipment (PPE)

- Marin T. Evidence Summary. Respiratory Infection Transmission (Community): Face Masks and Respirators. The Joanna Briggs Institute EBP Database. 2020; JBI23909
- Marin T. Evidence Summary. Respiratory Infection Transmission (Healthcare Workers): Face Masks and Respirators. The Joanna Briggs Institute EBP Database. 2020; JBI10300

Critical care

- Pattison N. End-of-life decisions and care in the midst of a global coronavirus (Covid-19) pandemic. 2020. Intensive and Critical Care Nursing. doi: 10.1016/j.iccn.2020.102862
- Lucchini A, et al. The "helmet bundle" in Covid-19 patients undergoing non-invasive ventilation. 2020. Intensive and Critical Care Nursing. doi.org/10.1016/j.iccn.2020.102875
- Lizarondo L. Evidence Summary. Moral Distress (Nurses): Interventions in Critical Care Settings. The JBI EBP Database. 2020;JBI23872

Cardiopulmonary resuscitation

- National Health Library and Knowledge Service: What guidance is available for healthcare workers on the provision of CPR for paediatric patients in hospital and community settings during the Covid-19 pandemic? (Evidence summary)
- National Health Library and Knowledge Service: What guidance is available for healthcare workers on the provision of CPR for patients with suspected or confirmed Covid-19 in hospital settings, including community assessment hubs and intermediate care facilities? (Evidence summary)

Recent Irish and international literature

Nursing education

- NMBI Nurse Authority to Refer for Radiological Procedures (Standards and Requirements for Education Programmes). 2020. Nursing and Midwifery Board of Ireland

ANPs

- Kerr L et al. Advanced Nurse Practitioners' (Emergency) perceptions of their role, positionality and professional identity: A narrative inquiry. J Adv Nurs 2020. 76(5): 1201-1210

Midwifery

- Cowman T et al. Back to the future: midwives' experiences of undertaking a return to midwifery practice programme. Br J Midwifery 2020. 28(4): 234-241

Children's nursing

- Reynolds J et al. Evaluating a nurse-led sleep support intervention to reduce melatonin prescribing in children and young people. Nurs Child Young People 2020. doi: 10.7748/ncyp.2020.e1272

Dementia

- Brown M, et al. Introduction to living with advanced dementia series. Nursing Older People 2020. doi: 10.7748/nop.2020.e1169

Library assistance

The library is open to members with research and search queries. If any member requires assistance, please contact library@inmo.ie or Tel: 01 6640614/625. The library can provide remote training if required. Open Monday-Thursday, 8.30am-5pm and Friday, 8.30am-4.30pm.

Getting the most from your library: Advanced Library Searching Techniques

Next course dates: Thursday, August 13, 2020

Venue: The Richmond Education and Event Centre, North Brunswick Street, Dublin 7

Fee: €90 INMO members; €145 non-members

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

Clinical guidance on the pronouncement of death

Edward Mathews discusses the interim guidance for nurses on the pronouncement of death that has recently come into effect

THE pronouncement of death by registered nurses in certain services, in identified circumstances, has been something envisaged since a national policy on the issue was agreed in 2017. However, it was not until the Covid-19 crisis emerged that the 2017 policy was activated. It has now been replaced by important *Interim Clinical Guidance for the Pronouncement of Death by Registered Nurses in Identified Services in the Context of the Global Covid-19 Pandemic*.

The interim guidance, which came into effect on April 30, 2020, will remain in place until the end of the Covid-19 emergency period as determined by the government, and will be reviewed on October 31, 2020.

This interim guidance is underpinned by a statement from the Coroners Society of Ireland recognising the role of registered nurses in the pronouncement of death in certain circumstances. Additionally, the interim guidance was preceded by national discussions during which a range of issues were discussed and agreed to ensure that registered nurses were appropriately facilitated and protected.

What follows is a summary of key aspects of the interim guidance, however, it is necessary to consider the document in detail.

Where will the interim guidance apply?

The interim guidance applies, currently, only to a limited number of services. It may only be introduced in HSE and Section 38 designated centres for older persons registered by HIQA and specialist palliative care services. Non-HSE services that meet this definition may also introduce the interim guidance. The INMO has sought that this be extended to include intellectual disability services which have a nursing resource available to them, however, this remains under discussion. No other service is authorised to introduce this role.

While a service may be permitted to introduce the interim guidance, it is not mandatory and the director of nursing has a discretion as to whether to introduce, and in addition treating doctors must agree that a nurse may pronounce death in the case of their patient.

Does a nurse have to participate?

The interim guidance makes it clear that even if a service decides to introduce the interim guidance, it is a voluntary decision for each nurse working there as to whether they participate. Therefore, you have a choice, even if the interim guidance is adopted, as to whether you participate in this role in any way.

What does the service need to do?

In order for the service to introduce the guidance there must be agreement from the director of nursing, a local communication policy supporting the guidance must be put in place, and the service must secure the agreement of the treating doctor(s).

In addition, the service must facilitate nurses with the time to undertake the necessary training, any additional support required to achieve competence, and must also support nurses in undertaking this role including any additional professional or personal supports which may be required having undertaken the role. The employer is also responsible for ongoing audit of practice in this area.

What must an individual nurse do prior to undertaking the new role?

Each nurse who agrees to undertake this role must complete an online education module and assessment. Thereafter, the nurse completes a self-declaration of competency. In the event that they do not feel competent in any area it is important that they declare this. Thereafter their manager will provide support, and complete a further document indicating whether competence has been achieved in the relevant areas.

Expected and unexpected deaths

Where the interim guidance is introduced there is a potential for the registered nurse to be involved in the pronouncement of death in the case of both expected and unexpected deaths, but the processes for each differ slightly.

In this context an expected death is a death which occurs:

- Following a period of illness that has been identified as terminal
- Where registered nurses and doctors have been involved in providing palliative care
- Where there is an agreement between the dying person, those important to the dying person and medical and nursing teams that no active intervention to prolonging life is ongoing
- A 'do not attempt resuscitation' (DNAR) decision has been made, and the decision is recorded in the dying person's healthcare record and has been communicated to the entire team

An unexpected death is a death other than an 'expected death' as defined above or a death where there was no expectation that the person was likely to die in the manner or at the time at which they did. So, in essence, unexpected deaths are any deaths which don't meet the definition as set out above, or where death was not expected.

The definition of expected deaths presupposes a course of illness and forward planning that results in an agreement or determination that there will be no attempt at resuscitation. This will involve

the person, the person's nursing team, the person's doctor and likely those important to the person. Notably, in this process the doctor, in order for the nurse to proceed to pronounce death, must also have consented to the nurse undertaking that role.

While it is beyond the scope of this piece to consider all of the issues, ethical and otherwise, associated with end of life care, it is important to reflect on the role of the person. This includes their autonomy in decision making, the importance of communication, the importance of safeguarding the rights and interests of the person and associated advocacy, the important, but not determinative, views of those important to the person, and the importance of appropriate and detailed documentation underpinning the processes leading up to, and the recording of, decisions in this area.

Detailed guidance has been provided by the HSE in relation to these issues and while the optimum situation is a decision by the person in relation to their future plans, we must also recognise that in the absence of capacity medical decisions may be made on future care, nursing retains an important advocacy role in these circumstances.

Overall, where decisions have been made and an expected death occurs – then a competent nurse may perform the necessary clinical assessments to pronounce death.

It is important firstly to recall the necessary infection prevention and control processes that must be adhered to in these circumstances, especially in the context of Covid-19.

The procedure for carrying out the assessment is as follows:

The registered nurse must:

- Check for clinical signs of death (box1), using a stethoscope and penlight or ophthalmoscope
- Repeat the check for clinical signs of death after 10 minutes
- If there is any uncertainty, repeat the steps within 30 minutes of initial assessment
- If after 30 minutes there is still uncertainty about pronouncement of death, confer with a colleague
- The assessment and declaration that 'death has occurred' should be undertaken in a calm and unhurried manner.

The clinical signs used when pronouncing death are:

- Absence of a carotid pulse for over one minute
- Absence of heart sounds for over one minute
- Absence of respiratory movements and breath sounds for over one minute
- Fixed pupils (unresponsive to bright lights)
- No response to painful stimuli (eg. sternal rub).

All signs must be present before death is pronounced.

Having completed the assessments and recorded these in Pronouncement of Death by a Registered Nurse Form and being satisfied that the expected death has occurred, the nurse liaises with the doctor and coroner prior to the removal of the body.

Contact with the doctor can occur the following morning if this is an out-of-hours period. They will also liaise with the funeral director. Throughout, and thereafter as appropriate, the nurse will also inform, and provide care to, those important to the deceased person. Thereafter, the service will contact all professionals involved in the care of the person.

The nurse will document the date and time of death; name and date of birth of the deceased; date and time of pronouncement; when deceased was last seen by the treating doctor. The name of the treating doctor and the date and time that he/she was informed of the death must be recorded. Similar details will be recorded regarding contact with the coroner, funeral director, those important to the person, and any pastoral support contacted.

Informing the coroner

It is important to recall that there are statutory requirements in relation to notification of the coroner, and registered nurses have statutory responsibilities to report deaths to the coroner in certain circumstances.

The local communication policy accompanying the introduction of the interim guidance will signpost the appropriate steps to take in this regard, however, if in any doubt the essential message is that the nurse does have a role in these circumstances to make a report to the coroner unless they reasonably believe that someone else has done so, therefore do check and if in any doubt seek advice from your manager and the assistance of the INMO if necessary.

Again, these are deaths that do not meet the definition of an expected death as set out above, or those in the more usual sense of the term – which were not expected to occur when they did. Firstly, if there are any signs of an unnatural cause of death then the nurse will liaise with the Gardai, who will in turn direct further necessary steps.

However, in other circumstances the nurse contacts the treating doctor. Thereafter, the doctor will liaise with the coroner. Following this, the nurse may be authorised to pronounce death. If authorised to pronounce death then the process proceeds as set out above. If not, the doctor must examine the body and the nurse does not undertake any roles in relation to pronouncement of death.

In the case of both expected and unexpected deaths where pronouncement of death has been undertaken by a nurse, and the doctor is satisfied, the body may be removed by an funeral director.

If there is a change in circumstances whereby a person is to be cremated or their body donated to medical science, then the body may not be removed until they have been examined by a doctor.

The nurse will complete Section 4 of the Pronouncement of Death by a Registered Nurse Form, and will cease involvement in that part of the care of the person.

Training

This interim guidance is designed to facilitate timely care to a person after their death in what remain challenging and exceptional times. It is important to emphasise that training for, and undertaking, this role is entirely voluntary on the part of individual nurses.

If you do elect to become involved you should be supported to undertake the necessary online training and assessment,and supported overall in this role as it may arise and thereafter. You must also be supported if you identify any competence deficits.

Once the interim guidance ceases, the National Policy for Pronouncement of Expected Deaths by Registered Nurses, 2017, will be reintroduced following consultation with the INMO. We will update you as matters progress, however, if you have any issues with the implementation of the interim guidance in your workplace, or any concerns, you should contact your INMO official for support.

Edward Mathews is INMO director of professional and regulatory services

Meet the Cork HSE Branch

Freda Hughes spoke to Cork HSE Branch chairperson Ester Fitzgerald about what it can offer during these challenging times

THE Cork HSE Branch covers a huge area of Co Cork and has roughly 2,000 members. Ester Fitzgerald has been chair since January 2020 when she took over from Jean O'Connell. Ms Fitzgerald was previously strike committee secretary and has been involved with the branch for most of her working life. She works as a CNM2 in the intensive care unit in Cork University Hospital.

There has been so much increased engagement with the Cork HSE Branch since the Covid-19 pandemic began. The branch had been due to have meetings and attend the INMO annual delegate conference (ADC) last month but of course everything was postponed. WhatsApp groups that were not hugely active before are now where all the activity is taking place. Local industrial relations officer Liam Conway sends a daily Covid-19 update to the branch's online group daily and this is met with questions and queries which are managed by the officers.

As issues arise, such as the lack of PPE or variations of policy, the group communicates to highlight issues and support each other. There is a rep in place for most areas and workplaces in the online group, and questions and answers can be fielded through them. The branch also sends out an update to workplaces.

Ms Fitzgerald told us: "The enhanced practice contract is probably the biggest issue for us at the moment. People are disillusioned. We have never worked so hard and some of us are waiting over a year for the salary increase that was promised.

"We have been pushing for this with the support of the union so hopefully we will receive it in the near future. PPE is also a huge issue for our members currently. They can get guidance from the union on best practice around this."

Ms Fitzgerald noted that people on Covid-19-related sick leave only get a flat paycheck, thus ending up on less pay because they have contracted the disease or been in contact with it in the workplace. This is something the branch will work on with the union.

She also stressed the negative impact of the government's lack of solutions to the childcare issue for frontline workers. Branch members are using their annual leave and unpaid leave in order to mind their children. They fear that by the time the pandemic is over they will have used up all of their leave and at that point they will be very much in need of a well-deserved break.

Ms Fitzgerald praised the support they receive from their industrial relations officer and encouraged all nurses and midwives to join the INMO.

"Join a union if you want to have support in your professional and your private life. The union is each and every one of us. Being able to identify union reps in your workplace is essential. It's not always appropriate to go to the HR manager or someone in management. The union provides guidance and gives you an independent professional voice in the workplace. Our industrial relations officer is excellent and has provided a huge amount of out of hours support during the pandemic," she said.

Solidarity among the Cork HSE Branch members has also increased and is a huge support during the battle against Covid-19. Messages of peer support when people are having a tough time mean a lot to hard working nurses and midwives. Issues with PPE can be discussed and escalated if necessary

Ms Fitzgerald said that the branch is also a great forum for sharing ideas, workplace knowledge and solutions.

"It's a good means of communication, a method of protecting yourself and of supporting each other," she told *WIN*.

She also said that it is an essential vehicle for getting a seat at national and regional meetings such as the ADC.

Ms Fitzgerald spoke of how branch members are coping while working through the pandemic.

"Covid-fatigue has hit everyone in the country, but it has certainly hit us in work now too. Adrenaline kept us going for the first few weeks but now it feels like a marathon. We need everyone to keep with the social distancing, cough etiquette and hand-washing to keep the curve flattened. Not having visitors in our hospitals and facilities is one of the hardest things because those personal relationships we build up at such difficult times are an important part of the care we give. This virus has hit everyone from the youngest to the oldest among us. We must stay strong. Our branch keeps us united," said Ms Fitzgerald.

If you are interested in joining your local branch, please contact your INMO industrial relations officer who will put you in contact with your local branch secretary.

Pictured above at their last AGM was the Cork HSE Branch: (l-r) Niamh Prayher, Rebecca Amosa, Marie Kennedy, Jenilyn Deliro, Bernie Lucy, Laurence Doran, Jean O Connell, Helen Mc Carthy, Margaret Coughlan, Mary Rea, Ger Mc Carthy, Amy O Connell, Ester Fitzgerald, Richie Butler, Eilish Fitzgerald and Lorraine O Connor

If you would like your branch featured in *WIN*, please email Freda.hughes@inmo.ie

Bulletin Board

With INMO director of industrial relations Tony Fitzpatrick

Query from member

I am working in the public health service and was absent last year with a pregnancy-related illness for most of my pregnancy. On returning to work after my maternity leave I was absent for one week with a non-pregnancy related illness and was advised that, as I had exhausted all my sick leave prior to commencing maternity leave, I no longer have access to paid sick leave so the one week absence was recorded as unpaid sick leave. Is pregnancy-related sick leave separate to normal sick leave?

Reply

Pregnancy-related sick leave is recorded as normal sick leave while you still have access to ordinary sick leave limits. So, if you are pregnant and you are ill then you will have to use up your three months full pay and three months half pay while you are absent. However, if you exhaust your sick leave due to a pregnancy-related illness then you will move to the pregnancy extension sick leave scheme and this is only at half pay but there is no limit on this and you could be on this until you start your maternity leave. You may qualify for Critical Illness Protocol (CIP) which is applicable if you are hospitalised with a pregnancy-related illness for more than two consecutive days. The CIP gives you a greater amount of sick leave, six months full pay and six months half pay (deducting any sick leave you have had in the previous four years). Once you return to work though, if you are absent on a non-pregnancy related illness, then your employer will carry out the four-year check as per normal practice. If you have exhausted your sick leave then they should look back over the previous four years and check how much of your sick leave was pregnancy-related and these days should be credited back to your record but they will only be credited back at half pay, not full pay. It is compensation for having to use up your sick leave prior to maternity leave for a pregnancy-related illness.

Query from member

I am currently out on sick leave due to Covid-19. Initially I had to self-Isolate as I was displaying symptoms but have now been diagnosed with a positive test. My employer advised that will be recorded as sick leave. Is this correct?

Reply

No. In this particular case, special leave with pay should apply when you were advised to self-isolate. Medical or HSE confirmation of this advice is required. This paid leave should not be recorded as sick leave; such absences will not affect your entitlement under the Public Service Sick Leave Scheme. This leave should be maintained separately and classed as Covid-19 paid leave. As you were already on special leave with pay as a preventative measure and subsequently fell ill, the special leave with pay will continue. However, the continuation of special leave with pay requires medical confirmation from a doctor for the duration. Special leave with pay should continue to be recorded, however the rules of sick leave – that is in relation to contact with manager and certification – will apply.

Know your rights and entitlements

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

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

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

Spotlight on: Neil Perry

'Pay parity would solve issues of recruitment and retention'

NEIL Perry is an emergency department nurse at Midlands Regional Hospital, Tullamore, where the ED has been divided into two areas to separate possible Covid-19 patients from patients with other conditions. Mr Perry said this has created an additional burden, having led to a reduction in staffing numbers in both areas.

It has also made his role as a clinical skills facilitator all the more important; in this role, to which he was recently appointed, Mr Perry is responsible for supporting staff in education in both clinical and classroom settings, and with the introduction of new equipment to the ED for the management of Covid-19 patients comes a need for training around how to use it. In the Covid-19 area staff are wearing full PPE and in the non-Covid-19 areas staff are wearing masks, as per the new national guidelines.

Mr Perry said: "We haven't seen a surge in ED yet from the pandemic, but there are some very sick patients in ICU. We've been lucky compared to the east of the country."

Originally a chef, Mr Perry suffered a motorcycle accident In 1998 on his way to work. He ended up with multiple fractures and was taken to the ED, through to surgery and on to outpatients. He said he was really taken aback by the care he received.

"I didn't really appreciate healthcare until that moment. I became interested in mobility or more so the lack of it."

When he recovered, Mr Perry took a job as an orthopaedic technician in the plaster room of the hospital in which he had been a patient following his accident. He worked with nurses who encouraged him to get back into adult education and train as a nurse. They put him on the nursing pathway and he has never looked back.

Mr Perry trained in Thames Valley University Hospital, London and was seconded by the ED there. As part of that agreement he began a contract with the hospital on finishing his training. He met his wife Avril, an Irish nurse, while briefly working in orthopaedics. He always knew she would return to Ireland and so in 2009 they moved back together and began working in the Irish health service, where he recognised many of the same policies that had been present in the UK and had led to a reduction in staff numbers and acute beds in hospitals there.

Mr Perry said he initially joined a nursing union in the UK purely for the indemnity insurance. Back in Ireland, however, Neil became involved with the INMO through the influence of other workplace activists who were motivated in trying to make improvements. From 2011 the trolley crisis was worsening so he and some of his colleagues decided to get involved.

"Initially my only motivation for joining a union was to make sure I was covered in my clinical practice. As time went on, I realised that the same health service issues kept returning and were never fully resolved. Instead of moaning about it I tried to be more proactive.

"I was previously a very back-seat person, but I realised that as a body of people locally we could change things and that we could also influence national policy. Through our actions with the union we have done that, particularly in ED with the introduction of the CNM posts and the location allowance to medical surgical areas. That's the power of the union."

One thing Mr Perry would like to change about nursing is the lack of pay parity with allied health professionals who share the same level of education and training as nurses and midwives. He believes if such parity was achieved, recruitment and retention would improve and it would attract more people to the two professions.

Mr Perry feels the focus needs to shift from acute hospitals to care in the community. He said increased investment in primary care facilities, along with more education, would greatly reduce the number of non-acute admissions to hospitals and shorten waiting times for beds.

Neil Perry: *"We have loads of nurse leaders at the top end but where we are lacking is boots-on-the-ground leaders in the clinical setting and in the community"*

"I think what we've learned in recent times is the acute hospital is not the be all and end all of care. Even leading up to this pandemic the elephant in the room was that the acute pathways almost always began through the ED. Now we're seeing more being done in the community and I think that really needs to be developed."

Mr Perry said there is a need for more nurse-led care and stressed the importance of ANPs as well as the need for nurse leaders to operate within the clinical setting.

"We have loads of nurse leaders at the top end but where we are lacking is boots-on-the-ground leaders in the clinical setting and in the community. ANPs are amazing and there should be more minor injury and minor incident clinics that could be run successfully by ANPs. There is a whole tier of healthcare and nursing that we have not really tapped into yet."

This article is part of our Nursing Now series. Nursing Now is a worldwide campaign that aims to achieve recognition of nurses' contribution to healthcare, gender equality, the economy and wider society. The aim of the campaign is to improve health globally by raising the profile of nurses worldwide and influencing policymakers and supporting nurses to lead, learn and build a global movement. For more information visit ***www.nursingnowireland.ie***

Antibiotic resistance and recognising signs of sepsis

This month the RCM highlights key modules related to Covid-19 that focus on antibiotic awareness and how to recognise maternal sepsis

THE Royal College of Midwives in the UK has highlighted some key modules that are relevant to the ongoing Covid-19 pandemic.

Antibiotic awareness

This i-learn module on antibiotic awareness seeks to increase awareness of antibiotic resistance. In particular, it seeks to promote the role of midwives in minimising the challenges of antibiotic resistance. Further, midwives should be aware of how appropriate antibiotic stewardship can promote a healthier childbearing continuum for women and babies. This module will take one hour to complete.

Importance of antibiotics

Antibiotics are important medicines that have both prophylactic and therapeutic uses for humans, animals and plants. Since penicillin was identified and then developed from the 1920s, this and later types of antibiotics have prevented many serious illnesses and premature deaths globally.[1]

However, the natural process of microbes adapting to the effects of antibiotics means that they are always increasing their resistance to antibiotics. Thus, some infections will then become difficult to treat effectively; hence, the term antimicrobial or especially, antibiotic resistance.[2]

This natural, evolutionary process is speeded up as a result of the abuse/misuse of antibiotics by both the public and professionals and has led to public health concerns on a global scale.[3]

The issue of antibiotic resistance is one of the most important threats to the health of everyone around the world and even extends into agriculture and horticulture.

Objective

On completion of this i-learn module you will:

- Understand the main associated factors for sepsis together with the key parameters of bacterial infection
- Be aware of the various classifications of antimicrobial agents
- Gain familiarity with the associated factors for antibiotic drug resistance
- Understand the key principles of antibiotic stewardship and how to implement these into clinical practice
- Be able to implement effective communication in seeking to advise women and their families on minimising infection and antibiotic drug resistance
- Be able to access appropriate sources of information/support to promote effective knowledge for women/families on the prevention of infection and antibiotic awareness together with resources for the multidisciplinary teams on the prevention of infection.

How to recognise maternal sepsis

Sepsis can progress rapidly causing serious maternal ill health and possibly death. This i-learn module will review the predisposing factors and causes of sepsis. Any infection can lead to sepsis and identification of the common and not so common sites of infection that may arise in the childbearing period are included.

Early recognition of signs and symptoms by midwives allows early referral and rapid implementation of care that can be lifesaving. This module will provide guidance on how to assess the woman to identify infection and possible sepsis. This will include a review of vital signs alongside signs and symptoms of infection. The need for structured, thorough assessment is emphasised.

Objective

By the end of this module you will be able to:

- Perform an assessment of the woman that will identify signs and symptoms of infection and/or sepsis
- Be aware of 'amber' and 'red' alerts with regard to features of sepsis and be able to make prompt referral for urgent medical assessment
- Understand what initial actions the midwife can instigate when sepsis is suspected/identified to ensure the woman receives the best possible prompt care
- Identify the factors that increase the risk of sepsis and seek measures to prevent sepsis.

References

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2. Shute J. (2015). Too much of a good thing. The Telegraph

3. World Health Organization (2014). World Health Statistics 2014: Large gains in life expectancy

RCM i-learn access for INMO midwife members

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

Tips on preparing for interviews

INMO student and new graduate officer **Catherine O'Connor** gives an overview of how best to get ready for job interviews

AS WE enter the summer months, many interns will now be thinking about where they would like to work once their internship finishes. In order to assist with thinking about the next steps, this month I would like to look at ways to prepare for interviews. Interviews can seem daunting especially if you are not used to doing them but remember that everyone gets nervous coming up to an interview, and if you prepare well beforehand, you will be ready on the day.

What to expect

Nursing and midwifery interviews are often done by panels, meaning there could be two to three people sitting across from you. One person will likely be taking notes throughout the interview – try not to get distracted by this. The questions tend to be mostly competency-based, but some may be designed to let the employer know how you might fit into the organisation. It is a good idea to prepare some answers for general questions about yourself like: 'Why did you go into nursing/midwifery?' or 'Tell me a bit about yourself', as this is your opportunity to stand out. It is also important that you are familiar with your CV and portfolio as anything you have written can be asked about during the interview.

Before the interview

Good interview preparation should start well before the day of the interview. Search for your name online to see what comes up, as employers sometimes search candidates before the interview. Remember that each workplace normally has a social media policy. The NMBI social media guidance document is available on its website (**www.nmbi.ie**). Researching the employer online is always beneficial – if you can demonstrate a genuine interest in the organisation, it can go in your favour. This includes knowing some key information on mission and ethos. Is the organisation is known for its work in a particular speciality? It is also worth reviewing the job description to see how well your skillset and CV match the role.

It is important to try to sleep well the night before, have a good breakfast and stay hydrated, as these will all help you to focus and perform well. Aim to arrive at least 10 minutes early; plan how you will get there and allow time for the unexpected, eg. delayed bus, difficulty finding a parking spot. Turn your phone off, discard any chewing gum, make eye contact and smile when you greet your interviewers. Hand shaking should be avoided at present due to Covid-19. It is possible that some interviews may be held over a video call due to Covid-19, but the same principles would apply.

Table 1. STAR technique

Situation	Describe the event or situation that you were in
Task	Explain the task you had to complete
Action	Describe the specific actions you took to complete the task
Result	Close with the results of your efforts

During the interview

Be sure to maintain eye contact with your interviewers. Be aware of your body language and the way you communicate, as some people tend to slouch, fidget or speak too quickly when they become nervous. Similarly, some people tend to punctuate sentences with 'you know' or 'like', or fill pauses with 'um' or 'ah' when nervous. Practising with friends/family beforehand and asking for honest feedback can help make you aware of what to look out for. It is ok to take a breath before answering a question or use phrases like 'That's an interesting question…' to buy yourself a little time to collect your thoughts before answering. The STAR technique *(see Table 1)* can be extremely helpful when answering competency-based questions, as it can be used to demonstrate previous experience, eg. 'How would you prioritise your workload at the start of a shift?'

Some questions may be skills/knowledge-based, such as 'Tell me about the EWS/ISBAR' or 'What are the five moments of hand hygiene?', while some may assess your professional development, eg. 'How do you keep up to date in your practice?' Others may assess how you communicate, eg. 'How would you deal with relatives who complain about the care of their loved one?' Remember that you are applying for a staff nurse/midwife position, so you should avoid limiting yourself by using phrases like 'I can't do that as I'm only an intern'. Instead, you could say what you would do as a staff nurse/midwife.

After the interview

Interviewers often ask candidates if they have any questions and it can be helpful to come up with a few questions to demonstrate interest. Thanking your interviewers for their time will leave them with a positive impression. Whether or not the interview goes well, you can ask for feedback on the interview when you are contacted with the result. This can help you to improve your interview skills whenever you next go for an interview.

Further resources

The INMO offer courses on interview skills. Due to Covid-19, some courses are now available online. Please keep an eye on **www.inmoprofessional.ie** for updates. Additionally, many colleges have career guidance services and offer assistance with CV preparation or mock interviews.

Join a Youth Forum

It's never too late to get involved. Both students and qualified nurses/midwives can be members of one of the regional Youth Forums if under the age of 35. To learn more about what is involved, please contact me at email: catherine.oconnor@inmo.ie

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A column by Maureen Flynn

Maintaining the principles of open disclosure in a pandemic

THIS month we draw attention to one of the foundations of quality and safety – open disclosure. The unprecedented environment and many new ways of working and restricting movement can impede on effective communication and the well-established processes for open disclosure. Understanding this, the National QI Team prepared a practical guide for maintaining the principles of open disclosure during the coronavirus pandemic.

Coronavirus and communication

Personal distancing and the requirement for staff to wear personal protective equipment (PPE) creates communication challenges causing patients, their families nurses and midwives to struggle to hear what is being said and to see who they are talking to. We may feel that our humanity and human connection with patients is compromised by PPE and our inability to provide physical comfort, such as holding a patient's hand. Conversations may be shortened. Physical contact is reduced to only necessary contact. Patients who are ill and vulnerable may be limited to talking to their loved ones only by telephone or video link with no physical contact. Patients are experiencing the loneliness of illness and isolation. Their families are living with anxiety and fear for their loved ones and distress due to not being able to be with them. We all fear Covid-19.

Openness and transparency

The HSE is committed to communicating in an open, honest and factual manner with all those affected by Covid-19. This involves providing factual information in relation to:

- Diagnosis, care and treatment
- Risks
- Source of infection (if known). It is important to protect the identity of all patients and staff who have tested positive for Covid-19. When informing people that they have been identified as a close contact of a person who has tested positive for Covid-19 the name of the patient or staff member are not provided due to their rights to confidentiality and data protection. The name of the ward or area where they were exposed and date of exposure to Covid-19 can be provided
- Contributory factors
- Up-to-date public health information and advice.

Tips for open disclosure meetings

During any crisis it is important that the principles of openness and transparency are maintained in relation to not only the management of and response to all patient safety incidents but also in relation to those affected by Covid-19.

Every effort must be made to engage in meaningful open disclosure with patients and their families in a timely manner. Face-to-face meetings are the preferred option when conducting formal open disclosure meetings, these may not be possible now due to restricted movement, visiting restrictions and the risks of exposure to Covid-19 for staff, in-patients and visitors.

Face-to-face meetings must only be facilitated when it is safe to do so and in an environment that meets all of the necessary infection prevention and control measures. An alternative method of communication must be discussed and agreed. The role of the designated person (key contact person) is critical in relation to liaising with the patient/relevant person and establishing their preferred option for communication, in addition to supporting them in preparing for and managing the meeting.

- Communication options may include telephone call, Skype call, Zoom, Microsoft teams, FaceTime etc, depending on what the patient/relevant person can access and which is easier for them to manage
- It is important that these calls are managed over a secure network
- The date and time of the call will be discussed and agreed with all parties
- The information provided during the call will be managed in line with the provisions of the open disclosure policy.

A summary of the meeting will be sent on to the relevant people.

Open Disclosure
Maintaining the Principles of Open Disclosure during the Coronavirus Pandemic and Covid-19 Restrictions

Get involved

At your next ward, team or unit meeting, you might like to talk about open disclosure and raise awareness among your colleagues. Infectious disease outbreaks like Covid-19 can be worrying. Your infection prevention and control team can assist and advise on infection prevention and control measures to protect the patient, their relevant person(s) and staff.

Most people's lives will change in some way over a period of days, weeks or months. This can affect your mental health. There are many things you can do to mind your mental health and support your colleagues during times like this – see list of resources below.

You can access the Covid-19 open disclosure practical guide and other information on open disclosure on the National QI Team website at **www.opendisclosure.ie**, or by contacting Angela Tysall, lead in open disclosure, email: angela.tysall@hse.ie or opendisclosure.office@hse.ie

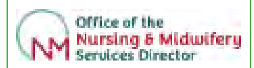
Maureen Flynn is the director of nursing ONMSD, QI Connections Lead, HSE National Quality Improvement

Acknowledgements: A particular thanks to my colleague Angela Tysall and the members of the Open Disclosure Team for developing this guide and assisting in preparing this column

Resources

- *Minding your mental health during the coronavirus pandemic https://www2.hse.ie/wellbeing/mental-health/covid-19/minding-your-mental-health-during-the-coronavirus-outbreak.html*
- *SilverCloud Health - Online mental health service providing free access to all HSE staff to four self-directed online programmes https://hse.silvercloudhealth.com/signup/*
- *Stress control programme available at stresscontrol.org*

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



Give a little respect

Those who behave in a challenging manner are simply raising their voices to be heard and need to be afforded respect, writes **Brian McDonald**

ARETHA Franklin and Erasure pleaded with us to give a little RESPECT. We espouse the word a lot but what does it mean? It can mean 'polite behaviour toward, or care for, someone or something that you think is important'.[1]

Respect is a short, simple word that undoubtedly appears in the guiding documentation of many organisations. Many interventions are subsequently guided by these organisational policies and it is required that organisational policy does not deviate from the laws of the land. By association, it is then essential that the laws of the land do not deviate from the Universal Declaration of Human Rights.[2]

That seems rational and presents an opportunity to become re-acquainted with the Declaration. It has an interesting line in its preamble – "whereas it is essential, if man is not to be compelled to have recourse, as a last resort, to rebellion against tyranny and oppression, that human rights should be protected by the rule of law". Tyranny – 'unfair or cruel use of power or authority'. Oppression – 'cruel and unfair treatment of people, especially by not giving them the same freedom, rights, etc. as other people'.

Those are strong words. What if we adapt the word 'rebellion' and employ terminology such as behaviours that challenge, challenging behaviour, behaviours of concern, responsive behaviours. Pick your phrase, whatever you feel comfortable with. Terminology will change again but what we must accept is that behaviours that challenge, aka 'rebellion', are manifestations of stress.

Brief consideration tells us that it all started with a medical model of care. A model which attempted to fix or contain impairments or differences in 'patients' using medical/other treatments, even when the impairment or difference did not cause pain or illness. It considered what was 'wrong' with the person, not necessarily what the person needed. It created low expectations resulting in loss of independence, choice and control.

The social model of care brought new attitudes that sought to remove barriers for 'the person' and offer increased choice, rights, participation and inclusion. Examples being person-centred planning, personal outcomes, social role valorisation, active support, positive behaviour support and self-directed supported living. But consider this:

- Was everything about the medical model bad?
- Is everything about the social model good?
- Have we given away the medical aspect of care of people with complex and specific needs to the detriment of the well-being of the individual?
- Should we be more focused on the biopsychosocial model?

Please have a look at Richard Handley's case to inform your considerations.[3]

The claim that 'behaviours that challenge are manifestations of stress' is often countered with "Sure how could *they* be stressed? Isn't everything provided for *them*?" To be fair *they* would appear, on the surface, to be well-supported by a wide variety of acronyms that support us in the care of *them*. The fact is, in a lot of cases, they are stressed because their access to a 'good life' is being impeded.[4] The packages aren't working for them. Maybe they're not being heard. Maybe they're lonely. Maybe they have limited choice. Maybe they're unwell. Maybe there are many other reasons that would cause any of us to be greatly distressed.

You can do assessments to discover this if you need to. Call them functional assessments, interview informed synthesised contingency analysis, or whatever you like, but ultimately, we need to discover what we're being told and support the person to address these issues.

Respectfully enquire in a way that can be understood and engaged with. Listen. You'll discover that it's often that simple. Sometimes as simple as a physical examination. Richard Handley would have appreciated that, rather than having the severe constipation that resulted in his death attributed to behaviours that challenge.

People who present with behaviours that challenge are simply raising their voice to be heard. We need to listen, with our eyes and our ears. My uncomplicated view is that we are being told one, or a combination, of four things (see *Figure 1*):

- Physiologically – something's not right… I need you to help me with it
- Communication – I am not being understood or I'm not understanding
- Environment – this is not the place for me. It could be if…
- Who – I'd like to be supported by people that know me and want to support me and are being looked after themselves.

Crucially, you will realise that we are not being asked to change their behaviour as much as we are being pleaded with to change our behaviour – as a person, as a team, as an organisation. Even as a nation.

This is not an assertion that disability services deliberately set out to have their service provision experienced as tyrannical and oppressive. There are so many amazing practices out there – just check out home sharing if you would like your soul lifted.[5] There are incredible people who listen and advocate and support and love doing so. I've been highly fortunate to work with, and for, some of these people. They were 'practice leaders' long before the concept was formalised.[6]

Notwithstanding the brilliance of some, we must acknowledge that there are practices that continue to happen that simply should not. Practices that come under the definitions of tyranny and oppression. We must confront these practices at all levels. Failure to do so results in 'normalisation of

deviance'[7] from which can result issues such as those exposed in Winterbourne,[8] Whorlton Hall[9] and our own Áras Attracta.[10]

Something else to consider – in disability services when your biopsychosocial needs, and particularly when your life situation changes, what do you become?

You may well become a business case. Risk funded. Someone who's quality of life depends on amended service provision being provided on a cost neutral basis. Numbers on a spreadsheet. Referenced as a 'sum of money' at meetings that you are not attending. Boxes on a form are ticked and you go into a queue.

Because the system labels you a 'business case', your choices, your rights, your levels of participation and inclusion can be severely impacted. Your stress increased and behaviours that challenge evident. You may be supported 'out of area' at high cost and a long way from home. You may be transferred to an acute mental health unit for a 'period of assessment' only to find yourself still languishing there 18 months later in an environment totally incongruent with your needs until your business case is prioritised.

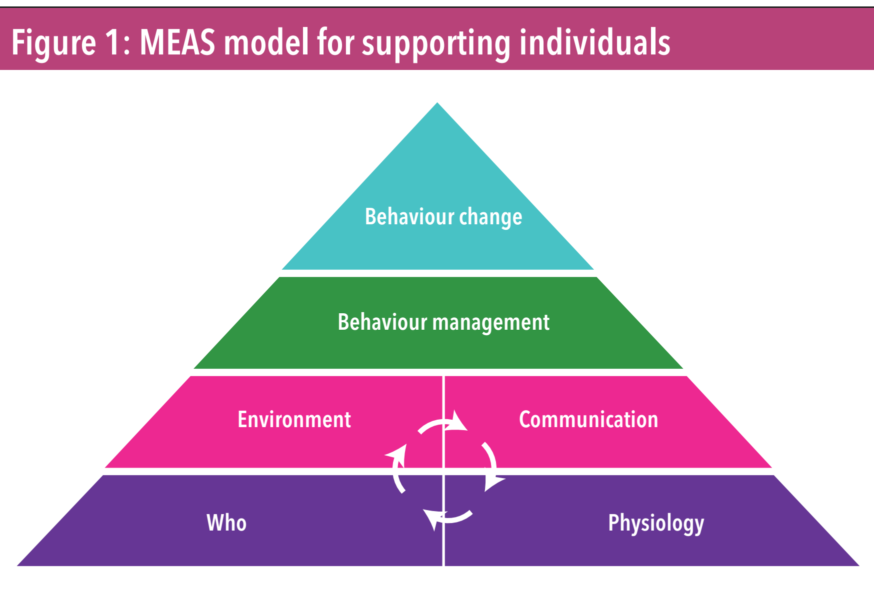
You are more likely to experience restrictive interventions, to receive psychotropic medication, to be a statistic in incident reporting systems and, ironically, to be more costly to the system. How stressed would you be? Would you cope? Would you react behaviourally? Are we now experiencing a financial model of care?

The default has become to refer *these people* to behaviour specialists in various guises with an expectation that they will change the person's behaviour to fit within the limitations of the service.

Ethical clinicians will hold a mirror up to that service and support it to reflect on what is helping, or hindering, the 'referral' or (Seán/Mary) as he/she prefers to be called. If you want to support someone who must resort to behaviours that challenge, get to know them and their story. Reduce the stressors in their lives. Engage in empathy. Step into their shoes and have a look at what their life is like. Increase the positives. Support them to be active and challenged in mind and body. Provide meaningful relationships.[11] Offer respect. Spend time with them.

I may be talking myself out of a job here but there was a time when we didn't have a proliferation of people trained in ABA, PBS, MEBS, etc. There were fewer staff and there seemed to be fewer issues. How can that be? Surely more staff and more behaviour support plans mean fewer behavioural issues.

Figure 1: MEAS model for supporting individuals



There is a simple and incredibly significant explanation – time. We had more of it to spend with the people we were supporting. If frontline staff were less overwhelmed with paperwork, meetings etc and were afforded the freedom to provide time as a PRN (as required) intervention the benefits would be far-reaching. Relationships would form. Skills would develop. Morale would improve. Quality of life would improve. Behavioural issues would reduce.

Is this a financial issue? Sometimes, but often it's about will, attitude, culture, creativity and the fundamentals of caring. It's about respect for the people who are supported by the service and respect for those providing the service (now there's a topic for another day). In my (almost) 30 years in care services I've worked with some very wise ward sisters, colleagues, unit directors, service managers, bus drivers, directors of services and advanced nurse practitioners who have shaped my practice. But, when it came to knowing their needs, none were wiser than any of the individuals who I've been privileged to support.

Covid-19 has been difficult for all. That goes without saying. But maybe we can learn something from it. My sense, from engaging with colleagues in services, is that behaviours that challenge statistics have reduced in numerous settings during the pandemic. Maybe offering people a gentler day with less pressure to be somewhere on someone else's timetable while supporting them with a staff team that is being valued, that is consistent and has time to get to know them is the way to go. It's worth a try.

Maybe you know an individual who is presenting with behaviours that challenge, who is living somewhere they didn't choose to live, with people they are not compatible with, where there are frequent staffing changes, with non-functioning communication strategies and underlying medical and/or mental health difficulties?

English comedian of old, Tommy Cooper had something to teach us through this innocent joke. He says "I went to the doctor the other day and I said, 'it hurts when I do this' (Tommy raises his hand) and the doctor says 'well, don't do it then'". Imagine you referred this individual to Tommy Cooper, what would he say? He'd say "don't do that to them then".

Respect works. Give it a go!

Brian Mc Donald is an RNID and positive behaviour support specialist

Addendum: Social media is a powerful space. Sometimes for good, sometimes not. This tweet appeared on my phone as I wrote this article:
'Time is always moving on. Nothing can stop it. We can't change the past, but we can learn from it to shape the future. Stress on "us" and "them" is a source of conflict. We neglect basic human qualities of kindness and compassion. Let's work together to create a happier future' - Dalai Lama, 20/4/2020 10.30 a.m.

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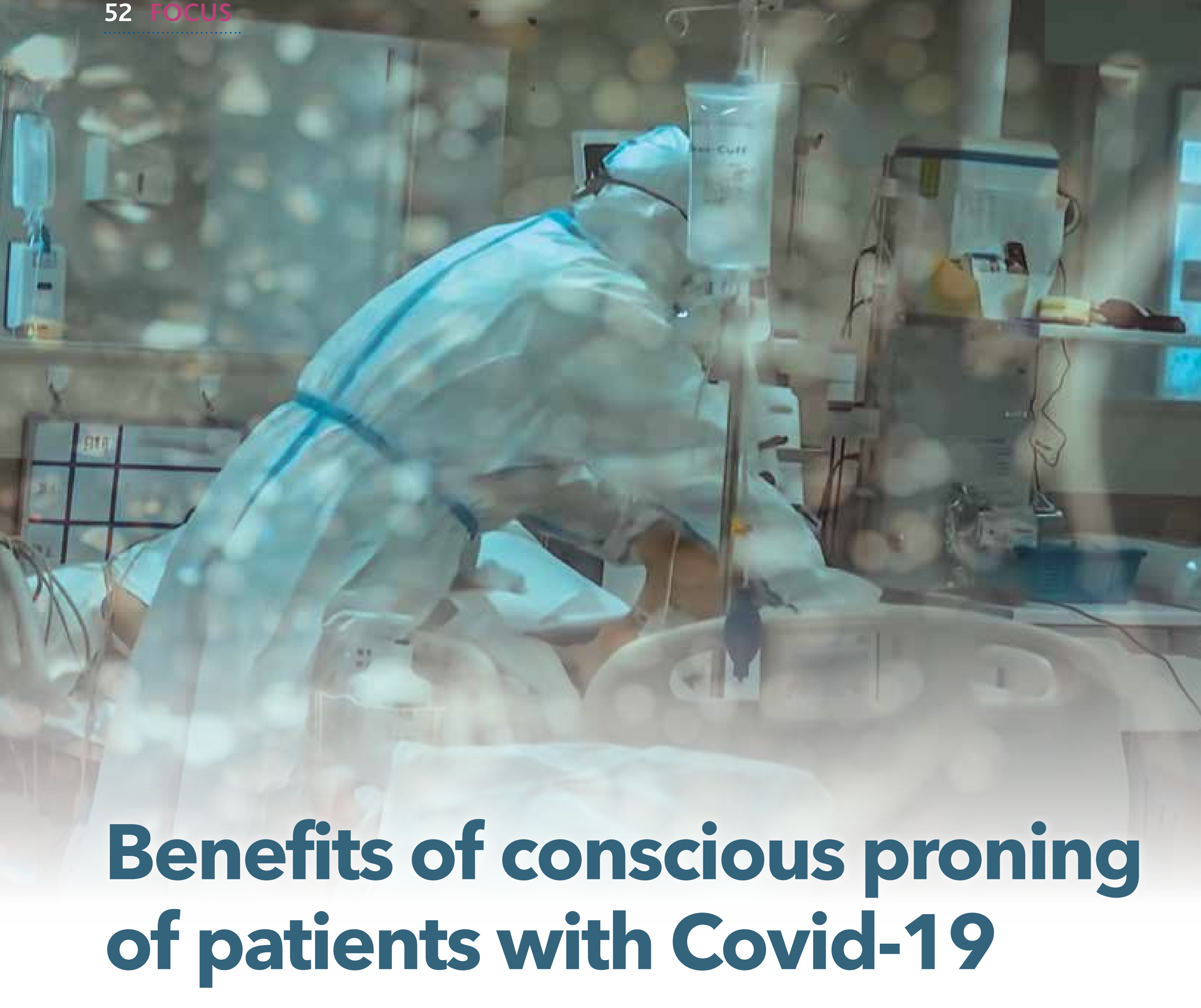

Benefits of conscious proning of patients with Covid-19

A team from **Portiuncula Hospital** discuss the evidence base for the early conscious proning of patients with a Covid-19 diagnosis

COVID-19 is a novel pathogenic virus caused by Sars-CoV2, severe acute respiratory syndrome coronavirus.[1] Most people who are infected with Covid-19 will experience respiratory symptoms but will recover. The HSE estimates about 80% of people will experience the disease as a mild illness and will recover without hospital intervention while a further 14% will experience a more severe illness. Significantly, a further 6% of people will go on to experience a critical illness.[2]

Sars-CoV2 may cause acute lung injury and acute respiratory distress syndrome (ARDS). This can lead to respiratory failure and may result in death.

A recent literature review by Diamond et al demonstrated an overall mortality rate for ARDS patients of 43%.[3] There is much evidence in the literature in relation to the management of ARDS and there is a rapidly expanding body of evidence in relation to the management of patients diagnosed with Covid-19 who go on to develop ARDS. This article will discuss the experience of conscious proning of a patient diagnosed with Covid-19 on a respiratory ward in a level 3 hospital.

ARDS is characterised by bilateral lung infiltrates and worsening hypoxaemia. It is assessed using a ratio of the patient's arterial oxygen level (PaO_2) to the fraction of oxygen in the air inspired (FiO2). Patients with a PaO_2:FiO_2 (PFR) of less than 200 are deemed to have severe ARDS.[4]

Patients diagnosed with Covid-19 who go on to develop severe hypoxaemia notably have little reduction in lung compliance which is in contrast to patients diagnosed with ARDS which is classically characterised by low lung compliance.[5] There is a strong evidence base in support of prone positioning of ARDS patients to improve oxygenation.

The PROSEVA ARDS trial confirmed a reduced mortality when proning was introduced and significantly the trial advocates for early implementation of proning. It showed mortality of 16% in proned patients versus 32.8% in supine patients. Data from the UK's Intensive Care National Audit and Research Centre (ICNARC) observed higher than expected

mortality among Covid-19 patients who are mechanically ventilated. This data reports that 66.3% of patients with Covid-19 who required mechanical ventilation died.[6]

Case study

A 59-year-old man presented to the emergency department via his GP with ongoing breathlessness. He had a background history of asthma (British Thoracic Society, level 2 asthma), moderate obstructive sleep apnoea and hypertension. On presentation his chest x-ray showed multilobar bilateral infiltrates. His oxygen saturations were 89% on room air in the ED, with a PFR of 257. A swab confirmed the diagnosis of Covid-19 infection.

On day two of admission he desaturated further requiring > 4Lpm of oxygen to maintain his saturations > 94%. A decision was made to carry out a trial of conscious proning with supplemental oxygen therapy.

In consultation with the respiratory consultant the conscious proning procedure was guided by senior respiratory physiotherapists and the respiratory nurse specialist. The procedure and rationale was fully explained to the patient in order to gain his co-operation. Pillows were placed for self-comfort and proning time was targeted at nine to 10 hours each day (three hours in morning, three hours in afternoon and three hours in evening).

In patients with moderate-to-severe ARDS who are on mechanical ventilation, it is suggested to aim for prone ventilation for 12-16 hours.[7] Despite a shorter proning duration than desired due to staffing constraints at night, the observed physiologic effects of proning on oxygenation were clearly apparent *(see Table)*. Throughout the proning trial the patient was monitored very closely with regular observation of vital signs including oxygen saturations (spO_2).

An immediate observation was that proning optimised the ventilation to perfusion ratio (V/Q) which improved oxygenation and PFR *(see Table)*. Despite the fact that initially the patient disliked the periods of time in prone position, he was very motivated by the improvement as he felt much less breathless. This was an important factor in his motivation to continue self proning.

It is possible that introducing a proning regime early in this patient's illness may have prevented him from requiring mechanical ventilation along with all the associated problems this entails. Antibiotic regime was a combination therapy with hydroxychloroquine and azithromycin, as was local recommendation at the time.

Table: Patient's cyclical improvements in oxygenation and PFR

Day	pO_2	fiO_2	PFR	spO_2	Intervention
Admission	7.2	0.21	257	89%	Supine on room air
	12.05	0.35	258	97%	Supine + supplemental oxygen(0.35) = Improved spO2, static PFR
Day 2	9.62	0.35	206	95%	Supine + supplemental oxygen(0.35) = Improved spO2, static PFR
	18.7	0.35	400	98%	Prone + supplemental oxygen (0.35) = Improved spO2, normal PFR
Day 7	9.59	0.35	205	94.50%	Supine + supplemental oxygen (0.35) = Maintained spO2, reduced PFR
	9.51	0.21	339	94.40%	Prone + room air = Acceptable spO2, normal PFR

A multidisciplinary approach was taken in the care of this patient and as a result of his anxiety in returning to supine following proning he was referred to the palliative services for symptom management. They recommended buccal midazolam hydrochloride when necessary prior to supining which proved very effective. The patient also monitored his own spO_2 which allowed him reassurance of his recovery.

The patient continued to improve each day and was subsequently discharged home after 14 days, which included 10 days of proning. He was then followed up at home for five more days having been provided with pulse oximetry. Thromboprophylaxis continued for one month post discharge.

This patient experienced a very positive outcome which can be attributed to the early intervention of a proning protocol under the supervision of a multidisciplinary respiratory team.

This strategy may not be suitable for every patient in a ward setting but consideration should be given to whether conscious proning – this decision will be guided by nurse-to-patient ratio and patient motivation – may be a beneficial intervention for patients with hypoxaemia and a diagnosis of Covid-19.

Early proning at ward level is possible provided a multidisciplinary respiratory team is available and this could be useful in pandemic surge if ICU beds are in short supply. A randomised control trial is warranted to further explore the outcomes of conscious proned patients with Covid-19.

Emma Burke is a respiratory nurse specialist, Ciara Dolan is a respiratory clinical specialist physiotherapist, Noreen Fallon is a candidate advanced nurse practitioner and Hilary McLoughlin is a consultant in respiratory medicine, all at Portiuncula Hospital, Galway

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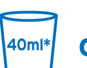
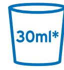
Serve as 1 or in shots of 3x  **or 4x** 

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**https://www.hse.ie/eng/about/who/cspd/ncps/medicines-management/oral-nutritional-supplements/

Date of preparation: October 2019
Job code: EN/3.2kcal.005.19

Nutritional guidance for the Covid-19 period

The HSE has issued advice to directors of nursing in residential care

COVID-19 in older people may cause loss of appetite, nausea, vomiting, diarrhoea, swallowing difficulties, loss of smell or taste, weight loss and fatigue. These can all lead to poor oral intake, which in turn increases the person's risk of malnutrition and frailty. The HSE has produced a new guidance document with advice and resources on nutritional support for older people in residential care settings, both public and private, during the Covid-19 pandemic.

The guidance emphasises that nutrition and hydration care are essential and should be recorded as part of a resident's care plan. Mealtimes are an important part of a resident's day, not only from the perspective of adequate nutrition for health, but also for socialisation, engagement, connection and assessment.

If a resident is consuming less than 50% of their meals, or has lost more than 2kg in the past month, then the following five key actions are recommended:

- Commence high-protein high-calorie diet
- Offer extra high-protein high-calorie snacks
- Offer regular drinks
- Prescribe oral nutritional supplements (ONS) as recommended in the nutrition support pathway
- Consider prescribing vitamin D.

The guidance stresses that any actions should be taken in consultation with the GP/prescriber and a dietitian, and that if your nursing home has access to dietetic support and a nutrition screening pathway, you should continue to avail of this.

Nutrition support pathway

The nutrition support pathway *(see next page)* contains suggestions primarily based on energy and protein content of oral nutritional supplements. Choice of supplement for a resident should consider multiple factors, such as taste preference, compliance and safe swallow recommendations. The guidance was designed to aid clinical decision making. It is not intended to outweigh clinical judgement. The guidance emphasises that the pathway is not suitable for patients with complex nutritional needs, rather their nutritional care should be managed by a dietitian.

Refeeding syndrome

Symptoms can arise due to shifts in electrolyte and fluid balance in malnourished residents on recommencement of eating, with potentially serious outcomes. This is uncommon in a nursing home setting under normal circumstances. However, acute illness increases likelihood. Those at highest risk are residents with a very low BMI (< 16kg/m^2) who have had very poor or no nutritional intake over a period of five to 10 days.

To help manage refeeding syndrome, the following is recommended in consultation with the GP:

- Reintroduce food or oral nutritional supplements gradually, building up slowly to full meals and ONS dosage over five days – refer to dietitian for specific guidance
- Prescribe thiamine ≥ 250mg IV daily for three days or 200-300mg *po* for 10 days
- Prescribe general multivitamin and mineral supplement
- It is best practice to request blood test electrolytes (U&E, Ca, PO4, Mg) daily for five days and then alternate days until stable. Electrolytes should be replaced where required, and ECG monitored where possible. The guidance notes that this may not be practical at this time.

For more information see **www.irspen.ie**

Guidance for assisting at mealtimes

The aim is to provide a pleasant mealtime experience with adequate and appropriate assistance, which may help residents who have a decreased appetite at this time and may be struggling to complete meals. It is important to be aware of the specific eating, drinking and swallowing requirements as set out by the speech and language therapist if the resident was assessed by one.

Residents should be upright and alert for all food and drinks and remain sitting upright for 30 minutes after. It is best to sit with the person at eye level either directly ahead or slightly to the right or left. Do not sit at the side as the person will find it difficult to see you. The person should be upright, centred and comfortable.

Some tips from the guidance include:

- Always ask if the person needs assistance rather than assuming they need it
- The person's independence should be maintained where possible
- Be guided by their wishes and respect their individuality and dignity at all times
- If there is a choice of cutlery, ask which they would like and follow any recommendations from the occupational therapist
- Make sure the person can reach all of their food. Offer to help open any packets
- Offer assistance to cut up food, but if the person wants to do it, let them
- If the person does need help feeding, give small mouthfuls at a time
- Respect the person's wishes if they choose to take only a few spoonfuls. Even small amounts can make a difference.

Nutrition and end of life care

- Identify and manage symptoms that may limit oral intake, eg. sore mouth, nausea, vomiting, constipation, diarrhoea, pain
- Advise patient and family that, at this time, care should focus on enjoyment of food rather than quantity of food consumed or reversing weight loss
- Provide assistance and support at mealtimes as required
- Offer favourite foods
- Encourage the resident to eat little and often as tolerated
- Finger foods may be useful as snacks or small meals
- Offer sips of drinks regularly
- Oral nutritional supplements should only be prescribed if they promote comfort and are tolerated.

More information

The guidance pack – which was written by Siobhan Kennelly, HSE National Clinical Advisory Group lead, Older Persons, and Margaret O'Neill, HSE national dietetic lead – also includes details of high protein meals, a snack menu, details on making fortified drinks and a breakdown of the vitamin D content of commonly used oral nutritional supplements. The full guidance document and further resources are available at **www.hse.ie/nutritionsupports**

– Alison Moore

Table: Covid-19 nutrition support pathway for residential care facilities for older persons

This HSE guidance is designed to aid clinical decision making for all residents during the Covid-19 period. If the resident has been recommended a therapeutic diet (renal, gluten free, diabetic) or is already established on an oral nutritional supplement or on enteral nutrition refer to dietitian before making any dietary changes

Useful tip: Mid upper arm circumference (MUAC) can be used to estimate BMI

Is resident consuming < 50% meals for > three days? and/or weight loss of > 2kg noted in the past month?

- NO → Continue to monitor
- YES ↓

Has the resident:
- A very low BMI (< 16kg/m²)?
- Experienced rapid weight loss?
- Little or no nutritional intake for 5-10 days?

- YES → Check if resident is at risk of refeeding syndrome or if resident is receiving end of life care
- NO ↓

Five key actions
- Commence on high-protein high-calorie diet
- Offer additional high-protein high-calorie snacks
- Offer regular drinks
- Prescribe oral nutritional supplement (ONS) as recommended below
- Consider prescribing vitamin D[1]

↓

Does the resident have dysphagia requiring thickened products?

YES →

Prescribe two thickened or pudding-style ONS per day

Thickened drinks
- Fresubin Thickened Level 2 200ml
- Fresubin Thickened Level 3 200ml
- Nutilis Complete Drink Level 3 125ml

Level 3-4 semi-solid pudding
- Aymes Crème 125g
- Ensure Plus Crème 125g
- Forticreme Complete 125g
- Fresubin 2Kcal Crème 125g
- Nutilis Fruit Level 4 150g
- Nutricrem 125g

NO ↓

Prescribe two bottles of a high protein ONS per day

Options include:
- Altraplen Protein 200ml
- Ensure Plus Advance 220ml or Ensure Plus HP 200ml
- Fortisip Compact Protein 125ml or Fortisip Extra 200ml
- Fresubin Protein Energy 200ml or Fresubin 3.2 Kcal 125ml

↓

Is there ongoing weight loss and poor oral intake?

- YES →
  - Refer to dietitian or GP
  - Ask if end-of-life care is indicated?
- NO → When the resident is established on adequate oral intake from food:
  - Consider reducing the quantity of ONS gradually after one month
  - Continue to monitor for recurrence of risk of malnutrition (monthly weight check)

1. It is safe to advise 20µg (800iu) vitamin D as a daily supplement (if no contraindications) to those who are NOT already on prescribed combination calcium/vitamin D supplements. For more information on vitamin D requirements see *pages 61* of this issue and *McKenna MJ, Flynn MAT. Covid-19, cocooning and vitamin D intake requirements. Ir MedJ 2020 (May); 113(5):79*

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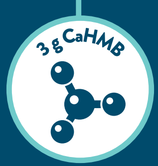

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† As shown in a randomised control trial to investigate the effects of a specialised ONS on older women (≥ 65 years) who underwent surgery for hip fracture vs. standard postoperative nutrition. Muscle function was measured by hand grip strength. ‡ Ensure Plus Advance was shown to preserve muscle mass in elderly patients after hip fracture surgery with rehabilitation when consumed twice a day for 30 days as compared to standard care. ¤ Dosage recommended for clinical improvements in nutritionally at-risk patients with poor muscle mass, pulmonary rehabilitation, poor wound healing, congestive heart failure, acute myocardial infarction, pneumonia, COPD and in older patients. ^ Calcium β-hydroxy-β-methylbutyrate.

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Date of Preparation: May 2020 | IE-ENSPA-2000013

Many adults continue to be at risk of new HPV infections[1]

Recommend Gardasil9 to prevent future infections against 9 of the most common high risk HPV types.

50% **of Cervical Cancers** are estimated to be due to HPV infections acquired after 20 years of age.[2]

9-VALENT HPV PROTECTION

Gardasil 9 is now available to order privately from MSD. msd@united-drug.com Freephone orderline 1800 200 845 Freefax orderline 1800 200 846

GARDASIL® 9 (Human Papillomavirus 9-valent Vaccine (Recombinant, adsorbed)).

This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions. See section 4.8 of the SPC for how to report adverse reactions.

ABRIDGED PRODUCT INFORMATION Refer to Summary of Product Characteristics before prescribing. **PRESENTATION** Gardasil 9 is supplied as a single dose pre-filled syringe containing 0.5 millilitre of suspension. Each dose of vaccine contains highly purified virus-like particles (VLPs) of the major capsid L1 protein of Human Papillomavirus (HPV). These are type 6 (30 mg), type 11 (40 mg), type 16 (60 mg), type 18 (40 mg), type 31 (20 mg), type 33 (20 mg), type 45 (20 mg), type 52 (20 mg) and type 58 (20 mg). **INDICATIONS** Gardasil 9 is a vaccine for use from the age of 9 years for the prevention of premalignant lesions and cancers affecting the cervix, vulva, vagina and anus caused by vaccine HPV-types and genital warts (condyloma acuminata) caused by specific HPV types. The indication is based on the demonstration of efficacy of Gardasil 9 in males and females 16 to 26 years of age and on the demonstration of immunogenicity of Gardasil 9 in children and adolescents aged 9 to 15 years. The use of Gardasil 9 should be in accordance with official recommendations. **DOSAGE AND ADMINISTRATION** *Individuals 9 to and including 14 years of age at time of first injection:* Gardasil 9 can be administered according to a 2-dose schedule. The second dose should be administered between 5 and 13 months after the first dose. If the second vaccine dose is administered earlier than 5 months after the first dose, a third dose should always be administered. Gardasil 9 can be administered according to a 3-dose (0, 2, 6 months) schedule. The second dose should be administered at least one month after the first dose and the third dose should be administered at least 3 months after the second dose. All three doses should be given within a 1-year period. *Individuals 15 years of age and older at time of first injection:* Gardasil 9 should be administered according to a 3-dose (0, 2, 6 months) schedule. The second dose should be administered at least one month after the first dose and the third dose should be administered at least 3 months after the second dose. All three doses should be given within a 1-year period. It is recommended that individuals who receive a first dose of Gardasil 9 complete the vaccination course with Gardasil 9. The need for a booster dose has not been established. Studies using a mixed regimen (interchangeability) of HPV vaccines were not performed for Gardasil 9. Subjects previously vaccinated with a 3dose regimen of quadrivalent HPV types 6, 11, 16, and 18 vaccine (Gardasil or Silgard), hereafter referred to as qHPV vaccine, may receive 3 doses of Gardasil 9. The use of Gardasil 9 should be in accordance with official recommendations. *Paediatric population (children <9 years of age):* The safety and efficacy of Gardasil 9 in children below 9 years of age have not been established. No data are available. The vaccine should be administered by intramuscular injection. The preferred site is the deltoid area of the upper arm or in the higher anterolateral area of the thigh. Gardasil 9 must not be injected intravascularly, subcutaneously or intradermally. The vaccine should not be mixed in the same syringe with any other vaccines and solution. **CONTRAINDICATIONS** Hypersensitivity to any component of the vaccine including active substances and/or excipients. Individuals with hypersensitivity after previous administration of Gardasil 9 or Gardasil /Silgard should not receive Gardasil 9. **PRECAUTIONS AND WARNINGS** In order to improve traceability of biological medicinal products, the name and batch number of the administered product should be clearly recorded. The decision to vaccinate an individual should take into account the risk for previous HPV exposure and potential benefit from vaccination. As with all injectable vaccines, appropriate medical treatment and supervision should always be readily available in case of rare anaphylactic reactions following the administration of the vaccine. The vaccine should be given with caution to individuals with thrombocytopaenia or any coagulation disorder because bleeding may occur following an intramuscular administration in these individuals. Syncope, sometimes associated with falling, can occur before or after vaccination with Gardasil 9 as a psychogenic response to the needle injection. Vaccinees should be observed for approximately 15 minutes after vaccination; procedures should be in place to avoid injury from faints. Vaccination should be postponed in individuals suffering from an acute severe febrile illness. However, the presence of a minor infection, such as a mild upper respiratory tract infection or low-grade fever, is not a contraindication for immunisation. As with any vaccine, vaccination with Gardasil 9 may not result in protection in all vaccine recipients. Gardasil 9 will only protect against diseases that are caused by HPV types targeted by the vaccine. The vaccine is for prophylactic use only and has no effect on active HPV infections or established clinical disease. The vaccine has not been shown to have a therapeutic effect and is not indicated for treatment of cervical, vulvar, vaginal and anal cancer, high-grade cervical, vulvar, vaginal and anal dysplastic lesions or genital warts. It is also not intended to prevent progression of other established HPV-related lesions. Gardasil 9 does not prevent lesions due to a vaccine HPV type in individuals infected with that HPV type at the time of vaccination. Vaccination is not a substitute for routine cervical screening. There are no data on the use of Gardasil 9 in individuals with impaired immune responsiveness. Safety and immunogenicity of a qHPV vaccine have been assessed in individuals aged from 7 to 12 years who are known to be infected with human immunodeficiency virus (HIV). Individuals with impaired immune responsiveness, due to either the use of potent immunosuppressive therapy, a genetic defect, Human Immunodeficiency Virus (HIV) infection, or other causes, may not respond to Gardasil 9. Long-term follow-up studies are currently ongoing to determine the duration of protection. There are no safety, immunogenicity or efficacy data to support interchangeability of Gardasil 9 with bivalent or quadrivalent HPV vaccines. **PREGNANCY AND LACTATION** There are insufficient data to recommend use of Gardasil 9 during pregnancy; therefore vaccination should be postponed until after completion of pregnancy. The vaccine can be given to breastfeeding women. No human data on the effect of Gardasil 9 on fertility are available. **SIDE EFFECTS** Very common side effects include: erythema, pain and swelling at the injection site and headache. Common side effects include: pruritus and bruising at the injection site, dizziness, nausea, pyrexia and fatigue. The post-marketing safety experience with qHPV vaccine is relevant to Gardasil 9 since the vaccines contain L1 HPV proteins of 4 of the same HPV types. The following adverse experiences have been spontaneously reported during post-approval use of qHPV vaccine and may also be seen in post-marketing experience with Gardasil 9: urticaria, bronchospasm, idiopathic thrombocytopenic purpura, acute disseminated encephalomyelitis, Guillain-Barré Syndrome and hypersensitivity reactions, including anaphylactic/anaphylactoid reactions. For a complete list of undesirable effects please refer to the Summary of Product Characteristics. **PACKAGE QUANTITIES** Single pack containing one 0.5 millilitre dose pre-filled syringe with two separate needles. **Legal category: POM**. **Marketing authorisation number:** EU/1/15/1007/002 (pre-filled syringe with two separate needles). **Marketing Authorisation holder:** MSD VACCINS, 162 avenue Jean Jaurès, 69007 Lyon, France. **Date of revision:** November 2019. © Merck Sharp & Dohme B.V. 2019. All rights reserved. Further information is available on request from: MSD, Red Oak North, South County Business Park, Leopardstown, Dublin 18 D18 X5K7 or from www.medicines.ie. **Date of preparation:** May 2020. II0033-R035

Adverse events should be reported. Reporting forms and information can be found at www.hpra.ie
Adverse events should also be reported to MSD (Tel: 01-299 8700)

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IE-GSL-00045

Cervical cancer screening enters new dimension

Mary Short explains the rationale behind the change from cytology to HPV testing for cervical cancer in Ireland

CERVICAL cancer is the eighth most commonly diagnosed cancer (excluding non-melanoma skin cancer) in women in Ireland. There are, on average, 88 deaths from cervical cancer each year. The incidence of cervical cancer in Ireland is increasing and, based on demography alone, is predicted to increase by 18% by 2040.

The cumulative lifetime risk (to age 74) of a diagnosis of cervical intraepithelial neoplasia (CIN) 1 is one in 13, and one in 112 for a diagnosis of invasive cervical cancer. The cumulative lifetime risk of death due to cervical cancer is one in 333. Cervical cancer incidence has been decreasing by 7% annually since 2015.[1]

Cervical cancer is associated with persistent infection with human papillomavirus (HPV). It is also associated with smoking, and cervical screening should be used opportunistically to discuss smoking cessation.

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.[2] In 2017 the Health Information and Quality Authority (HIQA) published a health technology assessment (HTA) report which was commissioned by CervicalCheck, and this policy change was approved by the Department of Health.[3]

The HTA report focused on HPV testing as the primary screening method for prevention of cervical cancer, highlighting emerging evidence, primarily from Australia and the Netherlands, which demonstrated the improvement in clinical effectiveness and cost-effectiveness of its organised screening programme.

The report concluded that HPV testing, together with a HPV vaccination programme (implemented for girls in 2010 and boys in 2019), was both the recommended strategy for the reduction in the incidence of cervical cancer and the prevalence of abnormal cells.

HPV has been shown to be responsible for the vast majority of squamous cell cervical cancers, so early identification of the virus and subsequent treatment for any abnormal cytology will reduce the incidence of cervical cancer in the future and some might suggest, possibly eradicate it.[4]

HPV testing

From the end of March this year, cervical screening changed from cytology (abnormal cell based screening) to HPV testing.

Cytology-based screening is primarily a test where pre-cancerous cells are detected. HPV testing detects HPV nucleic acids which are strongly associated with cervical cancer.

Any screening test will have false negatives and false positives and its use has to balance the ability of a test to detect the causal agent in this case HPV (sensitivity) with the likelihood of a positive test identifying underlying disease (specificity).

Initially, HPV testing may result in many positive tests which will put undue demands on colposcopy services (higher sensitivity/reduced specificity compared to cytology). With HPV vaccination (and the first cohort of women have already entered the screening system in 2018/19) it is anticipated that there will be a significant increase in the number of women being referred on to colposcopy in years two to three post HPV primary implementation; however over time these numbers will fall.

The new HPV programme is to my mind a more efficient way of screening – where those with active HPV infection are diagnosed and then followed up with cytology (reflex cytology) and treated if required.

From an epidemiological point of view, women may be divided into three categories for the purposes of screening as elucidated by Prof John O'Leary et al in a recent article:[5]

- The first category is 12 to 14 years, before sexual activity begins where the risk of acquisition of HPV is negligible. The majority in this age group will be offered prophylactic HPV vaccination – primary disease prevention
- The second category is 12-25 years, where exposure to HPV occurs as sexual activity begins. Persistent infection occurs most commonly in women over 25, but not all women over 25 have persistent infection. The majority of infections are transient and are cleared by the individual
- The third category is those aged 25 years and older where there is persistent HPV.

Women will automatically leave the screening programme on reaching their 65th birthday provided they have had a recent negative HPV screen.

In general, the presence of HPV is necessary, but not sufficient for the development of cervical cancer. Mild cellular changes and mild dysplasia (CIN 1) may occur after an acute HPV infection, but approximately 90% of these will regress without any treatment

However, persistent HPV infection may lead to precancerous cellular changes (CIN 2 and CIN 3 – high grade changes),

a proportion of which will progress, if not treated, to invasive cervical cancer over a period of 10 to 20 years.[6]

For the most part there will be very few changes to the provision of the screening programme in primary care. The starting age for first screening will remain at 25 years for the general population.

The emphasis will focus on the correct information on the strengths and limitations of cervical screening prior to taking the sample. There are minor changes to the cervical screening form which will accompany the sample.

Initially, the sample will be tested for the presence of HPV. If HPV is found to be present the sample will be further tested for the presence of abnormal cervical cells. If abnormal cells are found then the woman will be referred to colposcopy. If no abnormal cells are found the woman will be retested one year later.

Screening intervals will also change. Standard practice is a three-year interval up to 30 years of age, then five-yearly intervals to age 65. More detailed invites, recalls, results letters, will now be part of the programme

Continuing to screen

It might be asked why we bother to screen if the woman is HPV-negative on more than one occasion and has been vaccinated? HPV is responsible for the majority of cervical cancers; therefore it is important to continue screening. There is also the possibility of developing HPV through activation of a dormant virus or courtesy of a new partner.

It could be argued the using HPV testing as the primary test makes the screening test less specific. However follow-up cytology, should HPV be found, compensates for this lack of specificity.[4,7]

A Cochrane review published in 2018 looked at 40 papers on different screening methodologies. This review found that for every 1,000 women screened, around 20 women will have precancerous changes. The HPV test will correctly identify 18 of these women (but will miss two women). The current smear test will identify 15 of the women (but will miss five women). Unfortunately, two women per 1,000 could go on to develop cervical cancer.[8]

HPV vaccination

In 2010, quadrivalent vaccination against HPV 6, 11, 16 and 18 was introduced to the Irish national immunisation schedule for all girls in the first year of second level school or age equivalent.

A catch-up programme targeting girls in sixth year or age equivalent was run from 2011 until 2014. Cervical screening of women who have been vaccinated against HPV is recommended because the current quadrivalent vaccine does not protect against cervical cancers caused by other high-risk HPV types. The first cohort of young women vaccinated against HPV was due to enter the CervicalCheck programme in 2018-2019.

In September 2019 a HPV vaccination programme was introduced for boys.

Some strains of HPV are responsible for 90% of anogenital warts, but the virus is also responsible for oropharyngeal cancers and anogenital cancers.

Conclusion

With the new programme, the age at first testing remains the same for the population as a whole. The exceptions are those women newly-diagnosed as HIV positive or those awaiting renal transplant.

Women will be sent explanatory letters of invitation for the first screening or as part of the routine recall.

There is no need to retest women outside of the screening protocols as women who have had negative cytology results can be reassured as to the specificity of the test and those with prior abnormal smears will have had HPV testing and were treated accordingly.

Screening for immunocompromised women will start at 25 as per the general population.

Women who need renal transplants should be screened before transplantation.

With the new programme, in the first instance samples will be checked for the presence of HPV and if present the cytology will be performed. Initially there will be more referrals to colposcopy after the commencement of the service but this will diminish over time

Results will be sent directly to the woman and the sample-taker. Letters will have an explanatory content including results and referral pathways if appropriate.

Mary Short is a primary care adviser for HPV with CervicalCheck

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Covid-19: implications of vitamin D deficiency

Researchers are calling on the Irish government to update guidelines on vitamin D supplementation as a matter of urgency, particularly in the context of Covid-19, **Tara Horan** reports

HIGH rates of vitamin D deficiency in Ireland, particularly in older people, could have a significant negative impact on their immune response to infection, including Covid-19, according to researchers from The Irish Longitudinal Study on Ageing (TILDA) at Trinity College Dublin. In addition, they are concerned that the risk of vitamin D deficiency will have increased significantly for those cocooning and confined indoors.

Vitamin D plays a critical role in preventing respiratory infections, reducing antibiotic use and boosting the immune system response to infections, according to a report published by TILDA, *Vitamin D deficiency in Ireland – implications for Covid-19. Results from the Irish Longitudinal Study on Ageing (TILDA)*.[1]

Prof Rose Anne Kenny, principal investigator of TILDA and co-author of the report, said: "We have evidence to support a role for vitamin D in the prevention of chest infections, particularly in older adults who have low levels. In one study vitamin D reduced the risk of chest infections to half in people who took supplements. Though we do not know specifically about the role of vitamin D in Covid infections, given its wider implications for improving immune responses and clear evidence for bone and muscle health, those cocooning and other at-risk cohorts should ensure they have an adequate intake of vitamin D. Cocooning is a necessity but will reduce physical activity. Muscle deconditioning occurs rapidly in these circumstances and vitamin D will help to maintain muscle health and strength in the current crisis."

Dr Eamon Laird, research fellow in medical gerontology and co-author of the report, said: "These findings show our older adults have high levels of vitamin D deficiency which could have a significant negative impact on their immune response to infection. There is an even larger risk now of deficiency with those cocooning or confined indoors. However, vitamin D deficiency is not inevitable – eating foods such as oily fish, eggs, vitamin D fortified cereals or dairy products, and a daily 400 IU (10ug) vitamin D supplement can help avoid deficiency. However, Ireland needs a formal vitamin D food policy/recommendation, which we are still lacking – for instance Finland has such a policy and has virtually eliminated deficiency in its population."

The report describes:

- The importance of vitamin D for immune function
- The prevalence of vitamin D deficiency and vitamin D supplement use in Ireland by age group, gender, geographic location and by obesity and lung disease (particularly vulnerable to Covid-19)
- Those most at risk of deficiency
- The best sources of vitamin D
- Recommendations to improve status.

One in five people over the age of 55 are vitamin D deficient during the winter in the Republic of Ireland, with one in 12 remaining so throughout the year. Of particular concern is the cocooning age groups: nearly 30% of those aged over 70 and 47% of those aged over 85 are deficient in vitamin D. These latter age groups are considered to be 'extremely medically vulnerable' to the adverse health outcomes of Covid-19. According to the researchers, the fact that only 10.5% of those aged over 70 report taking a vitamin D supplement gives rise to extra concern because while cocooning many of these people will have even less sun exposure, putting them at a very high risk of deficiency.

"This is of key importance given the usefulness of vitamin D for immune function particularly at this time," the researchers said.

The report points to research on the essential role of vitamin D in helping to maintain bone and muscle health in older adults, as well as its key role in the prevention and the treatment of falls and fractures, and helping with the absorption of calcium from the gut. Recent research has also highlighted that it may have an important function within the immune system.

Vitamin D intake recommendations

During the winter period at least 10ug/day (400 IU) from the diet is required (due to the lack of sunlight for vitamin D synthesis). According to the report, recent data has shown that average intakes from diet are significantly below this level and therefore a 10ug (400 IU) vitamin D supplement may be required during the winter. For people who are housebound, due to illness or quarantine for an extended period, an upper supplement of 15-20ug/day (600-800 IU) may be required due to their lack of exposure to sunshine. In people over 70 years, 20-25ug/day (800-100IU) is recommended.

The report concludes that vitamin D is a potent immune-modifying micronutrient and if vitamin D status is sufficient, it could benefit vulnerable adults, in particular those over the age of 70 years who have been cocooning during the Covid-19 outbreak.

Vitamin D and inflammation

Further TILDA research from Dr Laird and Prof Kenny, in collaboration with Prof Jon Rhodes at the University of Liverpool, highlights the association between vitamin D levels and mortality from Covid-19.[2]

Published recently in the *Irish Medical Journal*,[2] the authors analysed all European adult population studies completed since 1999, which measured vitamin D and then compared vitamin D and death rates from Covid-19. Vitamin D can support the immune system through a number of immune pathways involved in fighting SARS2COV. This study shows that, counter intuitively, countries at lower latitude and typically sunny countries, such as Spain and northern Italy, had low concentrations of vitamin D and high rates of vitamin D deficiency.

These countries also experienced the highest infection and death rates in Europe. The northern latitude countries of Norway, Finland and Sweden have higher vitamin D levels despite less UVB sunlight exposure, because supplementation and fortification of foods is more common. These Nordic countries have lower Covid-19 infection and death rates. The correlation between low vitamin D levels and death from Covid-19 is statistically significant.

The authors propose that, whereas optimising vitamin D levels will certainly benefit bone and muscle health, the data suggests that it is also likely to reduce serious Covid-19 complications. This may be because vitamin D is important in regulation and suppression of the inflammatory cytokine response, which causes the severe consequences of Covid-19 and acute respiratory distress syndrome associated with ventilation and death.

Prof Kenny said: "In England, Scotland and Wales, public health bodies have revised recommendations since the Covid-19 outbreak. Recommendations now state that all adults should take at least 400 IU vitamin D daily. Whereas there are currently no results from randomised controlled trials to conclusively prove that vitamin D beneficially affects Covid-19 outcomes, there is strong circumstantial evidence of associations between vitamin D and the severity of Covid-19 responses, including death. This study further confirms this association. We are calling on the Irish government to update guidelines as a matter of urgency and encourage all adults to take supplements during the Covid-19 crisis. Deficiency is frequent in Ireland."

Dr Laird added: "Here we see observational evidence of a link of vitamin D with mortality. Optimising vitamin D intake to public health guidelines will certainly have benefits for overall health and support immune function. Research like this is still exploratory and we need further trials to have concrete evidence on the level of vitamin D that is needed for optimal immune function. However, studies like this also remind us how low our vitamin D status is in the population (even in sunny countries) and adds further weight to some sort of mandatory vitamin D fortification policy. If the Nordic countries are allowed to do this, there is no reason Ireland, the UK or rest of Europe can't also."

Mortality rates and different latitudes

The possibility of a relationship between vitamin D levels and mortality rates from Covid-19 was also explored by TILDA researchers in further published findings highlighting major discrepancies in mortality rates from Covid-19 at different latitudes worldwide.[3] Countries in the southern hemisphere, such as Australia, are recording relatively low Covid-related mortality, which the TILDA researchers state cannot simply be related to the later appearance and spread of the virus.

They have pointed to the high prevalence of vitamin D deficiency in northern hemisphere countries, and the possible role of the vitamin in suppressing severe inflammatory responses seen in patients seriously ill with Covid-19. Currently, all countries that lie below a latitude of 35° North have relatively low mortality from Covid-19. However, people in countries that lie 35° North and above receive insufficient sunlight for adequate vitamin D levels in winter and spring. These include Italy and Spain, which have low population levels of vitamin D. The researchers pointed out that mortality rates from Covid-19 are higher at these latitudes, with the exception of Nordic countries, where vitamin D supplementation is widespread and deficiency is much less common.

As a result of their findings, the researchers are recommending that all nursing home residents in Ireland take vitamin D.

Further insight in immuno-protection

Meanwhile, recent research by a team at TU Dublin and TCD lends further insight to the opinion that vitamin D supplements may enhance resistance to respiratory infections, such as Covid-19, and may also limit the severity of the illness for those who become infected.[4] The research was published in the *Irish Medical Journal*[4] and according to its co-author, Daniel McCartney, a lecturer in human nutrition and dietetics at TU Dublin, vitamin D deficiency is prevalent in Ireland, especially in older people, nursing home residents and hospital inpatients, "and may significantly increase the risk and severity of viral respiratory infections, including Covid-19".

He said: "Supplementing a healthy diet with 20-50 micrograms per day of vitamin D represents a cheap, safe and potentially very effective protection for Irish adults against Covid-19."

According to the study's co-author, Declan Byrne, a clinical senior lecturer at St James's Hospital and TCD's School of Medicine, such recommendations on vitamin D supplementation are important "while we await development of a vaccine and trial evidence of effective drug treatment for Covid-19. Our findings call for the immediate supplementation of all hospital inpatients, nursing home residents and older Irish adults with vitamin D. Our findings also suggest that vitamin D supplementation in the broader adult population, and particularly in frontline healthcare workers, may further help to limit infection and flatten the Covid-19 curve."

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INVOKANA® (canagliflozin) 100 mg & 300 mg film-coated tablets. **PRESCRIBING INFORMATION. Republic of Ireland Please refer to Summary of Product Characteristics (SmPC) before prescribing. INDICATIONS:** The treatment of adults with insufficiently controlled type 2 diabetes mellitus as an adjunct to diet and exercise as monotherapy when metformin is considered inappropriate due to intolerance or contraindications, or in addition to other medicinal products for the treatment of diabetes. **DOSAGE & ADMINISTRATION: Adults:** recommended starting dose: 100 mg once daily. In patients tolerating this dose and with eGFR ≥ 60 mL/min/1.73 m² needing tighter glycaemic control, dose can be increased to 300 mg once daily. For oral use, swallow whole. Caution increasing dose in patients ≥ 75 years old, with known cardiovascular disease or for whom initial canagliflozin-induced diuresis is a risk. Correct volume depletion prior to initiation. When add-on, consider lower dose of insulin or insulin secretagogue to reduce risk of hypoglycaemia. **Children:** no data available. **Elderly:** consider renal function and risk of volume depletion. **Renal impairment:** not to be initiated with eGFR < 60 mL/min/1.73 m². If eGFR falls below this value during treatment, adjust or maintain dose at 100 mg once daily. Discontinue if eGFR persistently < 45 mL/min/1.73 m². Not for use in end stage renal disease or patients on dialysis. **Hepatic impairment:** mild or moderate; no dose adjustment. Severe; not studied, not recommended. **CONTRAINDICATIONS:** Hypersensitivity to active substance or any excipient. **SPECIAL WARNINGS & PRECAUTIONS:** Not for use in type 1 diabetes. **Renal impairment:** eGFR < 60 mL/min/1.73 m²: higher incidence of adverse reactions associated with volume depletion particularly with 300 mg dose; more events of elevated potassium; greater increases in serum creatinine and blood urea nitrogen (BUN); limit dose to 100 mg once daily and discontinue when eGFR < 45 mL/min/1.73 m². Not studied in severe renal impairment. Monitor renal function prior to initiation and at least annually. **Volume depletion:** caution in patients for whom a canagliflozin-induced drop in blood pressure is a risk (e.g. known cardiovascular disease, eGFR < 60 mL/min/1.73 m², anti-hypertensive therapy with history of hypotension, on diuretics or elderly). Not recommended with loop diuretics or in volume depleted patients. Monitor volume status and serum electrolytes. **Diabetic ketoacidosis (DKA):** rare DKA cases reported, including life-threatening and fatal. Presentation may be atypical (blood glucose <14mmol/l). Consider DKA in event of non-specific symptoms. If DKA is suspected or diagnosed, discontinue ***Invokana*** treatment immediately. Interrupt treatment in patients who are undergoing major surgical procedures or have acute serious medical illnesses. Monitoring of (preferably blood) ketone levels is recommended in these patients. Consider risk factors for development of DKA before initiating ***Invokana*** treatment. **Elevated haematocrit:** careful monitoring if already elevated. **Genital mycotic infections:** risk in male and female patients, particularly in those with a history of GMI. **Lower limb amputation:** Consider risk factors before initiating. Monitor patients with a higher risk of amputation events. Counsel on routine preventative foot care and adequate hydration. Consider discontinuing ***Invokana*** when events preceding amputation occur (e.g. lower-extremity skin ulcer, infection, osteomyelitis or gangrene). **Urine laboratory assessment:** glucose in urine due to mechanism of action. **Lactose intolerance:** do not use in patients with galactose intolerance, total lactase deficiency or glucose-galactose malabsorption. **Necrotising fasciitis of the perineum (Fournier's gangrene):** post-marketing cases reported with SGLT2 inhibitors. Rare but serious, patients should seek medical attention if experiencing symptoms including pain, tenderness, erythema, genital/perineal swelling, fever, malaise. If Fournier's gangrene suspected, ***Invokana*** should be discontinued, and prompt treatment instituted. **INTERACTIONS: Diuretics:** may increase risk of dehydration and hypotension. **Insulin and insulin secretagogues:** risk of hypoglycaemia; consider lower dose of insulin or insulin secretagogue. **Effects of other medicines on *Invokana*:** Enzyme inducers (e.g. St. John's wort, rifampicin, barbiturates, phenytoin, carbamazepine, ritonavir, efavirenz) may decrease exposure of canagliflozin; monitor glycaemic control. Consider dose increase to 300 mg if administered with UGT enzyme inducer. Cholestyramine may reduce canagliflozin exposure; take canagliflozin at least 1 hour before or 4-6 hours after a bile acid sequestrant. **Effects of *Invokana* on other medicines:** Monitor patients on digoxin, other cardiac glycosides, dabigatran. Inhibition of Breast Cancer Resistance Protein cannot be excluded; possible increased exposure of drugs transported by BCRP (e.g. rosuvastatin and some anti-cancer agents). **PREGNANCY:** No human data. Not recommended. **LACTATION:** Unknown if excreted in human milk. Should not be used during breast-feeding. **SIDE EFFECTS: Very common (≥1/10):** hypoglycaemia in combination with insulin or sulphonylurea, vulvovaginal candidiasis. **Common (≥1/100 to <1/10):** constipation, thirst, nausea, polyuria or pollakiuria, urinary tract infection (including pyelonephritis and urosepsis), balanitis or balanoposthitis, dyslipidemia, haematocrit increased. **Uncommon (<1/100) but potentially serious:** anaphylactic reaction, diabetic ketoacidosis, syncope, hypotension, orthostatic hypotension, urticaria, angioedema, necrotising fasciitis of the perineum (Fournier's gangrene) (frequency not known), bone fracture, renal failure (mainly in the context of volume depletion), lower limb amputations (mainly of the toe and midfoot, incidence rate of 0.63 per 100 subject-years, vs 0.34 for placebo). **Refer to SmPC for details and other side effects. LEGAL CATEGORY:** POM. **PACK SIZES & MARKETING AUTHORISATION NUMBER(S): *Invokana* 100 mg film-coated tablets:** 30 tablets; EU/1/13/884/002. ***Invokana* 300 mg film-coated tablets:** 30 tablets; EU/1/13/884/006. **MARKETING AUTHORISATION HOLDER:** Janssen-Cilag International NV, Turnhoutseweg 30, B-2340 Beerse, Belgium. ® INVOKANA is a registered trade mark of Janssen-Cilag International NV and is used under licence. © 2017 Napp Pharmaceuticals Limited. **FURTHER INFORMATION IS AVAILABLE FROM:** Mundipharma Pharmaceuticals Limited, Millbank House, Arkle Road, Sandyford, Dublin 18. For medical information enquiries, please contact medicalinformation@mundipharma.ie **IRE/INV-19401 Date of Preparation** November 2019

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References: 1. INVOKANA SmPC www.medicines.ie November 2019. **2.** Afkarian M, *et al. Journal of the American Society of Nephrology.* 2013;24(2):302-3082. **3.** Perkovic V. *et al. Lancet Diabetes Endocrinol.* 2018 Sep;6(9):691-704. **4.** Neal B. *et al. N Engl J Med* 2017; 377:644-657.

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Diabetes and dementia

There is an urgent need to raise awareness of the potential neurological complications of diabetes, writes Catherine Dolan

EVIDENCE is mounting that diabetes is linked to potential complications involving the brain, including cognitive impairment, dementia and depression. It is estimated that having diabetes can increase a person's risk of developing dementia one-and-a-half to two-fold.

Cognitive impairment is when a person has trouble with mental functioning and can include difficulty remembering, learning new things, concentration or making decisions. Dementia occurs when cognitive impairment affects a person to the degree that it interferes with their daily life and functioning. It is thought that there are more than 400 causes of dementia. The most common cause is Alzheimer's disease and the second most common is vascular dementia.

Risks of developing dementia

There are a number of diabetes-related factors thought to increase an individual's risk of developing dementia. These include changes to the brain caused by chronic high or low blood glucose levels, damage to brain blood vessels and the effect of abnormal insulin hormone activity on the brain. Insulin, when not functioning as it should in individuals with diabetes, may adversely impact on memory and learning.

Given that both type 2 diabetes and dementia occur more frequently in older populations, the predicted increase in the ageing population globally means the numbers of individuals with these conditions is set to increase. This will mean an increased burden at an individual level, as well as on health services.

Management with dementia

Managing a chronic condition like diabetes usually involves a number of complex self-management tasks. These include diet, medications, monitoring blood glucose and responding to abnormal results, as well as co-ordinating healthcare visits. Cognitive impairment or dementia, when co-occurring with diabetes, makes effective management of such activities more complicated, particularly when memory and decision-making ability is impaired. This puts an individual at higher risk of diabetes-related complications, such as hypoglycaemia and hospitalisation.

Screening for cognitive impairment

It is recommended that older adults with diabetes are screened annually for cognitive impairment to allow healthcare professionals to adequately tailor diabetes treatment. Making diabetes treatment as simple as possible with an increase in support aims to reduce the risk of such complications in individuals with both diabetes and cognitive impairment or dementia.

As anti-dementia medication has a limited effect in slowing down dementia progression, there is an increasing emphasis being placed on dementia prevention. Adopting a healthy lifestyle can help reduce the risk of dementia.

Preventing dementia

Advice includes engaging in adequate levels of physical activity, maintaining a healthy weight, having a healthy diet (Mediterranean diet) and avoiding harmful use of alcohol, as well as managing high blood pressure and diabetes.

A number of these dementia risk factors overlap with type 2 diabetes risk factors. Improving awareness among members of the public of the importance of a healthy lifestyle in reducing the risk of getting type 2 diabetes and dementia might encourage individuals to engage in healthy lifestyle behaviours, particularly in early to midlife.

Awareness study

However, a 2017 study carried out in Ireland, which included a survey of over 500 members of the general public and people with diabetes, revealed a poor awareness of the link between diabetes and the brain.[1] Participants in this study were less aware of brain-related complications of diabetes, such as dementia and depression, compared to other potential diabetes complications, including kidney damage, vision loss and foot ulcers.

Furthermore, over two-thirds were not aware of the link between diabetes and dementia. This study also found responders had poor awareness about how a person could reduce their risk of getting dementia by adopting a healthy lifestyle, particularly in early to mid-life.

The findings suggest that there is an urgent need to raise awareness of the potential brain complications of diabetes. There is also a need to raise awareness of the fact that diabetes is, in itself, a risk factor for dementia.

Additionally, in those who already have diabetes, effective management of the condition may reduce the risk of developing cognitive impairment and dementia.

All healthcare professionals working with diabetes patients should explain to older patients in particular, or their family members, about how to prevent or reduce the risks of developing cognitive impairment and ask whether they have any current concerns about their memory.

Catherine Dolan is a consultant psychiatrist of old age with Sligo-Leitrim Mental Health Services

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A call for participants to a study on neurocognitive ageing in diabetes taking place in two regions in Ireland had commenced in early 2020. Recruitment has now been deferred until the Covid-19 crisis is resolved. However, the plan is to recommence recruitment afterwards. For more information about the study, please visit www.diabetes.ie/brain-diabetes-border-region-area-lifestyle-intervention-study-for-healthy-neurocognitive-ageing-in-diabetes/

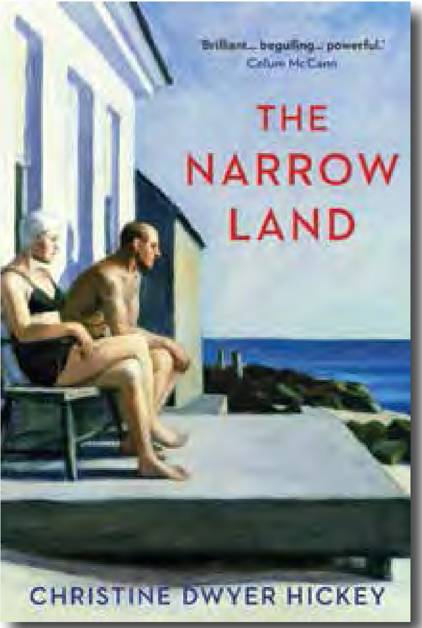
Human condition laid bare

EDWARD HOPPER was a celebrated American realist painter, perhaps best known for his melancholy 'Nighthawks' exterior view of the inside of a diner. His paintings are usually colourful yet sparse, the subjects often wistfully musing, perhaps on their lives and their attendant memories of loss and disappointment.

Hopper and his wife Josephine are characters in Christine Dwyer Hickey's latest novel, *The Narrow Land*, whose complex and often lonely characters could well have stepped out of a Hopper painting.

Christine Dwyer Hickey is an acclaimed multi-award-winning Dublin-born writer. Her 2004 novel, *Tatty*, was recently chosen as the Dublin One City, One Book 2020.

Beautifully written, *The Narrow Land* looks a the lives of a number of characters holidaying in Cape Cod in the north east of the US in the summer of 1950. Michael, a 10-year-old post-war orphan refugee from German, troubled by wartime experiences, is spending the summer with an American boy, Richie, and his extended



family. Michael and Richie have a fractious relationship, as do Edward Hopper and his less successful artistically thwarted wife, who are holidaying nearby. Ever the tortured artist, Edward Hopper, who is not in the best of health, becomes personally and artistically infatuated with Richie's beguiling and dying aunt, as does troubled Michael. Meanwhile, Hopper also forms a bond with the lonely Richie.

The undulating curve of these and other relationships as the summer progresses to its sad conclusion are skilfully handled throughout. The writer deftly but never frustratingly switches perspective from one character to another. Particularly effective is a party scene where the annoying but still strangely endearing Jo Hopper tragically reveals her very human idiosyncrasies, weaknesses and hubris for all to see.

Christine Dwyer Hickey's writing style is spare but telling, reminiscent in many ways of the classic modern American realist writers such as Updike, Ford and Carver – which is a great tribute to the quality of *The Narrow Land* – in other words it's that good.

– **Niall Hunter**

The Narrow Land by Christine Dwyer Hickey is published by Atlantic Books. ISBN-13: 978-1786496713. RRP: €12

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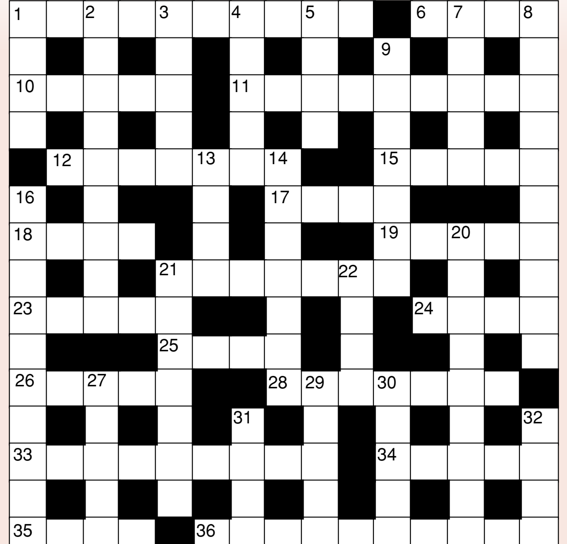
Across

1 When you key in this low line, it will not get the required of goals and points, it seems! (10)
6 Enquires (4)
10 A late morning makes a fib popular (3,2)
11 Extort money by threatening to reveal personal secrets (9)
12 Denies responsibility for (7)
15 Pulsate (5)
17 Mr Bana is seen in Central Jericho (4)
18 Eurosceptic British political party (1,1,1,1)
19 Muggy, sticky weather description (5)
21 The practice of giving backhanders (7)
23 Did Mr Crosby love this game? (5)
24 Practise needlecraft (4)
25 Back (4)
26 Went out like the tide (5)
28 Fall asleep with a small amount of liquid? That's not on! (4,3)
33 'Down Under' (9)
34 Characterised by vapour (5)
35 See 4 down
36 Ailment never suffered by aristocrats? (6,4)

Down

1 As unpretty as a pantomime sister (4)
2 One recommending food choices may become initiated, literally! (9)
3 & 7d Stage-name of the Beatles drummer (5,5)
4 & 35a Style of footwear for a cad from Havana? (5,4)
5 Gather a harvest (4)
7 See 3 down
8 Is it a statement of product lifespan or an instruction to retail beside a desert fruit? (4-2,4)
9 Lacking in detail (7)
13 Don, the Western listener (4)
14 A gull, perhaps (7)
16 Sudsy soak (6,4)
20 Programme of action presented by a political party, usually at election time (9)
21 International boundaries (7)
22 City in Nevada that describes itself as "the biggest little city in the world" (4)
27 Drip juices on a roast (5)
29 The kingdom of the true thousand (5)
30 Heathen (5)
31 As well (4)
32 Had a glance at some Cockney editions (4)



May crossword solution

Across: 1&9 Fra Angelico 3 War and Peace 8 Oldest 10 Exams 11 Noise 13 Jacob 15 Insipid 16 Bronchi 20 Tempt 21 Shark 23 & 2d Aches and pains 24 Placenta 25 Geneva 26 Transmitted 27 Ret

Down: 1 Flower girls 3 Wasps 4 Avarice 5 Preen 6 Acidic 7 Ego 12 Equidistant 13 Joist 14 Burst 17&18 Cochlear implant 19 Sahara 22 Knees 23 Amend 24 Pit

The winner of the MAY crossword is: Sheila Brehony Ballymote, Co Sligo

You can now email your entry to us at nursing@medmedia.ie by taking a photo of the completed crossword with your details included.
Closing date: Tuesday, June 23, 2020
If preferred you can post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin, A96E096

Name:
Address:

ICN calls for data on infection rates and deaths among health workers

'Current records underestimate the scale of the situation' – ICN CEO

THE International Council of Nurses (ICN) has called on governments to immediately commence the keeping of accurate records of infections and deaths among healthcare workers.

Failure to do this, according to the ICN, will increase the chances of more deaths.

The ICN believes existing data to be significantly underestimating the scale of the situation. Last month, the ICN reported that more than 100 nurses from around the world had died after contracting Covid-19. In addition, the WHO reported there had been 23,000 cases recorded among healthcare workers worldwide.

Data gathered by national nurses associations around the world and compiled by the ICN suggest that at least 90,000 healthcare workers have been infected, and more than 260 nurses have died.

The ICN says thousands of nurses have been infected with Covid-19 and hundreds have already died, but governments cannot say exactly how many because they are not collecting the data. The ICN says this failure to record both infection rates and deaths among healthcare workers is putting more nurses and their patients in danger.

Improved record-keeping, according to the ICN, would not only honour those who have already died on the Covid-19 frontline, but also inform prevention strategies such as testing PPE.

ICN CEO Howard Catton said: "The lack of official data on infections and deaths among nurses and other healthcare workers is scandalous. Nurses and healthcare workers have been put at greater risk because of the lack of PPE and poor preparedness for this pandemic. As a result, we have seen infection rates and, tragically, deaths rise on a daily basis.

"Governments' failure to collect this information in a consistent manner means that we do not have the data that would add to the science that could improve infection control and prevention measures, as well as save the lives of other healthcare workers."

The ICN's data was compiled across 30 countries and shows that, on average, 6% of all confirmed cases of Covid-19 are healthcare workers. Were that percentage repeated globally, the 3.5 million total confirmed cases would yield a figure for the number of infected healthcare workers of 210,000.

FSAI publishes new guidance on infant formula communications

NEW guidance on infant formula company communications to health professionals has been published by the Food Safety Authority of Ireland (FSAI).

This comes on foot of a change in EU food law in February 2020 that introduced a range of additional restrictions on the advertising and marketing of infant formula products suitable from age 0-12 months.

The FSAI was tasked with drawing up a detailed guidance document in conjunction with specialised nutrition companies to ensure compliance with food law around communications with health professionals. It has also developed a compliance assessment tool for the industry.

All commercial written electronic and verbal communication to health professionals on infant formula must comply with the new laws.

The restrictions involve discontinuing the use of most nutrition and health claims around infant formula (0-12 months) and should make product labels clearer. Product composition cannot be linked to breast milk, immune or gut health benefits. New scientific developments can be communicated but there is strict guidance on the definition of this.

For example, incomplete extracts from a scientific journal or a text book, or marketing phrases and slogans are among the elements that are not acceptable. The only health claim still permitted relates to reduction of risk from allergy to milk proteins.

The guidelines state that communication must not discourage breastfeeding or imply that bottle feeding is equivalent or superior to breastfeeding. It must not imply that any food possesses special characteristics.

All materials related to infant formula from 0-12 months must have a statement about the superiority of breastfeeding.

The full document *Guidance for compliance with food law when communicating with health professionals about infant formula products* is available on the FSAI website: **www.fsai.ie**

Hidradenitis Suppurativa Awareness Week

HIDRADENITIS suppurativa (HS) Awareness week, which takes place from June 1-7, aims to help healthcare workers recognise the signs and symptoms of the skin disorder.

HS is a chronic wound-forming skin disease that is widely misdiagnosed, leading to gradual progression and irreversible skin damage. HS has a prevalence similar to psoriasis in Ireland, however stigma often prevents patients seeking help, and subsequent medical attention often ends in misdiagnosis. If a patient has an outbreak of boils or exhibits red or tender lumps, lesions or nodules in the armpits, groin or anogenital areas, HS can be suspected, though it can occur almost anywhere on the body.

What can nurses do for HS patients?

- Recognise the early signs and suggest a GP/dermatology consult
- Support in terms of pain and wound management, and mental health
- A multidisciplinary approach is required, including expertise from different specialties, including nursing.

Covid-19 notice

The following meetings have been scheduled. However, pending further developments, we are keeping matters under constant review and unless there is a significant change in the public health situation, it is probable that all meetings, should they go ahead, will be conducted by teleconference or Zoom. **For more details on any listed meetings, contact jean.carroll@inmo.ie (unless otherwise indicated)**

June

Saturday 13
PHN Section meeting. To be hosted on Zoom from 11am

Saturday 13
CRGN Section meeting. From 11am

Monday 15
National Children's Nurses Section meeting via Zoom from 10.30am

Wednesday 24
CPC Section meeting via Zoom from 10.30am

Condolences

- The INMO, in particular the Limerick and North Tipperary branches, extends deepest sympathy to the husband, parents, brother and sisters of Sara Ryan, PHN. Condolences also to Sara's many colleagues in the community nursing service across the mid-west region. May she rest in peace.
- It is with great sadness that we offer our condolences to retired INMO member Nora Donagh and her extended family on the death of her beloved husband Barney, who was recently laid to rest in Newbridge. *Ar dheis Dé go raibh a hanam.*
- The INMO would like to express its deepest condolences to staff member Joanne Savage and her family on the recent passing of her father John Edwards. May he rest in peace.
- Outside of our professions, we also remember those colleagues in the health service who have passed away in recent weeks. Our thoughts are with their families, friends and co-workers.

INMO Membership Fees 2020

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

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- Excellent interpersonal and communication skills and be willing to be part of a team.

Job Descriptions, and further information on the above positions are available on **www.milfordcarecentre.ie**

Further enquiries for the CNS Posts may be made to **Jacqueline Holmes, Assistant Director of Nursing, Community Services, Milford Care Centre, Telephone 061-201773**

Interested candidates should submit their CV with a covering letter stating their interest in the post to Declan Deegan, Head of HR, Milford Care Centre, Castletroy, Limerick or by email: **recruitment@milfordcarecentre.ie** no later than **5pm on 17th June 2020**. Short-listing will apply.

International Council of Nurses 2021

Congress and Exhibition, June 5-9, 2021

Key dates:

- June 1, 2020: Online submission of abstracts opens
- July 31, 2020: Online submission of abstracts closes
- October 1, 2020: Online registration opens
- February 12, 2021: Deadline for registration of abstract presenters
- February 12, 2021: Early bird registration deadline
- June 5, 2021: ICN 2021 opens

Email: **icn2021@icn.ch**
Web: **www.icn/ch/events/icn-congress-abu-dhabi**

WIN

World of Irish Nursing & Midwifery remains open for advertisement bookings as normal throughout this difficult period.

Next issue: July/August 2020

Booking deadline: Tuesday, June 23

Tel: **01 271 0218**

email: **leon.ellison@medmedia.ie**

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Counselling Advice Line

1850 670 407

www.arag.ie

Are you struggling emotionally? Feeling stressed or anxious in work or at home? Need support in dealing with the Covid-19 outbreak?

In these challenging times, ARAG Legal Protection Limited, wish to remind the membership of the INMO of our free Counselling Advice Line which is available for you (and your family members, aged 16 or over, who live with you) to call at any time for confidential support from a qualified counsellor.

Call us on 01 670 7470

ARAG Legal Protection Ltd

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