

WIN



Journal of the
Irish Nurses and
Midwives Organisation

Latest course
information from
the INMO PDC
page 33

World of Irish Nursing & Midwifery

INMO meets Public Service Pay Commission

page 8

Nationwide action set to begin March 7

page 9

CPD: Breastfeeding problems

page 43

Understanding hyperemesis gravidarum better

page 53



Action on staffing crisis

Health service decline mirrors drop in nurses/midwives



9



43



49

NEWS & VIEWS

5 Editorial

The INMO is preparing for industrial action in the latest step to ease the current staffing crisis, writes Liam Doran, INMO general secretary

7 From the President

INMO president Martina Harkin-Kelly rounds up news from the Executive Council and beyond

8 News

Executive Council rejects inadequate proposals on staffing and recruitment... Nationwide action set to commence from March 7...INMO meets with Public Service Pay Commission...Monthly trolley figures surpass 10,000 for first time since records began... A health service to be ashamed of?... Social welfare rule change good news for international workers... Talks begin on opening state-of-the-art Limerick ED... South Tipp dispute referred to WRC... Members accept WRC proposals to resolve St Luke's dispute... Ongoing work to rule in Dungarvan... Nurses and midwives in action around the world... Sligo safe practice workshop...
Plus: Section news, page 17

18 International news

Elizabeth Adams discusses the recent OECD Policy Forum

49 Students & new graduates

Liam Conway updates readers on news for students and new graduates

FEATURES

16 Section focus

This month we focus on the Research Nurses and Midwives Section

21 Questions and answers

Bulletin board for industrial relations queries

23 Organising review

INMO organiser Albert Murphy highlights upcoming rep training courses

25 Focus

Christmas and the new-year period is a busy time for telephone triage nurses, writes Carmel Murphy

26 Focus

Robert Grant reports on a new partnership between RelateCare and WIT

29 Focus

Philip Hardie outlines the UCD professional certificate in enhancing clinical practice

46 Executive Council focus

A series profiling three members of the Executive each month

47 Media Watch

Ann Keating reviews INMO activities reported in the news

51 Midwifery matters

Deirdre Munro speaks to hyperemesis gravidarum survivor Caitlin Dean

54 Quality and safety

This month Maureen Flynn looks at 'liberating structures'

64 Update

Round up of healthcare news items

CLINICAL

43 CPD

This month our continuing professional education update focuses on breast-feeding problems

53 Midwifery

Deirdre Munro shares HIQA's guide to the new National Standards for Safer Better Maternity Services

57 Women's health

Deirdre Lundy discusses long-acting reversible contraception methods

LIVING

61 Book review

Review of Prof Brendan Kelly's *Hearing voices: The history of psychiatry in Ireland*
Plus: Monthly crossword competition

63 Finance

Marc Evans advises on ensuring you have the correct level of insurance cover for your home

JOBS & TRAINING

33 Professional Development

Eight-page pull-out section from the INMO PDC

66 Diary

Listing of meetings and events nationally and internationally

67 Recruitment & Training

Latest job and training opportunities in Ireland and overseas

WIN – World of Irish Nursing & Midwifery is distributed by controlled circulation to more than 32,000 members of the INMO. It is published monthly (10 issues a year) and is registered at the GPO as a periodical. Its contents in full are Copyright© of MedMedia Ltd. No articles may be reproduced either in full or in part without the prior, written permission of the publishers. The views expressed in this publication are not necessarily those of the INMO.

Annual Subscription: €145 incl. postage paid. Editorial Statement: *WIN* is produced by professional medical journalists working closely with individual nurses, midwives and officers on behalf of the INMO. Acceptance of an advertisement or article does not imply endorsement by the publishers or the Organisation.

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



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Members ready for action



AS I write this, the Organisation, along with members right across the public health service, is preparing for action, in the form of working to contract through a work to rule, in the latest step in our campaign for staffing, recruitment and retention initiatives to ease the current staffing crisis.

Representatives of the Department of Health/HSE/Department of Public Expenditure and Reform, following a number of lengthy engagements in the early days of February, presented a set of proposals that our Executive Council, following detailed consideration, viewed as wholly incapable of addressing the current staffing difficulties. In particular, the Council felt that the measures relating to staffing and recruitment were too little, too late. On the key issue of staff retention, the proposals were thought to be totally inadequate.

Throughout the recent engagement with the management side, the INMO has repeatedly sought a three-year nursing/midwifery workforce plan, with dynamic initiatives under the three headings of staffing, recruitment and retention aiming to achieve a nursing/midwifery workforce, of 40,000 whole-time equivalents in 2019.

At no stage have we suggested that the damage done by the recruitment embargo – leading to a 13% reduction in the nursing/midwifery workforce – can be undone in one year. We have consistently argued that Ireland must, at the very least, offer the best terms and conditions of employment for nurses and midwives that are available in other countries competing for our nurses/midwives. This requires improvements in staffing levels, attractive recruitment policies and very strong retention initiatives, so that we can initially stabilise, and then grow, the nursing/midwifery workforce.

In response, the management side, while recognising there is a problem, failed completely to understand the extent of the crisis. They failed to accept that a three-year plan, at a minimum, is required and to understand the dynamics arising from aggressive recruitment from the private healthcare sector, the UK and, for more experienced nurses, Australia and North America.

In addressing the pay issue for nurses and

midwives in Ireland, the INMO has recently met with the Public Service Pay Commission (PSPC). We have made both written and oral submissions on the labour market challenges that exist for nurses and midwives, at this time (*see page 8 for details*).

There is no doubt that the work of the PSPC – and its report on the labour market challenges affecting nurses/midwives – will form an important backdrop to the next round of discussions on public service pay. If health service management is truly concerned about addressing the current crisis, then they will also engage with the PSPC, acknowledge the labour market challenges and invite the Pay Commission to put forward its views on how those challenges can be addressed in the medium to long-term. This must form part of any final solution to the staffing, recruitment and retention crisis currently facing us.

These are, without doubt, very challenging times. Our members across the health service are overworked due to understaffing and ever-increasing acuity of the patient/client population. We want a set of positive, dynamic and robust initiatives that will begin immediately to rebuild the nursing and midwifery workforce in our public health service. The failure of management to agree to the required measures has left the Organisation with no choice but to commence action that will ensure service/activity levels are appropriate to available staffing levels.

Over the past number of years, nurses and midwives have suffered daily due to flawed manpower policies. That time has passed. This action is designed to ensure that every member, while undertaking the full range of nursing/midwifery duties, is not repeatedly asked to do the impossible – thus compromising patient care and their own health, safety and wellbeing. Once again enough is enough. Members prepare for action.

Liam Doran
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president



Executive Council

AS YOU know the Executive Council met on Wednesday, February 8 following a number of weeks of negotiations that resulted in a set of proposals emerging from the HSE. The fact that the Minister for Health found it necessary to commit to a ministerial order under the 2004 Health Act, Section 10, directing the HSE to agree a workforce plan spoke volumes. Despite this intervention, the proposals that emerged once again demonstrated just how far out of touch non-clinical management is with the frontline conditions of nurses and midwives across the country. The proposals were well and truly rejected by the Executive Council as they were seen as totally inadequate, requiring radical change to come up to the mark. The line was drawn in the sand and the message was loud and clear. Notice of nationwide industrial action to commence on March 7 was served on the employer.

I call on all members to hold the line, stay united and stand together. We comprise 33% of the HSE workforce, therefore we have power and strength in numbers to bring about change. I urge you to get involved in the campaign committees. I will be out and about in support and solidarity along with members of the Executive Council and INMO staff. Let us make every effort to change the face of nursing and midwifery in Ireland so that nurses and midwives will no longer work in an environment that puts the health and welfare of their patients, service users or clients – and their own health and safety – at risk.

The core objective of this action will involve each nurse or midwife doing the work of one nurse or midwife, ie. *working to contract*, and not the work of two or three, which has become the norm in recent years.

Finally, I have received many texts, tweets and emails over the past number of weeks but one tweet struck me – "Irish nurses to take extraordinary action". I thought about it and tweeted the following: "Yes, extraordinary I agree, but let me rephrase the word extraordinary – what is really sought is EXTRA staff that will allow nurses and midwives an ORDINARY day's work".

Meeting with RCM colleagues in Belfast

THIS inaugural exploratory meeting was convened in Belfast on January 27 last. Given Brexit, it is important that we investigate the potential advantages or disadvantages any collaboration between the INMO and the Royal College of Midwives (RCM) would have. I, alongside Executive Council members Karen Eccles and Mary Gorman and the INMO management team, met Jon Skewes, director for policy, employment relations and communications for the RCN, and his team to explore mutual arrangements for midwife members of both organisations. A memorandum of understanding (MOU) was discussed at the meeting. This MOU offers a major benefit for INMO midwife members in relation to accessing online education, evidence-based information and continuing professional development support. This was considered by Executive Council at the February national meeting and, subject to successfully negotiating the MOU, a motion will be prepared for consideration at ADC.

Centenary book editorial committee

EVENTS are currently being planned for the 2019 centenary celebrations. A book cataloguing the first 100 year's history of the Irish Nurses and Midwives Organisation is currently being written by Mark Loughrey. To support the planning and development process, the Executive Council has established a special editorial group to work with Mark on the production. I intend to keep you appraised of progress over the next 12 months. Thanks to Mark and the group – which is made up of the three officers, three trustees and three Executive Council members – for your time and commitment to this very worthwhile and feel-good venture.

Quote of the month

Courage is what it takes to stand up and speak

Courage is what it takes to sit down and listen"

- Sir Winston Churchill

Report from the Executive Council

Staffing, recruitment and retention dominated the agenda when the Executive Council met in early February. We were to consider the proposals that had emerged following the talks. The meeting timeframe was extended to allow an adequate review and discussion of the document to occur.

As president, I would like to thank the Executive Council members for the robust debate that followed as it gave a clear indication of their thoughts on the proposals. Their decision was taken based on the realities of the appalling working conditions that inadequate staffing levels have led to across the health service. Their message was loud and clear and I thank them on behalf of the membership for their passionate and committed decision to reject the proposals as being totally inadequate and too little too late.

This then triggered the 90% mandate for industrial action which commences on March 7 with an indefinite period of working to contract. Under this action, nurses and midwives will refuse to do overtime, cross cover or redeploy from ward to ward to plug gaps. They will continue to provide the normal range of duties on their allocated wards. March 13 will see the escalation of the dispute to rolling strikes focused on the acute hospitals.

As president, I urge you to stay in touch and get involved with the campaign committees.

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

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

Executive Council rejects inadequate proposals on staffing and recruitment

IN THE face of chronic overcrowding and understaffing in hospitals, residential care and community settings, the INMO Executive Council rejected recent staffing/recruitment/retention proposals put forward by the HSE as being totally inadequate.

"In their examination of the latest proposals, Executive Council members presented numerous examples of nurses and midwives unable to provide full care to their patients, working beyond the end of their shift without pay, unable to take meal breaks and facing unmanageable workloads because of the appalling conditions and inadequate staffing they now face every day," said INMO president Martina



INMO president Martina Harkin-Kelly: "Executive Council members presented numerous examples of appalling conditions and inadequate staffing they face every day"

Harkin-Kelly.

Executive Council members viewed the proposals put forward as completely inadequate in terms of retaining staff and recognising the reality of the workplace endured by nurses and midwives. On recruitment, the proposals were regarded as too little too late and still

not competing with that being offered in the private sector and in other countries.

INMO general secretary, Liam Doran said: "The clear message received from INMO members is that their workplaces are now unsafe and dangerously overcrowded. All areas are understaffed and the services are at breaking point, which will require radical solutions to take the pressure off struggling nurses and midwives. We need to attract and retain nurses and midwives in sufficient numbers to provide safe care – the current proposals contain no adequate remedies for this."

The rejection of the proposals, which emerged from late night talks on Tuesday,

February 7 after protracted talks, will now lead to the INMO exercising the 90% mandate it received in a ballot of members prior to Christmas.

The INMO has now served notice of nationwide action to commence on Tuesday, March 7, 2017. The action will take the form of an immediate, and continuous, work to rule involving nurses and midwives working to contract, resulting in a ban on overtime, cross cover and redeployment.

In addition, the Organisation will commence work stoppages if the dispute is not resolved, again as mandated by members in the recent ballot. These stoppages will commence in the week beginning Monday, March 13, 2017.

INMO meets with Public Service Pay Commission

THE INMO met, formally, with the Public Service Pay Commission on Monday, February 7, 2017.

The Public Service Pay Commission was established in late 2016 by the government to consider a range of issues related to public service pay, including the unwinding of the FEMPI legislation (which empowered government to impose cuts in pay) and to consider areas of the public service which have particular labour market challenges.

It was in this context of labour market challenges that the INMO met with the commission and made a formal written submission to it. This written submission can be accessed by members on the INMO website, www.inmo.ie

At the meeting with the commission the INMO delegation, which comprised Phil Ní Sheaghdha, director

of industrial relations, Dave Hughes, deputy general secretary, and Liam Doran, general secretary, elaborated on the written submission and engaged in a very lengthy question and answer session with members of the commission, on all issues related to the current labour market for nurses and midwives in Ireland.

As part of the written submission the INMO had reached agreement with health management that they would also acknowledge the fact that labour market challenges existed and that the recruitment/retention of nurses and midwives in the Irish public health service was a matter of increasing concern.

In its engagement with the INMO, the Pay Commission clearly said that it is not an adjudication body. It indicated its work, particularly with regard to labour market

challenges, will be made significantly easier if there is consensus among both unions and management, that difficulties with recruitment/retention exist and need to be addressed in any future set of negotiations. In this context it must be hoped that the acknowledgement by health management that problems do exist with regard to recruitment/retention will assist the Pay Commission. This will allow it come forward in its first report, which is due before the end of April, and lay out what it believes needs to be done, through direct collective bargaining, to address the problem.

In its submission and its oral presentation, the INMO repeatedly stressed that the long-term solution with regard to nursing/midwifery pay in Ireland, must be that the professions be afforded parity

of pay with all other degree level health professionals. The INMO consistently said, throughout the recent engagement, that this is the only way that the difficulties with regard to recruitment/retention of nurses and midwives in Ireland can be properly addressed.

In addition the INMO also said, in the context of the international labour market which exists for the Irish nurse/midwife, that Ireland must, at the very least, match the very best pay and conditions offered to nurses and midwives in other destination countries, ie. the UK, Australia and North America.

At the conclusion of the meeting, the commission indicated that it was going to meet with health service management. The commission also indicated it may seek further engagement with the INMO in the coming weeks.

Nationwide action set for March 7

Arrangements being finalised for commencement of work to rule

FOLLOWING the rejection of proposals put forward by the management side, the INMO at the time of going to press, was finalising arrangements for the commencement of nationwide action, in the form of a work to rule, from start of shift on Tuesday, March 7, 2017.

As part of this process which will see members continue to undertake their full range of duties, while highlighting the staffing crisis, the following details should be noted.

The INMO has now served formal notice on all public health sector employers of the commencement of this nationwide action, which essentially involves working to contract, commencing on Tuesday, March 7, 2017

This nationwide work to rule, which will apply in all areas of the public health service, involves members withdrawing their goodwill and refraining from undertaking the following duties:

- Redeployment, ie. from one ward to another during a shift
- Cross-cover, ie. from one geographic area to another in the community
- Working extra periods/hours beyond shift finishing time
- Withdrawing from overtime.

The central objective of this work to rule will be, in the absence of an adequate commitment from management to address the staffing/recruitment/retention issues, to force the contraction of services, ie. bed closures, so that activity levels match available staffing levels.

The INMO has established campaign committees in all workplaces, whose task it will be to engage with management locally on contingency planning and to manage/oversee the action from March 7.



Ready for action:

INMO Executive Council and directors announcing nationwide industrial action will commence on March 7, 2017, following rejection of the inadequate proposals to address staffing/recruitment/retention crisis

On Tuesday, March 7, 2017, to publicly mark the commencement of the nationwide campaign to address the staffing/recruitment/retention crisis, the Organisation will also undertake the following:

- Lunchtime protests (12.45pm-1.15pm) in large acute hospitals
- A social media (Thunderclap) event in all other work locations, allowing members, through the use of social media, to publicly indicate their support for the campaign.

As required in this situation, the INMO has met, and continues to meet, with management, both nationally and locally, to agree contingency measures to ensure the maintenance of essential services for the duration of the dispute.

In that regard the INMO met with the HSE, at national level, on Tuesday, February 21, 2017, with regard to contingency measures/planning and further meetings are ongoing.

The Organisation has also met with the Lansdowne Road Agreement National Oversight Body, and the Officers of the Public Services Committee of the ICTU, to discuss the issues

in dispute and to consider how matters could be progressed.

While contacts are ongoing, no further engagement with health service management, either directly or with the assistance of a third party, were scheduled at the time of going to press.

This campaign, as determined by the recent national ballot, is seeking initiatives which will begin to address, in a planned and coherent manner, the severe difficulties with regard to staffing/recruitment/retention which exist at this time.

In the absence of such initiatives the Organisation's action will be to have members undertake their full range of duties while highlighting the current staffing shortages by not cross-covering/redeploying/working overtime. In other words, if staffing levels cannot be improved then activity levels must be reduced in the interest of the health and safety of our members and to ensure they can deliver safe care through safe practice to patients/clients.

Speaking as we went to press INMO general secretary

Liam Doran said: "The INMO remains available for discussions, with regard to these critical issues, with health management, either directly or with the assistance of a third party.

"However, at this time, the focus of every member in every workplace across the country must be to engage with local campaign committees to ensure they are fully familiar with the nature and form of the work to rule due to commence at the start of shift on Tuesday, March 7, 2017.

"The proposals, rejected by the Executive Council, demonstrated, yet again, the failure of health management to understand the extent of the crisis and the current realities on the frontline. This action will demonstrate the additional, unrecognised, work done, every day, by nurses/midwives to the detriment of their own health and to patient care.

"It is now up to management to come forward with tangible measures which will begin to address the staffing/recruitment/retention crisis. If they will not increase the staff they will have to reduce the service."

Monthly trolley figures surpass 10,000 for first time since records began

THE number of admitted patients in Irish hospitals being cared for on trolleys in the month of January this year surpassed 10,000 for the first month since records began.

While the figures being reported for some of the hospitals in the Eastern region are showing some improvement, the main hospitals in Limerick, Cork and Galway are consistently reporting the highest levels of overcrowding, with:

- University Hospital Limerick

reaching a record high of 793 patients on trolleys in January

- Cork University Hospital with 667 admitted patients on trolleys in the month

- University Hospital Galway having 618 patients on trolleys in the month.

The record trend has continued into February, with the trolley figures remaining at crisis levels. In the first week of February there was a 25% increase in trolleys over the same week last year.

In early January, when trolley

figures were hovering at record high levels for a prolonged period, the INMO demanded a response from the HSE and the Department of Health on what special steps were being taken in response to the deteriorating overcrowding situation.

In addition, answers were demanded on what steps were taken to implement the recommendations of the expert group report issued last August, which called for additional nursing posts to be created and filled to look

after admitted patients in EDs and extra patients on wards.

INMO general secretary Liam Doran has called on the health minister to be proactive in response to the overcrowding, which is beyond crisis point at this stage. He said successive governments have failed to address the problem and that it must be a top priority for a government wide response throughout 2017.

Mr Doran also called for an emergency response from health service management.

Table. INMO trolley and ward watch analysis (Full year analysis 2006 - 2017)

Hospital	Jan 2006	Jan 2007	Jan 2008	Jan 2009	Jan 2010	Jan 2011	Jan 2012	Jan 2013	Jan 2014	Jan 2015	Jan 2016	Jan 2017
Beaumont Hospital	414	543	661	769	794	574	634	602	710	692	710	386
Connolly Hospital, Blanchardstown	259	280	250	286	216	456	378	279	635	595	372	225
Mater Misericordiae University Hospital	482	433	568	538	531	345	324	356	292	410	481	505
Naas General Hospital	441	45	216	355	367	491	194	239	221	369	437	240
St Colmille's Hospital	300	119	76	276	293	235	186	190	n/a	n/a	n/a	n/a
St James' Hospital	351	200	211	319	215	150	148	142	101	236	222	229
St Vincent's University Hospital	372	351	535	474	509	466	310	470	334	438	598	276
Tallaght Hospital	812	219	805	632	528	635	238	181	348	394	337	546
Eastern	3,431	2,190	3,322	3,649	3,453	3,352	2,412	2,459	2,641	3,134	3,157	2,407
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	47	52	111
Cavan General Hospital	408	361	287	196	277	516	316	220	91	71	183	33
Cork University Hospital	293	273	413	446	726	695	574	443	361	366	600	667
Letterkenny General Hospital	320	428	57	57	43	64	118	42	247	437	110	522
Louth County Hospital	41	14	52	62	4	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo University Hospital	158	253	168	271	261	144	91	165	256	311	159	70
Mercy University Hospital, Cork	197	165	200	155	169	272	117	316	211	170	228	290
Mid Western Regional Hospital, Ennis	157	197	28	29	35	127	21	79	0	7	92	46
Midland Regional Hospital, Mullingar,	38	23	36	54	284	214	295	171	447	374	426	540
Midland Regional Hospital, Portlaoise,	70	15	60	53	48	111	209	43	140	210	308	477
Midland Regional Hospital, Tullamore,	40	0	4	32	55	205	186	77	249	219	319	503
Monaghan General Hospital	n/a	50	52	29	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nenagh General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	28	18
Our Lady of Lourdes Hospital, Drogheda	349	313	290	399	476	455	589	410	462	735	601	469
Our Lady's Hospital, Navan	21	164	131	107	31	178	117	85	421	189	69	259
Portlincula Hospital	82	71	115	46	148	79	60	169	119	208	63	379
Roscommon County Hospital	79	91	162	165	146	191	n/a	n/a	n/a	n/a	n/a	n/a
Sligo Regional Hospital	94	72	124	143	197	245	108	96	142	191	302	279
South Tipperary General Hospital	155	27	134	54	158	52	126	245	294	158	302	556
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	n/a	38	130	96	204	239	313	536
University Hospital Galway	155	170	286	319	365	523	558	378	602	519	526	618
University Hospital Kerry	131	97	133	93	91	93	64	88	93	75	199	187
University Hospital Limerick	304	225	118	213	453	404	304	437	564	631	682	793
University Hospital Waterford	n/a	n/a	n/a	68	95	88	100	138	296	125	430	480
Wexford General Hospital	546	162	129	50	226	283	111	106	102	268	196	125
Country total	3,638	3,171	2,979	3,041	4,288	4,977	4,194	3,804	5,301	5,550	6,188	7,958
NATIONAL TOTAL	7,069	5,361	6,301	6,690	7,741	8,329	6,606	6,263	7,942	8,684	9,345	10,365

Comparison with total figure only:

Increase between 2016 and 2017: 11%
 Increase between 2015 and 2017: 19%
 Increase between 2014 and 2017: 31%
 Increase between 2013 and 2017: 66%

Increase between 2012 and 2017: 57%
 Increase between 2011 and 2017: 24%
 Increase between 2010 and 2017: 34%
 Increase between 2009 and 2017: 55%

Increase between 2008 and 2017: 65%
 Increase between 2007 and 2017: 93%
 Increase between 2006 and 2017: 47%



INMO deputy general secretary **Dave Hughes** warns that the Minister's shame and heartbreak will continue unless he faces up to market challenges

A health service to be ashamed of?

MINISTER for Health Simon Harris said he was "ashamed and heartbroken" having watched a preview of the *RTÉ Investigates* programme which was aired on Monday, February 6, 2017.

RTÉ broadcast these comments last in a sequence of clips where his predecessors, dating back to Mary Harney, had each made promises about hospital waiting lists. Mr Harris too, fell into the trap of making some promises in that programme.

Indeed cynicism grew when reports the following day emerged that most of those featured in the programme as a result of RTÉ's intervention, had achieved their treatments and others were now scheduled. The big revelation in the programme was that hospital waiting lists had trebled since December 2015 and that, with 535,000 individuals on hospital waiting lists at the end of 2016, Ireland ranked 21st of 35 nations surveyed by the European Health Index and was in the same ranking as the developing nations of Eastern Europe.

The programme makers had given individuals on those waiting lists cameras which depicted in graphic form, the human misery of being a patient on those waiting lists.

But, like every other story that makes the headlines for a couple of days in relation to the health service, the public interest moves on and the tolerance of the intolerable conditions for patients and staff who work in the health services is accepted as a matter of fact, as something that we can all be ashamed of and heartbroken about when it confronts us.

In reality however, the chronic state of waiting lists and the record levels of patients waiting on trolleys is a result of policy failures by successive governments, in spite of a weight of incontrovertible evidence about what was needed. The political choice made, over and over, was to put money ahead of the needs of the people and to deprive the health service of the investment needed at crucial times to cope with increasing demand, longer lifespans and the rapidly escalating birth rate.

Throughout the 1980s, 1990s and early 2000s, in spite of prosperity, hospitals were closed and bed numbers were reduced across the system. Little or no investment was put into primary care and so called 'centres of excellence' were loudly promoted as a panacea for acute care. The creation of the HSE was spun as being the equivalent of the Manchester Health Authority, in terms of population, and therefore justifiable for an entire nation.

The HSE was modelled on an already failed construct which was applied to the Eastern Regional Health Authority in the previous decade. The creation of the HSE was itself sold as a way of taking the 'parish pump' out of politics and the abolition of the board of the HSE subsequently eliminated virtually all political accountability, allowing the Department of Health to define itself as a policy organ that could only ask the HSE to deliver on certain priorities.

The current failings of the health service, with excessively long waiting lists and massive overcrowding and

understaffing, are the direct consequence of putting fiscal considerations ahead of the needs of the community.

The drop in nursing numbers from a high of 39,000 in December 2007 to a low of 33,768 at the end of 2013, directly mirrors the decline in our public health service.

The loss of more than 5,000 nursing and midwifery positions over a seven year period had a catastrophic impact on the health service. Many of the theatre cancellations and bed closures are attributable to the staff shortage that now exists.

The real scandal in terms of policy is that the Department of Health itself in 2002 published workforce planning policy documents which demonstrated the need to recruit and retain nurses. An attached study to this document, conducted by Geraldine McCarthy of UCC, chronicles the detrimental impact of constant turnover and staff shortages on patient care and patient outcomes.

Yet when it came to imposing a public service moratorium to save money, nursing and midwifery staff numbers were cut by almost 10%, while the total cut of staff across the public health service was close to 7%.

In those years, the INMO alone among the nursing and midwifery fraternity, constantly cried halt to the continuing decline in numbers and the need for safe staffing.

It has to be asked why the policy department stood idly by and allowed a decline, which it had itself predicted would be detrimental to the provision of public health services.

On February 7, 2017, a day after the *RTÉ Investigates* programme, the INMO presented a comprehensive submission to the Public Service Pay Commission.

As part of that comprehensive submission, the Public Service Pay Commission heard that nursing and midwifery pay and conditions of employment in Ireland are now significantly worse than those available in the other developed countries who are also seeking to recruit nurses and midwives in the context of a worldwide shortage.

The commission also heard from the Organisation that the relative pay of nurses/midwives, compared with the other professional grades in health and across the public service in Ireland, is lower than in all of the other developed nations, with only one exception.

The Public Service Pay Commission was told, in no uncertain terms, that the realignment of nursing and midwifery pay and hours of work to give them parity with all other therapeutic grades is imperative if Ireland is to provide a health service suitable to the needs of its people.

In a world where markets seem to dominate every conversation, it is now evident that the market for the supply of nurses and midwives demands that those nations competing for the professions will only win by increasing the value of those professions.

A failure to respond to the market challenge will prolong the 'shame and heartbreak' felt by the Minister and others, as the plight of patients will not be addressed by emotional pleas alone.

Social welfare rule changes good news for international workers

THE INMO has welcomed recent changes to social welfare benefit, which will benefit international nurses, midwives and other workers who wish to travel to their home country during maternity leave or other leave periods covered by social welfare.

The International Section of the INMO had called for this rule change, announced by Minister for Social Protection Leo Varadkar recently, in recognition of the significant contribution made by international nurses and midwives to the Irish health system, while at the same time acknowledging the family link that they maintain with their country of origin.

In addition, the INMO had been contacted by a number of nurses/midwives who had left the Irish state to travel home to India, the Philippines and other countries during leave periods covered by social welfare and, on return to work, were pursued by the

Department of Social Protection for overpayments in respect of maternity benefit.

The INMO wrote to the Department of Social Protection setting out the case why these rules were unfair to international workers. An INMO delegation comprising Dave Hughes, deputy general secretary, Albert Murphy, IRO and organiser, and Kylie Matterson, information officer, met senior officials in the Department of Social Protection and agreed that this was unfair to workers such as nurses and midwives from non EU countries who travelled home during maternity leave or to receive medical treatment. These workers have been paying their tax and PRSI and making a major contribution to the Irish health system.

The regulations set out in the Social Welfare Consolidation Act 2005 provided that certain contributory pensions were paid outside of the state for a limited period of time.

The new regulations extend the range of benefits that can be paid to a claimant while the claimant is absent from the state on holiday, to include maternity benefit (for up to six weeks), adoptive benefit (for up to six weeks), and paternity benefit (for up to two weeks).

These rights had existed for EU citizens, however, non-European employees working in the Irish state were not entitled to these payments. The INMO argued that these regulations disproportionately affected female employees such as nurses and midwives from India and the Philippines who wished to return to their home country for a time following the birth of a child or to receive medical treatment.

INMO director of regulation and social policy Edward Mathews said: "Nurses and midwives from overseas have, for a long time, and indeed continue, to make an essential contribution to our health

service. This initiative recognises the importance of their contribution, removes the burden of financial hardship arising from travelling to their home country during maternity leave and is an important development in the context of measures needed to ensure the continued recruitment and retention of nurses and midwives to address ongoing staff shortages. Our members warmly welcome the initiative by Minister for Social Protection Leo Varadkar and commend him for recognising the reality of life for nurses and midwives who commit themselves to our health service and our population, while, at the same time, maintaining commitments to their family and friends further afield."

A copy of the new Regulations *SI No 12 of 2017* is available from the INMO Information Office, Email: catherine.hopkins@inmo.ie

– Albert Murphy, INMO IRO and Organiser

Talks begin on opening state-of-the-art Limerick ED

THE HSE is engaging with the INMO to agree measures ahead of the opening of a new, state-of-the-art emergency department at Limerick University Hospital, which is currently proposed for May 2017.

The engagement process is being independently chaired by Janet Hughes, industrial relations consultant, with full

participation from ED nurse representatives.

From the outset of the process and on foot of initial consultation with members, the INMO has advised the chair of the priority issues for nurses, which include:

- An agreement on staffing levels
- Recruitment of the required nurses in advance of the transfer date

- An agreed escalation plan to be put in place when the number of admitted patients waiting on trolleys reaches a certain level.

An initial proposal by management on staffing levels was rejected by the INMO. A revised proposal which has merit was then put forward and is forming the basis of consultation with members.

Further meetings are scheduled to discuss management's proposals on the care of admitted patients who are not able to access a hospital bed.

If correctly staffed and operated, the new emergency department offers great potential to enhance the working conditions of nurses and the experience of patients.

– Mary Fogarty, INMO IRO

Is your INMO membership up to date?

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

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

Please advise the INMO directly if you have changed employer or work location
Contact the membership office with any updates through the main INMO switchboard at Tel: 01 6640600
or email: membership@inmo.ie



Important
message from
the INMO

South Tipperary dispute referred to WRC

A REFUSAL by HSE management at national level to fund the recruitment of 36 additional nurses and midwives to South Tipperary General Hospital has left INMO members with no option but to embark on industrial action.

Members previously deferred action on foot of an agreement with the CEO and senior management team of the South/

South West Hospital Group for an evidence based review of patient needs at the hospital. The review, which was carried out locally and verified by the reputable Dr Jonathan Drennan of UCC, concluded that the five medical and surgical wards needed 15 additional nurses and that a further 21 staff were required in other departments to safely provide the

services needed by the people of Tipperary.

The proposed work to rule, involving nurses focusing on direct patient care and setting aside non-direct care roles that was due to take place in late February was deferred, pending the outcome of talks at the Workplace Relations Commission.

– Mary Power, INMO IRO

Members accept WRC proposals to resolve St Luke's dispute

INMO members at St Luke's Hospital, Kilkenny have voted by 86% to accept Workplace Relations Commission proposals to resolve the dispute over overcrowding and staff shortages, particularly the placement of patients on trolleys on medical and surgical wards.

Following a conciliation conference on January 5, 2017 the WRC issued a set of interim proposals aimed at

resolving the dispute on January 13, 2017.

These were accepted by INMO members following a ballot and the Organisation then immediately sought a meeting with hospital management to ensure the full and speedy implementation of the WRC proposals.

This meeting was scheduled to take place on Monday, February 27, 2017.

INMO IRO Liz Curran said: "Our members have accepted the WRC proposals by an 86% majority. We will now closely monitor the implementation of the WRC proposals to ensure that the placement of additional trolleys on already-full medical and surgical wards in the hospital becomes, and remains, a thing of the past at St Luke's Hospital."

World news



Nurses and midwives in action around the world

Argentina

- Nurse dismissed from Playa Serena will continue at the health center

Australia

- Watchdog with teeth to name, shame and ban dodgy health providers

Bolivia

- The National Health Fund starts an indefinite strike

Brazil

- Nurses reject PMA proposal and go on strike
- Project provides for special retirement grant for nurses

Canada

- Negotiations to avoid a nursing strike in Northern Ontario

Dominican Republic

- Dominican Republic needs 10,000 nurses

France

- Nurses, pharmacists, dentists... anger rumbles!

India

- Gandhi nurses go on flash strike
- Nurses to continue strike until demands are met

Portugal

- Nurses not always recognised for the work they do

Spain

- Comin apologises to the nurses and clarifies that he does not hold them accountable for the trolleys in the corridors

UK

- Senior nurse pledges to 'step up efforts' to increase staffing
- Nurses travel hundreds of miles to fill staff shortage

US

- Trump's hiring freeze creates confusion for veterans affairs

Venezuela

- Nurses march to Caracas to demand better working conditions

Ongoing work to rule in Dungarvan

MEMBERS working in Dungarvan Community Hospital, Waterford have agreed by a majority decision not to expand their work to rule in the short term given management's commitment at a recent meeting to close a further 10 beds at this care of the older person facility. This work to rule has been ongoing since November, when nurses began setting aside their non-nursing roles in order to maximise patient care requirements.

– Mary Power, INMO IRO

Sligo safe practice workshop



More than 30 nurses and midwives from the northwest attended the INMO safe practice workshop held in at the Clayton Hotel, Sligo recently. The workshop, which consisted of a morning session and an afternoon session, aimed to provide nurses and midwives with the record tools to keep their patients safe. It was organised by INMO IRO Maura Hickey and facilitated by Michelle Russell. Feedback was very positive, with attendees stating they found it invaluable and most informative and that it was a workshop they felt that all nurses and midwives should do

Spotlight on Research Nurses and Midwives Section

THE INMO Research Nurses and Midwives Section's mission is to 'define, validate and advance clinical research nursing and midwifery as a speciality practice and to support the professional development of registered nurses and midwives who impact the care of clinical research participants across all clinical specialties'.

We look forward to working with our members to accomplish the 2017 plans which are aligned with the Section's objectives. During the year we aim to raise the profile of the Research Nurses and Midwives Section and increase membership to strengthen our position for collective bargaining. We also plan to initiate engagement with universities and local hospitals to jointly support training/educational opportunities that are deemed mutually beneficial to both the employing institution and hospitals. A substantial body of consultation is required to assess demand and identify a strategy for advancing the career pathway for research nursing in Ireland. We will also work on this with our members during 2017.

For more information on getting involved with the Section or if you wish to contact the officers, email: researchsectioninmo@gmail.com

Section Officers

Chairperson



Veronica McInerney

Vice chairperson



Thora El Sayed

Education officer



Helen O'Reilly

Secretary



Elizabeth Fogarty

Affiliation Form for INMO Section Membership

Name: _____

INMO membership No: _____

Home Address: _____

Tel (work): _____

Tel (home/mobile): _____

Email: _____

Place of employment: _____

Job title: _____

Second section option (to obtain information only): _____

Forward completed form to:

Mary Cradden, membership services officer,
INMO, Whitworth Building, North Brunswick St, Dublin 4

Tick ONE relevant Section you wish to affiliate with

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

CPC Section to hold inaugural seminar

FEBRUARY was a busy month for the national sections, with the majority of sections holding their annual general meetings and to decide on motions for debate ahead of the upcoming INMO annual delegate conference in May.

Among the number of

sections that met last month was the Clinical Placement Co-ordinators Section, which is organising its inaugural seminar on March 30, 2017 in the INMO Professional Development Centre.

Topics to be discussed at the seminar will include mental

health awareness in the workplace, dealing with conflict management, guidelines on best practice in documentation and preceptorship guidance.

Booking is essential and can be made by contacting the INMO at Tel: 01 6640618 or visit www.inmoprofessional.ie

Retired nurses and midwives Cavan outing

THE Retired Nurses and Midwives Section is organising a four-night, five-day break in the Cavan Crystal Hotel from Sunday, April 30 to Thursday May 4, 2017.

The cost of the trip is €310 per person sharing, with a single supplement of €15 per night. Four days touring Cavan and Northern Ireland are also included in the package.

Those going on the trip are meeting at 11am on Sunday, April 30 at Parnell Square (near Findlater's Church).

To book your place, contact Annette McGinley at Tel: 074 9135201.

Full payment is due by April 7, 2017. Immediate booking is advised as it is a bank holiday weekend.

Celebrating 50 years of the ODN Section

THE ODN Section conference is taking place in the Crowne Plaza Hotel, Santry, Dublin 9 on March 24-25. All conference delegates are invited to attend a gala dinner on the Friday night, which forms part of the ODN Section's 50th anniversary celebrations. Bookings can be made online at inmoprofessional.ie or Tel: 01 6640641.

International nurses elect new section officers

THE International Nurses Section met in the INMO Professional Development Centre on February 8 to welcome new members and elect new section officers.

Newly elected officers include: Elizabeth Allauigan from St James's Hospital, Dublin, who was elected chairperson; Grace Oduwole from Cherry Orchard Hospital,

Dublin, who was elected vice chairperson; and Yermisi Jegede who was elected as the section secretary.

Ibukun Oyedele, outgoing chairperson, was thanked for her leadership and guidance of the section over the past few years. The section also extended thanks to Cres Abragan who remains on as the education officer.

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Person-centred approach to healthcare

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

Dr Paul De Raeve, European Federation of Nurses Associations (EFN) general secretary, represented the 35 European national nursing associations at the Organisation for Economic Co-operation and Development (OECD) Policy Forum on the future of health, in Paris in January 2017.

The OECD, established in 1961 and with 35 member countries, is focused on promoting policies that will improve the economic and social wellbeing of people around the world. It provides a forum in which governments and others can work together to share experiences and seek solutions to common problems. Working with governments provides the OECD with insight into what drives economic, social and environmental change.

The organisation analyses and compares data to predict future trends, setting international standards on a wide range of issues from agriculture and tax to the safety of chemicals.

The OECD also examines issues that directly affect individuals, including payment of taxes and social security, comparison of school systems and pension systems in different countries etc. It draws

on facts and real-life experience to recommend policies designed to improve the quality of people's lives.

The organisation works with labour, through the Trade Union Advisory Committee (TUAC) and civil society organisations. The common thread of their work is a shared commitment to market economies backed by democratic institutions and focused on the wellbeing of all citizens.

Some 500 participants representing civil society, patients, providers, policy makers, academics and industry came together at the OECD forum to discuss key issues including:

- Harnessing digital technology and data to create proactive, people-centred systems
- Caring for people with complex needs
- The importance of measuring what matters to people and to patients.

The forum also featured a conversation among a small group of health ministers about their views on the future of health and healthcare.

The OECD, in framing the debate at the forum, noted that societies and their healthcare systems are facing profound challenges and people's needs and

expectations are also changing.

Meanwhile, digital technology is opening new possibilities and promising to disrupt existing processes and modalities, as well as principles and beliefs. While other industries have reinvented themselves around the consumer, in healthcare, the OECD reports a gap "still exists between people who have one foot in the future and services that are stuck in the past."

According to the OECD, "in a world of increasing complexity – as well as opportunity – our healthcare systems simply must organise around the needs of the service user. A people-centred approach promises to raise quality, reduce waste and, most importantly, improve our health and wellbeing."

Dr Paul De Raeve, in reporting on his participation at the forum, stated that in relation to healthcare, people at the centre, implies nurses with patients at the centre.

To achieve the best health outcome for the EU population, the investment in the frontline will yield the most benefit. Dr De Raeve was critical of the constant request to collect more data and the burden that is placed on frontline staff, with little or no benefit to delivering care. In fact, he believes that the opposite result is achieved with frontline staff leaving under the burden and pressure.

The EFN general secretary has called on "the patient organisations and health professionals to build strong alliances to jointly agree on health system reform, regardless of what ministers and international Institutions will decide on value based health outcomes measurements."

Dr De Raeve advocates that "we will definitely need to build strong alliances to reform in a non-disruptive way. But where do policy-makers fit? Where do politicians fit? Where does industry fit in this story? Who drives who?"

In addition, Dr De Raeve also highlighted the different national health and social care systems, and indicated that the EU member states should share the same values for health and social care: universality,

solidarity and equity – values which drive the daily efforts of 6 million nurses in the EU. He questioned if these values are part of austerity. “Are these values part of the new disruptive models decided by people who never cared about the individual patient?”

In responding to the increasing public demand for quality, safety, equity and access to healthcare, Dr De Raeve highlighted that nurses are increasingly concerned as it is very evident that the sustainability equation is challenging proper investments in health and nursing care.

At the Policy Forum, the EFN was interested to learn how healthcare systems can be better organised around the needs, preferences and capabilities.

As nurses have a key role to play both in managing and preventing disease and conditions, have a unique and privileged position of having direct access to individuals’ care needs and an in-depth knowledge of the patterns and treatment of diseases across the care trajectory, solutions should reflect nurses views.

Dr De Raeve stated that “solutions without engaging frontline nurses are no solutions”. The EFN has demonstrated this through the design of eHealth services, building on 120 existing cost-effective practices, leading to new and changing roles for nurses, as health coaches and as case managers, for example.

ENS4Care, the European Commission funded project of which the INMO was a thematic leader in relation to nurse e-Prescribing, identifies many existing good practices in various areas such as different forms of rehabilitation (cardiac rehabilitation, COPD rehabilitation), prevention of malnutrition and social isolation and prevention of heart diseases.

In today’s digital era, sharing, gathering and easy access to personal information is our reality. The new challenges of the social healthcare systems are privacy of health information, institutional and cultural barriers to create people-centred health systems, engaging providers and professionals in the required change.

Healthcare systems collect significant quantities of data, but limited information on the impact and results on the people they serve. As such, policies usually have a very economic approach towards value-driven health ecosystems, it is crucial that the measurement of outcomes are designed with and for patients, and to focus on more robust health outcomes measurement (including nursing sensitive

European Union – what’s in it for me?

A NEW book, entitled *The European Union, what’s in it for me?*, written by EFN general secretary, Dr Paul de Raeve, offers nurses and midwives a valuable and insightful resource into the politics and strategic direction of health policy that shapes frontline nursing and midwifery practice in the EU.

From an INMO perspective, it is imperative that, on behalf of our members, we have a voice to influence the future strategic direction of the professions.

Membership of the EFN is vital to ensure that nurses and midwives on the frontline have a mechanism to shape the health agenda and to ensure optimal care for the populations they serve and this book is an excellent resource to understanding and appreciating the complexities and challenges of policy development in the EU and the implications for nurses and midwives in delivering care.

It covers the many challenges faced by the EU and presents that nurses and nursing are part of the solution.

Dr De Raeve explores and asks the difficult question about the EU and the complex political labyrinth that is not understood by many. He asks a number of key questions such as “are EU civil servants simply producing legislation in view of their own created cocoon, far away from daily reality?” and “How can we bring ordinary EU citizens closer to the European project, its solutions?”.

This book provides a unique and

data) to improve the quality of care for patients, strengthen public health interventions and contribute to the wider economic goals and societal wellbeing.

Participants at the forum agreed that the time is now to involve people and patients in their health and their care through steps such as:

- More intelligent use of technology and electronic data
- Measuring more of what people want from their health systems
- Policies and regulation that promote team-based care designed around needs and preferences of individuals and communities.

As a key player at EU level, the EFN will follow this OECD debate closely and will question the contribution of the European Commission to make sure health systems are more people-centred and give more



Dr Paul De Raeve, EFN general secretary, and author of *European Union – what’s in it for me?* Dr De Raeve also represented the 35 national nursing associations at a recent OECD Policy Forum

insightful perspective into the EU and the role and engagement of the professions. The INMO Library holds a small number of copies for reference and copies can be purchased at www.lap-publishing.com/catalog/details/store/gb/book/978-3-330-03381-8/the-european-union,-what-s-in-it-for-me



recognition to the frontline nurses, stressing the role of leadership and international collaboration within a more integrated multidisciplinary approach of healthcare professionals.

Nurses, with the right knowledge and skills are a considerable added value and form an important link between technological innovation, health promotion and disease prevention.

The outcomes and key messages from this event were discussed at the follow-on ministerial meeting. Additional information and video recording of all sessions are available by ‘webcast’ at: www.oecd.org/health/ministerial/policy-forum. All nurses and midwives can continue to contribute to the debate online by using #FutureOfHealth.

Elizabeth Adams is INMO director of professional development



Bulletin Board

With INMO director of industrial relations Phil Ni Sheaghda



Query from member

I have been working as an agency nurse for a number of years. How is incremental credit granted for my time spent in the role of agency nurse?

Reply

Incremental credit is granted on appointment to nurses and

midwives based on all previous genuine nursing and midwifery experience in Ireland and abroad. One increment would be granted for one year reckonable service. One year's service is equivalent to 52 weeks' reckonable service.

A reckonable service week is any week in which the employee has worked. Letters from hospitals on headed note paper stating what increment you are starting a new position on will suffice.

If you have worked for a number of agencies, contact them and ask them to confirm your record of service.

Query from member

How are basic working and employment conditions defined for agency nurses?

Reply

Basic working and employment conditions are defined under the Employees (Temporary Agency Work) Act 2012. The Act defines basic working and employment conditions as pay, working time, rest periods, rest breaks, night work, annual leave and public holidays.

It should be noted that the Act defines pay as basic pay and any pay in excess of basic pay in respect of:

- Shift premium
- Piece work
- Overtime

- Unsociable hours worked
- Hours worked on a Sunday.

With regard to location and specialist qualification allowances, and following a claim taken by the INMO on behalf of five agency nurses, the Labour Court has determined that location and specialist qualification allowances come within the definition of basic pay. This means that from the June 16, 2015, agency nurses and midwives may benefit from either the specialist qualification allowance or location allowance where they meet the relevant criteria.

The specialist qualification allowance is payable to nurses and midwives employed directly on duties in specialist areas in which they are employed. The location allowance is payable to nurses and midwives employed on duties in designated locations, eg. emergency departments, operating rooms, intensive care units etc. A full list of the areas in which the location and specialist qualification allowances payable are available from the INMO website and the Information Office.



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

It's time to schedule some rep training



INMO organiser Albert Murphy urges workplace reps to sign up for one of the upcoming rep training courses

THE INMO is running two advanced training courses for workplace reps in the first half of 2017. The first of these will be held on April 12-13 in the Newpark Hotel, Kilkenny, with the second being held on June 27-28 in the Cork INMO Offices.

These courses are held over two days; day one runs from 2pm-6pm and day two is a full day from 9.30am-5pm. All INMO reps who have attended a basic reps training course in the past two years have been invited to attend these courses.

The advanced rep course consists of presentations on:

- The importance of meetings
- Fair procedures at work
- Democracy in the union and organising.

The Organisation is also holding basic rep training courses in the coming months in Dublin, Limerick and Sligo (*see page 22 for further details*).

If you would like to get more experience in how to represent your colleagues at work, you should consider doing this course. The course is run in a relatively informal manner and will give you the skills and confidence to represent your colleagues effectively in the workplace.

Feedback from those who have attended the rep courses is very positive, with members reporting that they have found them to be beneficial and enjoyable.

Applying for a rep training course

If you are interested in attending either

of the two rep training courses, please contact Martina Dunne on Tel: 01 664 0626 or via email: martina.dunne@inmo.ie

Did you know?

The INMO is happy to organise courses in workplaces around the country on various subjects such as the new sick leave rules, statement writing and fitness to practise issues.

If you are interested in organising any of these courses in your own workplace, please contact your local IRO to set one up. These courses can be held at times that are convenient for members, such as at lunchtime or other break times.

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

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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 **your** 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.

All hands on deck for telephone triage nurses

Christmas and the new-year period is one of the busiest times of the year for telephone triage nurses across the country, with a significant increase in call volumes, writes **Carmel Murphy**



CHRISTMAS is the busiest time of the year for the out of hours GP services. The period from December 23 to the January 3 stretches the services countrywide as the public attend the out of hours primary care services. This year was particularly difficult, with the EDs bursting at the seams and the flu season commencing earlier than usual.

Statistics

In Shannondoc, the 2016 Christmas/new year period showed an increase of 10% in the call volumes from Christmas 2015, with 7,500 calls taken during the four days of the Christmas period and the three days of the new year weekend. This is an increase of 300% for a similar time period during the remainder of the year.

Telephone triage nurses managed the busy period well, with an average call-back time of 21 minutes. December 26 and 27 were the busiest days, with the highest daily volume of 1,150 calls and a new high of 550 calls in a four-hour period. The call-back times for routine calls occasionally reached the two-hour mark, however we worked hard to avoid this length of call back and used a rapid triage system at the 60-minute mark as a safety valve to get through unusually high volumes.

Nurse advice calls over this time was 24% – an increase of 6% from the previous year. Normally, nurse advice rates are around 30% but due to high volumes and time constraints, more patients are referred to the call centre during the busy Christmas period as nurse advice calls take longer.

The overall percentage reviewed by the

GPs was down 6% and doctors referred 7% of their patients to ED after review.

Overall, 5% of Shannondoc calls were referred to the ED, marking a reduction of 4% from Christmas 2015.

The top 10 presenting conditions this Christmas were cough, infection, chesty cough/wheeze, pain, temperature, generally unwell, sore throat, vomiting, injury and rash. Respiratory tract infections, sore throats and flu accounted for over 50% of illnesses in the Midwest area. Flu rates tripled during the 12 days of Christmas.

Chest pain, abdominal pain, epigastric issues, gout, anxiety, depression and suicidal intent are some of the calls that feature on a day-to-day basis, but these are even more prevalent over the Christmas period. There was a notable increase in respiratory conditions from asthmatic attacks and croup to exacerbation of COAD.

The increase in respiratory problems affected the over 65s with a 30% increase in calls compared to Christmas 2015. The 16 to 65 age group saw a reduction of 40% in calls and the under 6s remained static, at 20% of calls received.

Planning for the busy period

Planning for Christmas begins in August when management makes extensive use of data analytics, which plot the projected figures for the following Christmas. This year call volumes were as expected, with the predicted busy periods well staffed. Extra doctors are assigned to the centres with an on-call system used as backup. Extra doctors were called in on Christmas

day this year to cope with the increased volume. The centres were very busy and the centre staff and drivers were stretched to the limit.

Extensive lists of GPs, pharmacies, dentists, are composed and available at all work stations. Large boards show where there are extra doctors on duty and outline the centres where telephone nurses can double and treble book appointments.

Shannondoc liaises extensively with colleagues in the ambulance service with 0.5% of calls being referred by ambulance to hospital. GPs provide a backup to the paramedics when requested. The service is also in contact frequently with the psychiatric services and the crisis nurses in particular. The Gardaí are on speed dial and occasionally the fire brigade and coast guard are among the services we liaise with.

The telephone triage nurses, call takers and office staff work a very busy Christmas schedule. There is no annual leave for the four-week period before and during Christmas and the new year. This results in maximum staff on duty on the busy days over the holiday season – an increase at busy times of 50%-75% in staffing levels.

Out-of-hours GP services are a hive of activity around the Christmas period, the noise levels increase hugely, breaks are rare and rushed and Christmas spirit is hard to find but everyone rallies together and the combined effort gets the team through the added workload.

Carmel Murphy is a telephone triage nurse and chairperson of the Telephone Triage Section of the INMO



Progressive partnership

Pictured (l-r) were: Conor O'Byrne, RelateCare CEO; Kari Kontz, RelateCare director of clinical and wellness; Claire Phelan, former RelateCare director of operations; Suzanne Denieffe, head of Department of Nursing and Healthcare, WIT; John Wells, head of the School of Health Sciences, WIT; Farah Quili, student nurse, RelateCare/WIT; Cathy Hunt, student nurse, RelateCare/WIT; Louise Bennett, lecturer, School of Health Sciences, WIT; Frances Finn, lecturer in nursing, WIT; and Valerie O'Keeffe, RelateCare operations manager

RelateCare and WIT have launched a partnership allowing student nurses to experience the future of healthcare. Robert Grant reports

IN A corner of the southeast of Ireland an ecosystem of connected health innovation is being developed through an exciting new partnership between Waterford Institute of Technology School of Health Sciences and RelateCare, a Waterford-based organisation that specialises in patient access and patient engagement solutions, with a focus on the US healthcare industry.

Bringing education, innovation and industry together, students of the WIT are being afforded a unique opportunity with RelateCare: to gain real-world experience dealing with vulnerable patients in need of care, but doing so through technological solutions that allow this care to be delivered at a distance.

RelateCare partners with health systems who struggle to communicate effectively with patients as they move along their care journey. By offering communication solutions from when a patient first wishes to access care by scheduling an appointment, all the way to receiving a call from one of our nurses after being discharged to home, RelateCare increases patient access and ensure the patient is engaged in their health at all times.

For the past number of years, students from the WIT general nursing programme have been gaining invaluable experience as part of RelateCare's post-discharge programme.¹ The programme delivers follow-up communications to patients across the world after they have been discharged from hospital. The programme has already won awards,² and been responsible for reducing the number of unnecessary

re-admissions at one of the world's leading health systems, Cleveland Clinic.³

And at a time when governments⁴ across the world, Ireland included,⁵ are seeking ways to reduce the burden on overcrowded hospitals, this kind of innovative partnership is offering potential solutions.

"Having the students from the WIT make these calls has been a great success for all involved" says Conor O Byrne, CEO of RelateCare.

"Their knowledge and integrity allows us to trust them to care for vulnerable patients, while also freeing up our qualified Registered Nurses to focus on the more high-risk cases. Plus they gain valuable experience in technology solutions that one day can be applied to Irish healthcare systems," he added.

Students, based in Waterford, contact patients between two to five days following discharge to check for new or worsening symptoms, remind them of their discharge and medication instructions and schedule a new appointment if necessary. If serious issues are present, the patient is immediately escalated to a qualified registered nurse.

The benefits to the students are significant as they get the chance to apply their theoretical knowledge to real-world situations. They develop the skills to comfort patients who are often distressed and overwhelmed, while also making sure escalations happen in a timely manner. This requires a mix of patience, respect, alertness and care.

In addition to this patient-centred

experience, the students are also exposed to technological solutions that are not yet available in Ireland.

Electronic health records (EHR) are a real-time digital record of a patient's paper chart that make information available instantly and securely to authorized users.⁶ They can include a patient's medical history, diagnoses, medications, treatment plans, allergies, x-rays and test results. EHRs allow patient health information to be created and managed in a digital format that can then be shared with other providers across more than one healthcare organisation. Research has shown that the introduction of EHRs reduced medical error and hospitalisations by more than 50% in one US healthcare insurer.⁷

By accessing the electronic records of patients from the Cleveland Clinic, the students in Waterford can understand the patient's medical history, medication programme and treatment plan, which allows them to offer personalised outreach care.

Ireland has yet to universally adopt EHR technologies, however there are determined moves to introduce them in the next few years. Led by Richard Corbridge, CIO of the HSE, there have been promising steps taken to ready the Irish healthcare system for an EHR system by 2019. For example, the Irish Haemophilia Society is a forerunner in its use of technology systems and has been using an electronic patient record system since 2008, and with much success.

While there are plans in place, there is still a distance to go before universal

adoption. It is hoped the new National Children's Hospital at St James's Hospital will become the first publicly-funded hospital using EHRs.

Once these adoptions become universal, those WIT students who have spent time with RelateCare will have a significant advantage in navigating these sophisticated technologies while delivering worldclass care.

The students themselves are fully aware of the opportunity to learn and grow as more fully developed nurses. Joanne Claxton, a recent graduate from the BSc in Applied Healthcare, commented: "I saw how advanced American healthcare is in comparison to our own Irish system and how adopting electronic health record would greatly improve efficiencies and waiting times in Ireland."

Niall Duggan, a current third year student also noticed the impact this could have in Ireland: "As students, we hear in the news all the time about huge waiting lists and lack of hospital beds, Since working here, I can't help but think if the Irish healthcare system could adopt some of the service RelateCare provide it would be

a solution to many of these problems".

Waterford Institute of Technology School of Health Sciences has a rich tradition of training students for challenging work in the hospital, but this kind of telehealth solution presents a new kind of challenge by using technology to deliver healthcare at a distance. This compliments WIT's forward-looking approach to education and learning.

Frances Finn, lecturer in nursing and healthcare at WIT, pointed to this growing relationship, "The expression of this close and successful working relationship is the establishment of the BSc in Applied Health Care, which, as part of its programme content, has modules on healthcare informatics and connected health. RelateCare provides an excellent learning experience for students on this programme in relation to many facets of connected health and we see further development of this programme in partnership with RelateCare as significant and exciting."

Perhaps as Ireland moves towards the adoption of Electronic Health Records, RelateCare and WIT will be uniquely positioned to finally deliver on the promised

benefits of technology for how we understand and deliver healthcare. So far, the partnership has been a great success and it looks set to continue growing and developing solutions to the problems in healthcare in Ireland, the US and across the globe.

Dr Robert Grant is a research and marketing analyst at RelateCare

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UK/MPR/0217/0165

Date of preparation: February 2017.





Enhancing practice in nursing and midwifery

The INMO/UCD professional certificate in enhancing clinical practice provides participants with an opportunity to develop reflective practice skills while maintaining their CPD, writes **Philip Hardie**

ENHANCING clinical practice is an innovative and exciting collaborative programme developed in conjunction with the INMO and the UCD School of Nursing, Midwifery and Health Systems – Ireland's largest and longest established nursing school.

The professional certificate in enhancing clinical practice, which is a level 8 qualification, is ideal for nurses or midwives who are considering returning to third-level education or wishing to continue their professional development to maintain and enhance their knowledge and skills.

The programme will provide participants with key academic and technological skills required for third-level postgraduate education programmes and continuing professional development.

To be eligible for enrolment, candidates must have completed six days of educational programmes or a minimum of 30 continuing education units (CEUs) with the INMO prior to applying to UCD. Completion of the INMO PDC programme, 'Academic writing and research appraisal simplified', is compulsory for applicants.

On acceptance to the course, participants will complete a 12-week blended learning programme at the UCD School of Nursing, Midwifery and Health Systems, which includes one day of scheduled face-to-face sessions on the UCD campus,

where learners work collaboratively, share experiences and participate in individual and group tasks. The remaining weeks are based online, comprising weekly online lectures and activities that aid and support both the in-class sessions and assessment. On completion of the programme, students will be awarded five European Credit Transfer and Accumulation System (ECTS) credits in preparation for the opportunity to undertake further graduate level studies both nationally and internationally.

Aims

The aim of this programme is to develop and enrich participants' skills and ability to reflect on their practice and how their ongoing continuing professional development contributes to the knowledge, skills, values and beliefs required to enhance their practice in nursing and midwifery. The programme will facilitate the process by which participants look at the heart of their experiences; examining them in detail while making changes that may foster a change in practice, based on their learning. Its initiative is to create an environment where each participant can gain a greater self-awareness, examining their personal attributes including their beliefs, values, qualities, strengths and limitations, which impact on their delivery of care.

Literature on the theory and models of

reflection and how reflection can promote life-long personal and professional development is examined. Weekly tasks are set to develop reflective practice skills, which consist of self-awareness, description, critical analysis, synthesis and evaluation. The skills of reflective writing are developed, therefore providing participants with the tools to produce a clear and comprehensive account of the situation being described. Participants learn to identify and illuminate their existing knowledge, feelings and assumptions, and their relevance to the situation being explored.

Programme structure

Participants will be expected to partake in weekly online discussions forums, which provide an opportunity to discuss the topics being covered. Thinking and writing skills are developed each week and the programme allows time for in-depth reflection as participants can reflect, research and compose their thoughts before taking part.

The discussion forums also facilitate learning by allowing participants to review and respond to the work of others. A great sense of a class community is often evident. It is this joint learning between online classes and in-class participation that makes the conversations among participants so rich and so valued. The online discussion forums allow participants to

work at a time that suits them best to learn and from the comfort of their own home.

Another key component of the enhancing clinical practice programme is the development and mastering of academic writing skills. The first step in mastering academic writing is to develop literature searching skills. Participants will receive a demonstration on how to use library resources and how to develop their literature search skills. The UCD library has a comprehensive collection of resources, including international academic databases, books, journals and audio/visual materials, and students can access most resources off campus.

Additionally, participants will be guided on evaluating information on the internet and developing skills in looking at the authorship, publishing body, objectivity and critical appraisal to ensure quality and accuracy of their sources.

Students will be asked to complete pieces of academic writing and access will be provided to academic writing and citation guidelines used within UCD.

Individual feedback will be provided to each participant on assignments. The feedback will highlight the strengths and weaknesses of a given piece of work and

set out ways in which the student can improve the work by encouraging them to think critically about their work and reflect on ways to improve.

Outcomes

On completion of the enhancing clinical practice module, students will have developed their own personal/reflective portfolio. This portfolio allows the participants to present achievements and evidence of performance in a clear and orderly way. It can be used to showcase their work and demonstrate evidence of accountable professional practice. Participants may find the portfolio beneficial when applying for a job promotion or it could contribute to any future requirements set out by the Nursing and Midwifery Board of Ireland under the Nurses and Midwives Act 2011 in demonstrating continuing professional development.

While a large proportion of this programme is online, participants who may be reluctant towards technology should not be apprehensive as there are great supports available at UCD from educational technologists.

Participants will receive a tutorial on navigating and using the user-friendly

virtual learning environment, Blackboard, along with the process of submitting assignments and receiving feedback.

Continued technical support is provided to the participant throughout the programme. There is a wide variety of support services also available at the library to all participants of the programme including in-house and online tutorials, academic writing skills workshops, laptop loan services, disability services, individual study rooms and group study rooms.

UCD facilities

A bonus to enrolling in this programme is, as registered UCD students, participants will have full access to UCD facilities. The UCD campus at Belfield has undergone a massive transformation in recent years. As well as amenities such as five woodland walks across the parkland campus, students benefit from some of the best learning, sport and social facilities in the world, including a 50-metre Olympic-specification swimming pool, gym, a 125-seat state-of-the-art performance theatre, a 90-seat multimedia 3D cinema, lecture theatre halls what use the very latest in technology and a choice of cafés.

Philip Hardie, School of Nursing, Midwifery and Health Systems, UCD

University College Dublin School of Nursing, Midwifery and Health Systems Professional Certificate Enhancing Clinical Practice

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For more information on this programme, contact Marie O'Flanagan, graduate relations manager in UCD at Tel: 01 7166432 or email: marie.oflanagan@ucd.ie. Alternatively, you can contact the INMO Professional Development Centre at email: pdc@inmoprofessional.ie or Tel: 01 6640642

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This one-day course is aimed at registered nurses and midwives who are undertaking third-level academic programmes. This course will assist participants in completing their written assignments. The objective of the workshop is to help prepare the student for academic study which requires efficient literature searching, research critique and accurate referencing skills. For more details on INMO courses or to make a booking, visit www.inmoprofessional.ie or Tel: 01 6640641/2



Breastfeeding problems

In the latest clinical update in this continuing professional development series, **Catherine Lewis, Nina Thirlway and Gerry Morrow** examine some common breastfeeding problems

THE World Health Organization recommends exclusive breastfeeding until an infant is at least six months of age to achieve optimal growth, development and health.¹ Studies have shown many benefits of breastfeeding to both mother and infant. Mothers who breastfeed have reduced rates of breast and ovarian cancer, and reduced incidence of obesity.² Infants who are breastfed show a reduction in the incidence and severity of infections including respiratory and urinary tract infections, and also reductions in the risk of developing diabetes, obesity, asthma, and eczema.² Breastfed babies are also at a decreased risk of sudden infant death and childhood cancers.

There is some evidence to suggest that breastfeeding may also be important for child development and academic achievement.³ A 2010 report on children's foundation years found that "no other health behaviour (than breastfeeding) has such a broad spectrum and long-lasting impact on population health, with the potential to improve life chances, as well as survival and health".^{2,4}

Breastfeeding rates in Ireland are currently among the lowest in the world.⁵ Approximately 42% of Irish mothers are breastfeeding when they leave hospital, compared with 67% in the UK and 89% in Europe as a whole.⁵

Effective and efficient breastfeeding requires optimal infant positioning and attachment to the breast, if this is not achieved problems such as reduced milk production and transfer, nipple pain and nipple damage can occur which may lead to other possible breastfeeding problems such as infection and abscess development.¹

Assessing breastfeeding women

Assessment should include history and examination of both mother and infant, including general history, pregnancy

complications, medications, previous breast surgery, gestation of infant, birth weight and weight gain, behaviour at the breast (pulling, biting, coughing, breathlessness, sleepiness), cleft/lip palate, tongue-tie, and use of a pacifier.^{6,7,8}

The woman should be observed breastfeeding and expressing milk by a person with appropriate training and expertise. She should be asked about her breastfeeding history including previous breastfeeding experiences, problems, pain, any breast or nipple sensitivity before pregnancy, milk supply issues, pattern of breastfeeding, expressing of milk, other fluids or foods given and use of nipple shields or breast shells.^{6,7,8}

Discuss breast and/or nipple pain history including when the pain started, any nipple trauma, timing of the pain (during feeding, after, constant), location of the pain, and character and severity (burning, itching, sharp, dull). Ask about associated signs and symptoms (fever, breast skin changes, nipple colour changes, nipple shape or appearance after feeds) and any exacerbating or relieving factors (cold, heat, massage or touch). Determine any previous treatments such as analgesia, topical or oral drugs including antibiotics.^{6,7,8}

Breastfeeding problems

There are a variety of causes of breast pain in breastfeeding women and more than one cause may co-exist at one time. It is important that breastfeeding problems are recognised and managed promptly to allow the woman to continue breastfeeding without pain.

Initially, breast pain may occur between the second and sixth day after delivery when the breast is full and the milk 'comes in'. This is normal, and the pain usually settles within a few weeks' post-partum. Nipple pain also often occurs for the first few minutes of breastfeeding and resolves with the continuation of the feed. Pain



often improves during the first few weeks of breastfeeding. Common causes of breastfeeding problems that may require management are discussed below.^{1,6,8}

Engorgement

Engorgement may occur in the first few days after birth when there has been no or insufficient milk removal. Pain typically starts in the first few days after birth, is often in both breasts, and is worse before a feed. Infant attachment may be difficult due to breast fullness. The woman may have a mild, short-lived fever. The whole breast is typically swollen and may appear shiny with some redness. The nipple may be stretched and look flat in appearance. Engorgement can also occur when breastfeeding becomes restricted or infant demands have decreased. Engorgement is more common in women who have had breast implants.

The woman should be advised to feed her infant with no restrictions on the frequency or length of feeds. She should wear

a well-fitting bra and clothing that does not restrict the breasts. Advice should be given on self-management techniques such as simple analgesia (for example paracetamol) for pain relief, breast massage after feeds and expressing milk to relieve full breasts. Heat packs or a warm shower before feeding or expressing milk can stimulate milk let-down, and cold packs after feeding or expressing can be used to relieve pain and swelling.

Nipple pain

Inefficient positioning and attachment typically causes nipple pain at the start of a breastfeed that continues throughout the feed. Pressure from suckling may cause blanching and compression of the nipple, and fissuring across the top of the nipple or around the base. There may be flattening of the nipple from side to side, with a pressure line across the tip.

Advise the woman to continue breastfeeding wherever possible, and that reducing the duration of feeds is unlikely to relieve nipple pain. A thin layer of white soft paraffin or expressed breast milk can be used if the nipple skin is cracked or fissured.

If symptoms persist, consider the possibility of nipple infection. Bacterial infection may present with nipple discharge, crusting, redness, and fissuring. Candida infection typically causes burning pain in both nipples, itching and hypersensitivity, especially during and soon after feeds.

There may be deep breast pain radiating into the breast and chest. Typically, the pain does not resolve despite improved positioning and attachment, or follows a period of pain-free breastfeeding. If bacterial infection is suspected antibiotics should be given such as fusidic acid 2% cream to be used after every breastfeed for five to seven days. For severe infections 500mg flucloxacillin should be prescribed for use four times a day for seven days (erythromycin should be given for women who are allergic to penicillin).

Mastitis and breast abscess

Mastitis may be infectious or non-infectious and is usually secondary to milk not being removed effectively from the breast. Non-infectious mastitis is more likely where there is no nipple damage and poor drainage of one part of the breast due to external pressure such as tight clothing, car seat belts, or extended intervals between feeds. Infectious mastitis is more likely if there is a nipple fissure or damage, which may become infected. Engorgement or blocked ducts may lead to mastitis, which

may then develop into a breast abscess.

Mastitis may present with a hard painful swelling in a wedge-shape in one breast, with redness of the overlying skin. The woman often has a fever and appears unwell. A breast abscess may present with a worsening painful breast lump, and the overlying skin is often red and warm. There may be a persistent fever.

Women should continue to feed from the affected breast if possible. Pain relief and antibiotics should be given. If the woman is showing signs of serious infection she should be admitted to hospital with her infant to allow for continuation of breastfeeding. If a breast abscess is suspected the woman should be referred urgently to a surgeon.

Low milk supply

Low milk supply can be caused by insufficient access to the breast which can be indicated by short or infrequent feeds; no night feeds, use of a pacifier, or giving supplementary feeds other than breast milk. Maternal depression, stress, and/or anxiety may result in a reduced response to infant feeding cues and a reduced frequency of feeds, which leads to reduced stimulation of milk production.

Ineffective infant positioning and attachment suggested by frequent feeding more than every two hours; no long intervals between feeds; feeding for less than five minutes or longer than 40 minutes' duration may also indicate a low milk supply. The infant may be generally unsettled, have faltering growth, or show signs of dehydration.

Advise on increasing skin-to-skin contact; to feed her infant with no restrictions on the frequency or length of feeds; offering both breasts at each feed; and alternating between breasts. The woman may also wish to express milk after feeds to stimulate milk production.

Milk oversupply

If a woman has an oversupply of milk her breasts may be very full with possible engorgement or blocked ducts. She may have a painful, forceful milk let-down reflex and milk leakage and/or milk spraying from the opposite breast when feeding. The infant may choke or splutter while on the breast, suffer from colic or frequent, explosive loose stools and they may have rapid or excessive weight gain.

Milk oversupply can be caused by ineffective infant positioning and attachment during which the infant may not remove milk efficiently so suckles a lot, stimulating the breast to produce excessive milk.

Swapping sides too early and not allowing the infant to finish feeding from the first breast can also lead to supply issues.

Ensure that the woman is aware of early feeding cues that suggest an infant is hungry, so that breastfeeds are initiated at appropriate times. Advise that if the infant is unable to attach effectively to the breast due to breast fullness, it may be helpful to express a small amount of milk until the flow slows down, and then try to attach the infant to the breast. Advise on feeding from one breast for each feed, to help reduce milk supply.

General information

Advice on continuing breastfeeding should be given wherever possible. Provide advice on optimal infant positioning and attachment to the breast, simple analgesia, massage, and expression of milk, if appropriate and advise the woman to wear a well-fitting bra and clothing that does not restrict the breasts.^{1,8}

Further information on breastfeeding support is available from:

- Breastfeeding.ie: www.breastfeeding.ie/
- La Leche League of Ireland: www.lalecheleagueireland.com
- Cuidiú: www.cuidiu-ict.ie/supports_breastfeeding

Catherine Lewis is a clinical author at Clarity Informatics, Nina Thirlway is style editor at Clarity Informatics and Dr Gerry Morrow is editor and medical director at Clarity Informatics.

Clarity Informatics is contracted by the National Institute for Health and Care Excellence (NICE) to provide clinical content for the Clinical Knowledge Summaries service available through the Clarity Informatics Prodigy website at: <http://prodigy.clarity.co.uk/>.

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

CPD Quiz

1. Benefits of breastfeeding include:

- A) Decreased risk of sudden infant death
- B) Lower risk of asthma in infant
- C) Reduced rate of breast and ovarian cancer in mother
- D) Reduced rates of obesity in mother and child

2. Breast pain usually first occurs how long after birth:

- A) Two to six days
- B) Two to six hours
- C) Two weeks
- D) Six weeks

3. Ineffective infant positioning and attachment can cause:

- A) Low milk supply
- B) Milk over supply
- C) Nipple pain
- D) Mastitis

4. Breastfeeding women should be advised to:

- A) Wear a tight-fitting bra
- B) Stop feeding from a painful breast
- C) Supplement breastfeeding with formula
- D) Continue breastfeeding wherever possible

5. The WHO recommends exclusive breastfeeding until an infant is at least:

- A) Six days old
- B) Six months old
- C) Six weeks old
- D) 16 months old

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

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

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Date of preparation: January 2017. Code: UK/MOV/0117/0149b.



Introducing Executive Council members



Karen Clarke

Clinical placement co-ordinator,
Our Lady of Lourdes Hospital

I work as a clinical placement co-ordinator based in Our Lady of Lourdes Hospital in Drogheda. As a team we cover four acute sites: Our Lady of Lourdes; Louth County, Dundalk; Our Lady's Hospital, Navan; and the Hermitage in Lucan.

I trained in London in the 90s and returned home in early 2000. I hold a degree in business studies and health-care management and I am currently undertaking a course in project management. I have worked as a staff nurse, CNM1 and CNM2 on acute medical and surgical wards. I have also worked in infection control and as the regional overseas nurse facilitator.

I have been a member of the INMO for 17 years and have been the branch secretary for seven years. I have been an active rep for over six years, representing my nursing and midwifery colleagues at many forums. I have worked hard with other INMO representatives to strengthen membership on site.

I believe as professionals we have the power to bring about change. We are the largest discipline employed in the health sector and by standing together we are an incredibly strong group.

Not only do nurses and midwives provide care, but they act as role models for students providing guidance and support in an ever increasing demanding environment.

A safe working environment with adequate professionals to provide safe care to their patients and to support our students must be in place. As a member of the Executive Council it is my priority to advocate on behalf of all nurses and midwives.

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Frances Cullen

Senior staff nurse,
Ballina District Hospital

I am delighted and honoured to be given a position on the Executive Council representing care of the older person section. I am a senior staff nurse and love caring for elderly patients. I have a postgraduate honours degree in gerontology from NUIG.

My 1998 teaching and assessing

certificate from the ENB in the UK along with a preceptorship course, assists me in nurturing student nurses and school leavers doing Fetac/QQI Level 5. Having trained in London and gained experience in teaching hospitals across a range of disciplines, I then returned home. Living away from home and family was an education in itself. I have great empathy for nurses and midwives having to immigrate because Ireland is not able to compete with what is on offer to them abroad.

About eight years ago I became an INMO rep. As a member and vice chair of the Ballina/Belmullet Branch, I am an advocate for members and keep them informed. Having worked full

time for the past 15 years, I feel that more and more is expected from the nurse. We have to rely heavily on HCAs to assist and maintain safe standards of care for our patients, while the documentation and accountability remains with the RGN. Being a member of the INMO is so important in order to feel protected and safe in the legal minefield environment we work in.

It is the first time a nurse from Ballina District Hospital has sat on the INMO Executive Council and I am delighted to meet this new challenge. I look forward to working hard on behalf of members and assisting in meeting the goals of the organisation.

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Karen Eccles

Staff nurse, Theatre,
Cavan General Hospital

I am very happy to be given the opportunity to serve a second term on Executive Council representing my nursing and midwifery colleagues with a special interest and representation for perioperative nurses.

I currently work in Theatre in Cavan

General Hospital as a staff nurse. I qualified as an RGN in Canterbury, Kent and completed the theatre and anaesthetic course at St Thomas's in London and subsequently practised at the Blackrock clinic and as a CNM in St Vincent's Hospital's theatre department. I have been a long-standing member of the INMO and have been very active recently as a rep attending joint reviews, the WRC, the Labour Court and the recent ED negotiations.

Working conditions, recruitment and retention, adequate remuneration, respect for the nursing and midwifery professions and the vital role we play in the health service will be my major objectives for this term.

I will continue to highlight the risk to nurses, midwives and patients as a result of inappropriate redeployment and look forward to the early recognition and implementation of the findings of the current pilots on the Taskforce for staffing and skill mix and support mandatory staffing levels.

Maintaining and improving nursing and midwifery standards is dependent on CPD, excessive workloads and insufficient staffing all impact on access to continuing education. I believe this is a shared responsibility for both nurse/midwife and employer and will campaign for protected study time and leave for our professions.

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Too little, too late

There has been broad coverage of the INMO's plan to commence a work to rule this month over the ongoing staff crisis. Ann Keating reports



Nurses to begin work to rule on March 7 was a headline in *The Irish Examiner* (February 9). "Nurses are to begin a work to rule from next month – and have threatened to escalate to a series of rolling stoppages days later if the dispute over overcrowding and under-staffing is not resolved. From March 7, the work to rule will be "immediate and continuous" and will involve the 35,000 members of the Irish Nurses and Midwives Organisation "working to contract resulting in a ban on overtime, cross cover and redeployment. The rolling work stoppages are scheduled to begin on March 13 if there is no resolution. The union has acknowledged the action could result in bed closures and more patients on trolleys. It follows a rejection of staffing, recruitment and retention proposals put forward by the HSE following late-night talks on Tuesday. The union described those proposals as "too little, too late" and "totally inadequate" and said it was exercising the 90% mandate it received in a ballot of its members prior to Christmas." Liam Doran said "The clear message received from INMO members is that their workplaces are now unsafe and dangerously overcrowded. All areas are understaffed and the services are at breaking point which will require radical solutions to take the pressure off struggling nurses and midwives."

The *Daily Mail* (February 9) ran a headline – **Nurses say they will go on strike next month**. "The Irish Nurses and Midwives Organisation last night announced that from March 7 its 36,000 members will no longer work overtime, will not cover for other absent staff and will not redeploy to other parts of their hospitals. The planned action will escalate a week later to involve rolling work stoppages in hospitals

and community services if the dispute is not solved... Martina Harkin-Kelly, INMO president said "In considering the proposals, Executive Council members presented numerous examples of nurses and midwives unable to provide full care to their patients, working beyond the end of their shift without pay, unable to take meal breaks and facing unmanageable workloads because of the appalling conditions, and inadequate staffing they now face every day." Liam Doran said "We need to attract and retain nurses and midwives in sufficient numbers to provide safe care and the current proposals contain no adequate remedies for this."

The Irish Times (February 9) also covered the story – **Hospital beds to close in nurses' dispute**. "Bed closures and cuts to services in hospitals are likely from March 7 as nurses take industrial action in a dispute over staff recruitment and retention. Liam Doran said as part of the industrial action, nurses would provide the full range of services in their ward or area but would not move from one ward to another to cover absent colleagues who had not been replaced or staff vacancies that had not been filled... He described the government's proposals for the retention of existing staff as "flawed and shallow"... Mr Doran rejected suggestions that the dispute was about money. However, he confirmed that the INMO had sought the restoration of a broad range of allowances, which were abolished in 2011, for nurses recruited in recent years. The INMO also sought that the health service should recognise all hours worked by nurses, including when they had to work through meal breaks. It also looked for one hour of work time a week to be devoted to professional and educational development.

INMO strongly critical of health service management's "fanciful accounting" was a headline in the *Irish Medical News* (February 14). "It has been estimated that it would have cost almost €180 million to implement proposals put forward by nurses to resolve the dispute over recruitment and retention, almost four times more than last November's €50 million Garda deal. However, Liam Doran, general secretary of the INMO, responded by saying that these figures were an exaggeration, indicating "more fanciful accounting" by health service management. In the face of chronic overcrowding and understaffing in our hospitals, residential care and community settings the Irish Nurses and Midwives Organisation Executive Council rejected staffing/recruitment/retention proposals by the HSE, dismissing them as totally inadequate. INMO president, Martina Harkin-Kelly, outlined the unfair working conditions expected of their members, stating that nurses and midwives are unable to provide full care and attention to their patients."

€1,000 pay rise

The *Irish Independent* (February 18) reported that **Refusal to give nurses pay rise will 'inflare' dispute**. "A union has warned the government it will "inflare" a dispute over staff shortages if it refuses to give nurses a €1,000 pay rise for taking industrial action. The Irish Nurses and Midwives Organisation's caution came after Minister for Public Expenditure and Reform, Paschal Donohoe, said there would be "consequences" if "we get to a point that there is industrial difficulty."

Ann Keating is INMO media relations officer
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Nominations open for preceptor award

Student Officer **Liam Conway** discusses the INMO Preceptor of the Year Award and current issues affecting students and new graduates

THE INMO is delighted to announce that the annual Preceptor of the Year award has opened once again for nominations. The Organisation would like to thank Cornmarket for its continued sponsorship of this prize. The award will be given to an INMO member, who has inspired and motivated a nursing/midwifery student to reach their potential.

The award gives recognition to the essential work of preceptors, which is a fundamental component of nursing and midwifery education.

Students can nominate their preceptor before the April 7 online or by email via the form available at www.inmo.ie/Preceptor_of_the_Year. The winning preceptor, with a guest, will be invited to receive their prize, which includes €1,000 cash, at the annual awards dinner at the ADC in Wexford in May. The student member who nominates the winning preceptor will also be invited with a guest to the awards dinner and will receive a smaller prize.

Graduate increment (2011-2015 group)

Graduates from this period working in HSE hospitals and facilities should have received confirmation that their incremental credit has been adjusted or a date when your increment will be changed. If this is not the case you should contact your local human resources department. If you have any issues regarding the implementation or queries regarding this increment, please contact me by email : liam.conway@inmo.ie or Tel: 01 664 0628.

This increment entitles those who graduated between 2011-2015 to the recognition of their 36-week internship as incremental credit. As a result, each individual member from this group will move to their next increment on the point of scale following 112 days of their last incremental date.

So, for example, staff nurses/midwives who graduated in 2015 were placed on the



INMO Dublin Youth Forum Pictured (l-r): were: Catherine O'Connor, chairperson; Clarence Soliman, secretary; and Matthew Robson, vice chairperson

first point of the salary scale on October, 3, 2015, should have moved to the second point on the same date in 2016. The third point increment should then be granted after a further 112 days, allowing for incremental credit in respect of 36-week clinical placement.

Please note, children's and general nursing groups calculate their incremental credit due date from the period they started working as a pre-reg or staff nurse.

So, those who graduated in 2016 were placed on the first point on February 1, 2016 and the second point on the same date in 2017 and the third point increment should then be granted after a further 112 days, allowing for incremental credit in respect of 36-week clinical placement.

Important: If you started as a pre-registered nurse or midwife that time worked as a pre-reg is to be included in the 112 days. Thus, if you worked for four weeks as a pre-reg then that would mean 112 days less four weeks rostered as a pre-reg.

Please note these are examples and each individual member will have a different start date and increment date.

Getting Involved

The annual general meetings for the Student Section, Dublin Youth Forum,

Western Youth Forum and Cork Youth Forum took place in February. It is not too late to join the Student Section or the youth forums. Please contact me if you are interested in getting involved and having your say.

Industrial action and campaign

Students please keep an eye out for the Student E-Link as I will be issuing regular updates for the upcoming campaign of action. This will be sent via email (see also pages 8-9).

Contact Details

If you have any issues or queries please contact me.

- email : liam.conway@inmo.ie
- Tel: 01 664 0628.

Hyperemesis gravidarum

Role of evidence-based information

Deirdre Munro spoke to Caitlin Dean, a survivor of hyperemesis gravidarum, about living with the condition through three pregnancies

NAUSEA and vomiting in early pregnancy are very common, affecting approximately 80% of pregnancies. Hyperemesis gravidarum (HG), a severe form affecting only about 1% of pregnancies worldwide, generally includes intractable nausea/vomiting, signs of dehydration, electrolyte imbalances and weight loss, excluding other diagnoses. The onset is generally in the first trimester, peaking by 12 weeks, with most women having resolution of symptoms by 20 weeks.¹

I spoke with Caitlin Dean, a nurse and survivor of hyperemesis gravidarum, and invited her to share her experience and increasing expertise on this condition.

"Plenty of people can imagine that crippling nausea and near constant vomiting for anything more than two days is not nice, even if it 'for a good reason', but, really, the nausea and vomiting is only one aspect of a life-changing, family-limiting, and sanity-destroying condition that takes over your every waking moment for nine long and extraordinarily lonely months.

"HG is not only nausea and vomiting. It is a sense of smell so powerful and warped that your loved ones can't come near enough to comfort you without triggering retching. It is not being able to swallow your own saliva without puking it back up, so you just have to spit constantly into a towel or a cup. It is not just days lying still in a dark room but weeks and even months of it. It is not being able to eat or drink for days and being racked with guilt about the unknown harm you imagine you're doing to your baby before it is even formed.

"And then seeking help and being faced with more guilt about taking medication during pregnancy thanks to old stigmas and a lack of awareness. It's having a life threatening condition which people tell you constantly to take ginger for!

"The mental toll that all of the above takes is understandably profound. And yet, what I've described above is only a fraction of what HG is to the thousands of women who suffer it every year. There is also the financial toll on families, the damaged relationships, the long term complications and damage to your gastrointestinal tract, the memories of smells that can trigger nausea and panic many years after. It becomes easy to see why post traumatic stress disorder is common after HG not just for women but their partners too.

"What I have come to realise is that I am a woman who experiences HG during pregnancy and therefore I can only maintain a pregnancy with medication. But it's not just my own preconceptions that caused my feelings of guilt; it was the whole of society, lay people and medical professionals, immediate family and total strangers who questioned my 'choice' to take medication for a condition which, prior to IV therapy and anti-emetics, was the leading cause of death in early pregnancy," Caitlin explained.

What the research says

A recent Cochrane systematic review by Boelig et al 2016, included 25 studies with 2052 women.² There were 18 different comparisons, with interventions including acupuncture/acupressure, intravenous fluids and various drug treatments, and only a small amount of data on each. There was an absence of studies of dietary or other lifestyle interventions.

This review reports that "there is little high-quality and consistent evidence supporting any one intervention, which should be taken into account when making management decisions."

Sarah Chapman of Cochrane Evidence explains: "The Cochrane reviewers note shortcomings of the evidence that

highlight the need for consistency in how HG is defined, for a core set of outcomes using validated measures, and for larger placebo-controlled trials".³ Caitlin Dean welcomes work on core outcomes and an agreed definition of HG, by the team that conducted a recent systematic review on corticosteroids for HG and agrees these issues as essential for making research useful.

HG and Ireland

Evidence-based information provision and support are two of the most effective ways to help women with HG and reduce the psychological burden of the condition. To that end a group of ex-sufferers and interested healthcare professionals have collaborated to establish Ireland's first charity for people affected by HG. Hyperemesis Ireland, as it is to be known, will aim to provide up-to-date information about seeking help and treatment for the condition, enabling easy access to the evidence women need about medications to make informed decisions. Additionally, it is hoped the information they provide will support doctors, nurses and midwives to provide safe and effective treatment to women.

Like the established UK charity Pregnancy Sickness Support, Hyperemesis Ireland will provide one-to-one peer support for women and their partners to get through the challenging and stressful months of sickness.

For more information about the charity and HG services in Ireland please go to:

- www.hyperemesisireland.org
- www.facebook.com/Hyperemesis-Support-Group-of-Ireland-296658161918/

Deirdre Munro is education officer of the INMO Midwives Section and founder of GlobalVillageMidwives Twitter @DeirdreMunro

References and reading list on request from nursing@medmedia.ie (Quote WIN 25(2):Munro 53)

New care standards: Improving maternity quality and safety

Deirdre Munro shares HIQA's guide to the new National Standards for Safer Better Maternity Services

LAST December the Health Information and Quality Authority (HIQA) published National Standards for Safer Better Maternity Services. The standards describe what safe, high-quality maternity services should look like.

Following a number of high-profile failings in the delivery of safe, high-quality care in maternity services, HIQA committed to the development of specific standards for maternity services to drive improvements in quality and safety. Ireland's first National Maternity Strategy, 'Creating a Better Future Together' was launched in January 2016. These standards have been designed to support the implementation of the National Maternity Strategy.

Maternity services

The standards define maternity services as any location where maternity care is provided to women and their babies. Maternity care includes care for women when they first look for care before and during pregnancy, during labour and birth, as well as the care of the woman and her baby after birth.

Maternity care can be provided in the community, in maternity hospitals or in maternity units in general hospitals. A maternity service provider is any person, organisation or part of an organisation delivering maternity care.

The standards

Good maternal health and safe, high-quality maternity care impacts on the health and life chances of newborn babies, their healthy development and their long-term health. Recent reviews and investigations of maternity services in Ireland have highlighted a need to develop standards that are specific to maternity services. Ireland's first National Maternity Strategy was launched in January 2016. The Strategy and these National Maternity Standards provide the building blocks to provide a consistently safe, high-quality maternity service.

What are they?

The Standards cover eight areas. They encompass the care of women and their

babies from before pregnancy until six weeks after the birth of the baby. They do not cover assisted human reproductive services. Each standard statement describes an 'outcome' for women and babies receiving care. Safe, high-quality maternity care is provided to women and their babies when a service achieves these outcomes. Each standard statement also has a number of examples of good care, called features, listed underneath them. These describe what a maternity service is likely to be doing if it meets the standard

Overview of the eight themes

- 1. Person-centred care and support:** This theme describes how maternity services always place women and their babies at the centre of what they do. This includes protecting the rights of women and their babies, respecting their values and preferences and involving them in their care
- 2. Effective care and support:** This theme describes how maternity services can deliver the best outcomes for women and their babies, using information based on the best available evidence. It includes ensuring that women and their babies receive the right care and support at the right time and in the right place
- 3. Safe care and support:** This theme outlines how maternity services protect women and their babies by preventing and minimizing avoidable harm, and learning lessons if something goes wrong so that the likelihood of these events happening again is reduced
- 4. Better health and wellbeing:** This theme describes how maternity services work with women in order to support women to make healthier choices, improve their health and wellbeing, and that of their families.
- 5. Leadership, governance and management:** This theme describes how maternity services organise and run themselves. The theme explores how services make themselves accountable, make decisions, manage risks, and meet their strategic, legal and financial obligations

6. Workforce: This theme covers planning, recruiting, managing, organising, supervising and developing staff so that maternity services have the numbers of staff with the skills and abilities they need to respond to the needs of women and their babies

7. Use of Resources: A maternity service's resources include human, physical and financial resources. This theme describes how maternity services can use their resources to deliver the best possible outcomes for women and their babies within available resources

8. Use of Information: This theme describes how maternity services can use information to plan, deliver, monitor, manage and improve their services. Reviewing data regularly is a straightforward way to check trends and take action if any concerns come to light.

The National Maternity Strategy and the National Standards, when implemented, represent necessary building blocks to providing a consistently safe, high-quality maternity service, which will work towards restoring public confidence in the service.

Comment

Implementation is a science and methodology that is always overlooked. The main focus of implementation, reported as high as 80%, is often on the 'action' rather than the 'preparation', reported as low as 20%, when in fact it should be the reverse. Implementation failures are due to a lack of preparation. Midwives and healthcare professionals need ample time, resources and preparation to implement the strategy and standards for maternity services in Ireland.

*Deirdre Munro is education officer of the INMO Midwives Section and founder of GlobalVillageMidwives
Twitter @DeirdreMunro*

Resources

1. The full report available at: www.hiqa.ie/publications/national-standards-safer-better-maternity-services
2. HIQA Guide directly quoted and used for this article: [file:///C:/Users/Dmmun/Downloads/guide-to-national-standards-maternity-services%20\(1\).pdf](file:///C:/Users/Dmmun/Downloads/guide-to-national-standards-maternity-services%20(1).pdf)

Quality & Safety

A column by
Maureen Flynn



Liberating structures: revealing ideas and including everyone

ARE you interested in practising new ways to inspire, motivate, facilitate or encourage creativity? If so, you may enjoy using 'liberating structures' in your work.

Liberating structures

Liberating structures (LS) are a collection of highly engaging and interactive tools that can be used by facilitators and groups to reveal creative ideas for improving quality.

When we feel included and engaged we do a better job. The best ideas often come from unexpected sources, however we have to ask the right questions and create an environment where this can happen. LS help by fostering lively participation in groups of any size, making it possible to truly include everyone. This sparks inventiveness; by using these simple structures in how we interact we can 'liberate' content or subject matter and in healthcare we can use them as a means to support teams in improving quality of care and their working environment.

LS are a 'disruptive' innovation that can replace more conventional approaches. LS have a base in complexity science and were initially developed by Keith McCandless and Henri Lipmanowicz in 2002.

Using liberating structures

A menu of 34 tailored structures is publicly available on the website www.liberatingstructures.com. When you click on the relevant section of the menu you will find detailed instructions on how to use them. It also provides helpful tips and trips and examples.

This approach is both practical and feasible because LS are simple and easy to learn. They can be used by everyone at every level. No lengthy training courses or special talents are required; a step-by-step guide is freely available. Mastery is simply a matter of practice.

Benefits

Liberating structures encourage us to discover a vast reserve of contributions and



Liberating structures menu

latent innovation within ourselves. They also encourage us to distribute control in order for participants to shape direction themselves.

LS initiatives in healthcare include; preventing the spread of healthcare acquired infection in the US and Canada; reducing errors in safety challenges – eg. medication reconciliation and patient falls; shifting hospital culture from a tradition of top-down only to more self-organisation; connecting innovators across the US and the UK; and, launching a variety of transformational leadership initiatives in nursing and medical schools.

When LS are part of everyday interactions, it is possible to:

- Include and 'unleash' everyone
- Practice deep respect for people and local solutions
- Build trust as you go
- Learn by failing forward
- Practice self-discovery within a group
- Amplify freedom and responsibility
- Emphasise possibilities: believe before you see
- Invite creative destruction to enable innovation
- Engage in 'seriously playful' curiosity
- Never start without a clear purpose.

Most importantly, implementation becomes greatly simplified and accelerated

because all share ownership of the ideas and decisions that have been co-developed. There is no need to explain and convince. There should be no need to twist arms with buy-in strategies.

How does the Irish 'Liberating Structures User Group' Work?

Our experience of using this novel approach is growing in Ireland. A group of enthusiasts have formed a LSUser group that meets to connect, get help and try something new monthly. Sessions are informal, fun and interactive! All you need is a sense of humour, a willingness to get involved and your imagination.

Get involved

If you are interested in learning more, why not start with reading more on the LS pages on the web. We are also delighted to welcome new members to join the Irish LS user group. There is no cost and there's no need to register - just turn up on the evening! We meet in a central Dublin venue from 6-7.30pm. Upcoming dates are as follows:

- Monday, April 3
- Thursday, April 27
- Thursday, June 1
- Monday, July 3
- Thursday, August 3
- Monday, September 4
- Monday, October 2
- Monday, November 6
- Monday, December 4

Further information

Find out more about the LS Users Group by emailing LiberatingStructuresIreland@gmail.com or follow us on twitter on: @LSUsers. Find out more about liberating structures and users group around the world on www.liberatingstructures.com.

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

Acknowledgement

Thank you to Juanita Guidera, lead for staff engagement, HSE Quality Improvement Division, for assistance in preparing this column and Dr Michael Gardam and Leah Gitterman for introducing us to the world of liberating structures



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





Long-acting reversible contraception

LARC methods have several differentiating features from other forms of contraception which can make them particularly suited to certain groups of women. **Deirdre Lundy** examines the options

Part one of a two-part series

LONG-ACTING reversible contraception (LARC) is the term used to describe types of contraception that provide protection for an extended period and involve little user effort. As a result of this lack of need for compliance, they have been shown to be the most effective options for women who want to avoid pregnancy.

In Ireland, most women opt for condoms or an oral contraceptive unless prompted to consider a LARC.¹ However, condoms and the pill are among the least reliable alternatives (see Table 1) as both require significant user compliance.² If used 'perfectly' the combined oestrogen/progestagen pill should allow as few as 0.3 pregnancies for every 100 women per year of use – a very small failure rate. In actuality, the failure rate of the combined pill is closer to eight pregnancies per 100 women/year.

PI refers to the 'pearl index' of contraceptive efficacy. It tabulates the number of pregnancies per 100 women per year of use. The 'perfect' PI refers to efficacy when a product is used exactly as advised, where the 'typical' PI refers to the efficacy that is seen among the average user.

Can healthcare providers make a difference?

A US study asked just that question: would women choose LARC methods over pills and condoms if given the choice (and if access to LARC was facilitated)? The answer was positive.³ The 2008 contraceptive 'CHOICE' project was conducted in various university and community-based health centres all over St Louis in Missouri, US. Interestingly, among the women who chose an intrauterine device (IUD), almost half were nulliparous, even though this is often perceived as a barrier to IU contraception by Irish healthcare providers and patients alike.

Barriers to successful contraception include: forgetting to take a tablet at a critical time; vomiting after taking a pill; or being on a course of liver enzyme inducing medications.³ Younger women are often less disciplined in pill taking than their older counterparts. LARC is particularly well suited for sexually active young women. While LARC methods may be expensive initially, they are more cost-effective than the pill after as little as 12 months.

Depo-Provera

Medroxyprogesterone acetate has been available as the 150mg deep IM injection Depo-Provera for decades in Ireland. The large bolus of progestagen delivered to the gluteus or deltoid muscle has a strong impact on the hypothalamic-pituitary-ovarian hormone axis causing anovulation. It can be started at any time of the cycle with or without a period, as long as a current pregnancy can be ruled out.

It begins to work almost immediately and is one of the most effective contraceptives available, with a PI of 0.3 pregnancies per 100 women/year. Typical efficacy is closer to three pregnancies per 100 women/year (late attenders and not managing to find deep muscle when administering the injection are possible explanations).

Impact, benefits and potential side-effects

The impact on ovarian activity can sometimes be so profound that circulating oestrogen levels may drop and a transient reduction in bone mineral density can result. This phenomenon has never been linked to an increase in fracture risk and recovers within weeks of discontinuing the Depo-Provera. It is for this reason that women under 18 (who have yet to achieve their maximal bone density) and women over 45 (who are starting to lose bone

density more rapidly) might benefit from a fracture risk assessment before commencing this product.

If they are already high risk for fracture with a multiplicity of lifestyle risks (eg. very low BMI, heavy smoking, sedentary lifestyle, high-dose steroid use, etc) then Depo-Provera may not be the wisest option for them. If they have considered and then rejected other options, even these women may use the Depo-Provera injection, but a two-yearly reassessment is recommended.⁴

For most healthy young women, the benefits of Depo-Provera contraception far outweigh any risk and it is an excellent option for women who need highly reliable contraception but aren't prepared to commit to the cost of an implant or IUD.

The anovulation lasts for at least 12 weeks; the UK Faculty of Sexual and Reproductive Healthcare (FSRH), advises that Depo-Provera can be protective for up to 13 or 14 weeks – although this is outside the product licence of an injection every 12 weeks. For women on liver enzyme-inducing medications there is no need to shorten the injection intervals as was previously thought as the large dose of progestagen is fully cleared by the liver in the first pass.

The relatively high dose of synthetic progestagen may have some unwanted side-effects, however. Some women complain of acne, bloating, headache, alopecia, flushes, decreased libido or moodiness, but causation has never been established. A small but significant proportion of women experience rapid weight gain – Depo-Provera is the only form of contraception proven to do this. Weight gain is more likely to be an issue for women under 18 years of age with a body mass index (BMI) $\geq 30\text{kg/m}^2$ and if this is an issue it is



likely to get worse. Alternatives should be considered.

Use of Depo-Provera usually results in a much lighter or non-existent PV bleed after the first or second injection. While this is reversible it may interfere with conception for six to 12 months after the injections are discontinued so forward planning is suggested. Being amenorrhoeic on Depo-Provera does not imply low fertility and in fact the amenorrhoea may be beneficial for women who suffer from menorrhagia or endometriosis, are HIV positive, suffer from severe dysmenorrhoea or who are homeless.

Use with combined pill

Before becoming amenorrhoeic, some users experience unscheduled bleeding in the first three to six months. For those who are medically eligible, a three-month prescription of the combined pill (COC) may be offered to help resolve this annoying side-effect.

The pill can be taken in the usual cyclic manner or continuously without the pill-free interval (this too is outside the product license). Longer-term use of the Depo-Provera with additional COC has not been studied and is a matter of clinical judgement. Alternatively, unscheduled bleeding can be controlled with 500mg mefenamic acid up to three times daily for five days. Persistent unscheduled bleeding should be investigated and STIs and other pathologies ruled out.

Depo-Provera is suitable for breastfeeding mothers and women who have been told to avoid oestrogen-containing pills because of obesity or smoking. It is only UK Medical Eligibility Criteria (UKMEC) Category 2 (benefits outweigh risks) for women who currently have or have had a deep vein thrombosis or suffer from migraine with aura.

Mirena intra-uterine system

Since its launch in Ireland in 1998, the Mirena intrauterine hormonal contraceptive system (IUS) has revolutionised the concept of in-utero contraception. Prior to the development of Mirena, the only IU contraceptives in Ireland were all copper-bearing. Copper devices are reliable contraceptives but copper usually creates longer and heavier periods for wearers. Since it is often the older, parous women who typically opt for IU contraception and since many of those are already struggling with menorrhagia, only a limited selection of women were suitable for IU products.

Mirena has a good 'period improving' effect and helps ease menorrhagia and dysmenorrhoea. These effects are derived

Table 1: Contraceptive methods and reliability (typical use v perfect use)

Contraceptive method	Typical use PI*	Perfect use PI*
Implanon	.05	.05
Male sterilisation	.15	0.1
Mirena IUS	.2	0.2
Female sterilisation	.5	0.5
Copper coils	.8	0.6
Depo-Provera	3	0.3
Nuvaring	8	0.3
Evra patch	8	0.3
COCP	8	0.3
Cerazette POP	8	0.3
Noriday POP	15	3
Male condom	15	2
Diaphragm	16	6
Vaginal sponge	16-32	9-20
Female condom	21	5
Natural methods	25	3-5
Withdrawal	27	4
Spermicides	29	18

*PI: pearl index tabulates the number of pregnancies/100 women/year. Perfect PI refers to efficacy when a product is used exactly as advised, whereas typical PI refers to efficacy seen among the average user⁸

from the hormone-bearing frame on the Mirena device. Mirena is made up of a plastic frame similar to many copper IU devices but, unlike those devices, Mirena has a levonorgestrel progestagen reservoir running down its vertical shaft.

The levonorgestrel hormone is a good contraceptive. It alters cervical mucus, rendering it hostile to sperm. It also alters the endometrium making it less receptive to implantation. These, among other contraceptive effects, prevent pregnancy. Occasionally, enough of the progestagen hormone is absorbed into the uterine vasculature (and then on into the systemic circulation) to cause anovulation.

The most novel effect of IU levonorgestrel is that it causes significant endometrial depletion. The microscopic features seen within the endometria of Mirena wearers are similar to those expected to be seen in the presence of a foreign body (eg. surface undulations, inflammatory cell infiltration, and stromal haemosiderin deposition) as well as features seen as a result of progestagen exposure (eg. glandular atrophy and stromal decidualisation).⁵

Initially this may create longer or more frequent PV bleeding, while the womb lining is being shed, but eventually the thinner, lighter endometrium should mean shorter, lighter periods for most women. It is the only IUD available in Ireland that does this. Its smaller, sister brand Jaydess will not lighten periods and copper devices usually make them worse.

Mirena was licensed for the treatment of menorrhagia in 2001 and swiftly became a much more popular option for that condition than hysterectomy. Multiple studies exist exploring the decline in hysterectomy rates in communities where Mirena became available.

A Mirena is made of a plastic membrane reservoir containing 52mg of levonorgestrel wrapped around a T-shaped, polyethylene frame. There are two, thin nylon threads or strings at the base of the device that are designed to extend through the cervical canal and into the top of the vagina to aid removal. The membrane only allows 20µg of the hormone to escape over 24 hours in the first few years, dropping down to 12µg and then 10µg in the fourth and fifth years of use respectively. This

gives the device long-term effectiveness for at least five years.

If a woman using a Mirena that is less than five years in situ chooses to take hormone replacement therapy (HRT) she only requires an oestrogen product, as the Mirena's levonorgestrel will protect her endometrium from unhealthy proliferation that unopposed oestrogen might cause.

If a woman over the age of 50 requires HRT and is keeping a Mirena beyond the five-year license for contraception (as is allowed by FSRH – www.fsrh.org) she must use a combination oestrogen plus progestogen HRT product. Sometimes a new device may be inserted for women over 50 either for HRT or if menorrhagia is starting to return.

Placement can be offered at any time of the cycle as long as pregnancy can be reasonably ruled out. The FSRH has guidelines on how this can be established.⁷

Mirena is expensive at the outset although cost-effective over the five or more years of use. It is covered by the Drugs Payment Scheme and currently non-medical card holders will pay €144 for it and other medications they require in that calendar month. Insertion charges vary. Mirena insertion is covered by the GMS.

All relevant healthcare providers should be familiar with the exclusion criteria, advantages, disadvantages, likely side effects, cost, etc. of all contraceptives. It's most important that a woman can make an informed choice about her method before spending money on something costly.

Contraindications to Mirena

Contraindications to Mirena include recent septic abortion, CVA, MI, trophoblastic pregnancy with continued elevated beta-hCG levels, current breast, ovarian or endometrial cancer, uterine fibroids that distort the uterine cavity, current pelvic inflammatory disease (PID), chlamydia or gonorrhoea, pelvic TB, severe liver disease, SLE with antiphospholipid antibodies and/or severe thrombocytopenia.

Nulliparity, multiple Caesarean sections and a past history of ectopic pregnancy or PID are not contraindications to any IU device.

Risks and rare adverse events

These include pain on insertion, insertion failure, vasovagal reactions, bleeding, perforation, migration, expulsion and failure of the device. Overall, ectopic pregnancy rates are reduced by using efficacious contraception including a Mirena. Unfortunately though, when a rare failure with a Mirena in situ does occur, that pregnancy

is more likely to be ectopic and requires urgent referral.

Infection is a rare complication of Mirena placement. For the first 20 days after insertion a woman is more vulnerable to ascending infection as the cervical mucus plug has been breached by instrumentation and placement of the foreign body. If the inserter uses aseptic technique and if the patient is free from an STI at the time of placement the risk of infection thereafter is the same for any other sexually active woman. This is true for all IUD wearers.

Perforation of the uterus is a rare but important known risk and is much more likely to occur with inexperience and if performed too soon post-partum. Women should wait at least six to eight weeks after spontaneous vaginal delivery and eight to 12 weeks after uncomplicated C section for this reason. Bridging contraception with non-oestrogen hormones like the POP or Depo-Provera can be offered immediately post partum while arranging IUD insertion.

Systemic absorption of the levonorgestrel while minimal may still cause noticeable side-effects, eg. headache/migraine, nervousness, dizziness, nausea, vomiting, bloating, breast tenderness or pain, weight gain, changes in hair growth, acne, depression, changes in mood, loss of interest in sex, itching or skin rash, and puffiness in the face, hands, ankles or feet. Return to fertility is immediate after the device is removed.

In addition to counselling, women considering a Mirena insertion should have a bimanual and speculum exam by the device prescriber. This will establish if the patient has gynaecological issues that prevent her from using an IUD.

Nucleic acid amplification test (NAAT) screening for vaginal STIs can be offered if necessary (young patients and women with new partners are particularly at risk). The more occult infections like chlamydia and gonorrhoea are most important to rule out. Bridging contraception should be advised, but if the woman does not wish to take this she should be advised to abstain from intercourse for three weeks prior to insertion.

Once inserted, the device may take up to an additional seven days before it becomes fully effective and a six-week post insertion check-up is recommended to confirm the nylon strings of the device are still present and that the patient is well.

Jaydess

Jaydess may be described as 'Mirena-lite'. It is an effective IU contraceptive

but smaller in size and lighter in hormone load. It doesn't last as long and won't help menorrhagia but it does deliver effective contraception for three years.

Jaydess comprises a plastic membrane reservoir of 13.5mg of levonorgestrel wrapped around a small, T-shaped, polyethylene frame. Unlike the Mirena, Jaydess's vertical stem contains a silver ring located close to the horizontal arms so you can identify one from the other on ultrasound scan or x-ray. It's a smaller device than a Mirena (28 x 30 x 1.55mm) and insertion tends to be easier and less uncomfortable.

Unlike Mirena, Jaydess is not recommended as a first-line contraceptive for nulliparous women. But after discussion of alternatives, Jaydess may be inserted into women under 18 years. The counselling and pre-insertion preparation for Jaydess are similar to that of Mirena.

According to FSRH guidance, use of Jaydess in women under 18 years of age should not generally be restricted (UKMEC 2) and it can be used from menarche to menopause.⁶

The SPC for Jaydess quotes an ectopic rate of 0.11 per 100 women/year, and it quotes an ectopic rate of 50% with failures. Therefore, women who become pregnant while using Jaydess are advised to seek advice and immediately exclude ectopic pregnancy. The FSRH has explained why differences in the absolute and relative risks of ectopic pregnancy between Mirena and Jaydess should be interpreted with caution until more pregnancy data are available.⁷

Deirdre Lundy is a general practitioner in Bray, Co Wicklow. Part two of this article in the April issue of WIN, will discuss copper IUDs and Implanon

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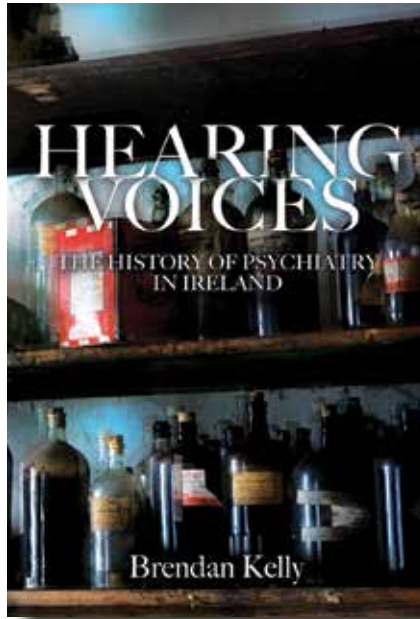
Learning from our history

IRELAND had more asylum beds for the mentally ill than any other country in the world in the mid-1900s. Why was that? Did we have an unusually high rate of mental illness? If not, who from Irish society was filling these institutions and why?

Hearing voices: The history of psychiatry in Ireland by Prof Brendan Kelly, professor of psychiatry, TCD and medical historian, is a detailed and fascinating account of the history of psychiatry from the asylum era to the present day.

In an in-depth medical and social history using the archives, Prof Kelly addresses some of the unresolved questions about the evolution of our psychiatric institutions. He also looks at the present situation and the future of mental health care.

Prof Kelly charts the development of the asylums in Ireland that provided for not just the mentally ill, but many other people who did not fit into a strict social milieu and were incarcerated as a result. As Ireland became weighed down by unimaginable poverty during the 1800s, the asylums functioned as a "vast, unwieldy social welfare system for patients and possibly some staff".



He argues that as a society, Ireland had an insatiable hunger for institutionalisation.

The book covers the seismic effects of major events such as the famine, when many people were tipped over the edge, and the impact of the First World War.

It describes the development of

treatments such as electroshock therapy and lobotomy. A significant step in medical treatment was the introduction of the antipsychotic drug Largactil in 1954. This made it possible for people with severe mental disorders to at least tolerate life in the community and be able to leave mental institutions.

In more recent years, the emphasis has been on care in the community. However, the book's foreword points out that suicides post-discharge today are higher than they were in the 1800s, despite advances in care and in medication, so it's not yet time to pat ourselves on the back.

Prof Kelly concludes with the sobering words that members of the asylum staff were often the only ones at the funerals of forgotten patients – "a small measure of humanity given by a society that has always excluded the mentally ill".

Even in the context of today's services and our attitudes to the mentally ill, Prof Kelly's parting words are: "We must do better."

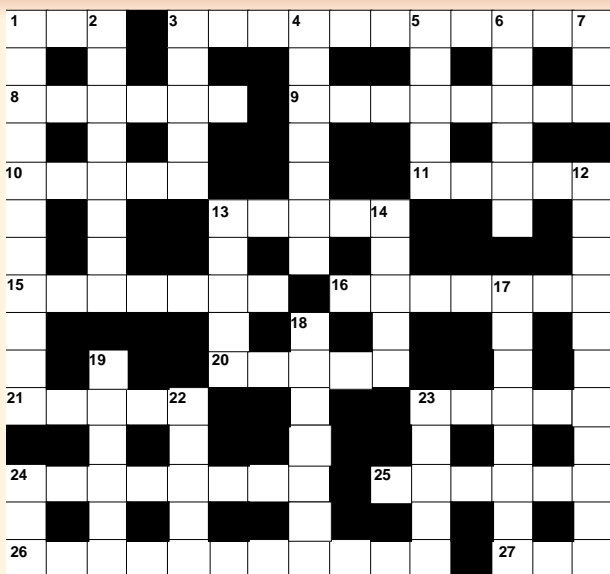
—Geraldine Meagan

Hearing voices: The history of psychiatry in Ireland is published by Irish Academic Press, 2016 ISBN-13: 978-1911024347 RRP €39.99

Crossword Competition



WIN A €30 BOOK TOKEN



Across

- 1 Take a seat (3)
- 3 The bonnet I cided could be a blessing in disguise (11)
- 8 Hinder (6)
- 9 Noticed what is scattered over beds (8)
- 10 Adhesive (5)
- 11 Ornamental bush (5)
- 13 Devil (5)
- 15 Actress Doris and rugby pundit Tony have provided part of the hospital (3,4)
- 16 Behind schedule for arrival (7)
- 20 Large, stringed instruments (5)
- 21 Birds with black plumage (5)
- 23 Copper or lead, for example (5)
- 24 Large marsupial (8)
- 25 Polar (6)
- 26 Get a pill to a Clare town for sport (5,6)
- 27 Hip-hop music (3)

Down

- 1 Trod on a banana skin, getting a record injury? (7,4)
- 2 Woven work of art (8)
- 3 Emblem (5)
- 4 Developed gradually (7)
- 5 Ruminates, masticates (5)
- 6 Turn upside down (6)
- 7 Bushwhacker Kelly, the northern editor (3)
- 12 Informal American item of headgear (8,3)
- 13 Scottish inlet such as Forth or Clyde (5)
- 14 Launches oneself into the swimming pool (5)
- 17 Ruler with absolute authority (8)
- 18 This soldier finds love in a monster! (7)
- 19 Mingle, rub shoulders (6)
- 22 Town in Meath (5)
- 23 Female horses (5)
- 24 Equipment (3)

Solutions to September crossword:

- Across:**
 1. Pig 3. Quicksilver 8. Rasher
 9. Bully off 10. Churn 11. Moist
 13. Volga 15. Address 16. Gazette
 20. Stale 21. Lunar 23. Chaff
 24. Boot camp 25. Common
 26. Baker's dozen 27. Axe
- Down**
 1. Paracetamol 2. Gestured
 3. Queen 4. Cubicle 5. Islam
 6. Violin 7. Ref 12. Take offence
 13. Vases 14. Aware 17. Toxaemia
 18. Calypso 19. Uncork 22. Racer
 23. Crown 24. Bib

The winner of the February crossword is:
**Miriam Hogan,
 Santry, Dublin 9**

Name:
 Address:

The prize will go to the first correct entry opened.
 Closing date: Tuesday, March 21, 2017
 Post your entry to: Crossword Competition, WIN, MedMedia Publications,
 17 Adelaide Street, Dun Laoghaire, Co Dublin

MONEY MATTERS



Getting home insurance right

Tips from Marc Evans to ensure you have the correct level of cover for your home

HOME insurance provides you with peace of mind, knowing the value of your home is protected. We all know that your home represents more than just a house – home insurance covers buildings, contents and allows for separate all risks cover for your most treasured items. The value of insurance is demonstrated at the time of a claim and products have been enhanced to make benefits more relevant and accessible while accounting for changing lifestyles.

The frequently asked questions below should help you determine your most suitable level of cover and discover more about the benefits on offer.

Rebuild value

It is not the market value of your home you should insure; it is the estimated cost to rebuild and replace the entire home.

It's important to know your 'home' is much bigger than the four walls around you. The word 'home' generally refers to:

The home and its domestic outbuildings, garages, greenhouses, sanitary fixtures, swimming pools, tennis courts, patios, terraces, drives, footpaths, walls, gates, hedges, fences, aerials, satellite aerials and their fittings and masts, including landlord's fixtures and fittings, all on the same site.

This may seem complicated but really, you need to keep in mind; you are insuring your house and the area around it for which you, the homeowner, are responsible.

If you are in doubt, the Chartered Surveyors of Ireland website has an easy to use calculator to guide you: www.scsi.ie/advice/house_rebuilding_calculator

Contents

As with your home, you should insure your contents for what it would cost to replace them.

When it comes to assets within your home, contents are defined as: all property including business equipment, valuables, clothing, personal effects and money in your home or its domestic outbuildings,

Checklist of benefits		
✓ Insurance company/broker	✓ Smoke alarm discount	
✓ Policy excess	✓ Alternative accommodation	✓ Accidental damage
✓ Home Rescue	✓ Personal money	✓ Satellite aerials
✓ Fire brigade cover	✓ Contents in transit	✓ Christmas gifts
✓ Door locks	✓ Public liability	✓ Wedding gifts
✓ Freezer contents	✓ Unoccupancy period	✓ Loss of oil
✓ Alarm discount	✓ Unspecified all risks cover	

garages or greenhouses owned by any member of your Household or for which they are responsible. An easy way to look at it is to think of it as all items that would fall out if you turned the house upside down! Remember tools and equipment kept in outbuildings or garages need to be taken into account when deciding on the amount of cover you require.

For particularly valuable items, you should consider separate specific all-risks cover.

Essential benefits to consider

Policy features and benefits will differ by insurer. It is important to remember that the cheapest policy is not always the best policy. Use the checklist above when reviewing your quotes to see what exactly you are getting for your premium.

Home rescue

When accidents happen, it's important to know that cover for a claim is not the only way your insurer is there to help. Home Rescue provides an emergency repair service to secure your home and prevent further loss or damage, as a result of one of the following: Leaks; electrical faults; loss or theft of keys; storm or accidental damage to the roof or breakage of glass which renders your home insecure.

This benefit allows you to get to the source of the problem quickly, any time – day or night. As this service is an added benefit, it won't count as a claim against your home insurance policy.

Getting the best price

To ensure you are getting the right price for the required benefits, you should make sure:

- Buildings and contents are insured for the correct amount and are not over or under insured
- Valuable items such as engagement rings are covered separately
- Check the excess amount, ie. how much you have to pay if you claim
- The insurer/broker is advised of professionally installed security and fire alarms
- The insurer is advised if you haven't claimed for over three years, it may reduce your premium.

You can avail of two months' free offer¹ when you buy a new home insurance policy with Cornmarket between now and the end of June 2017 (subject to a minimum premium of €334.52). For more information Tel: 01-4086202.

Marc Evans is a director of Cornmarket Group Financial Services Ltd

Discount applies in year one only and is inclusive of Government levy. Only one discount can be used with each eligible proposal

¹ Two months' free insurance in year one is based on a 16.7% discount off the normal year one Allianz premium, and is only available to new customers taking out a new home insurance policy through Cornmarket and underwritten by Allianz. Underwriter criteria, terms and conditions apply. Any applicable discounts are applied at quotation stage. We are unable to issue discounts retrospectively. Allianz plc is regulated by the Central Bank of Ireland. Cornmarket Group Financial Services Ltd is regulated by the Central Bank of Ireland. Cornmarket is part of the Great-West Lifeco group of companies, one of the world's leading life assurance organisations. Telephone calls may be recorded for quality control and training purposes.

Win €100 vouchers with Groupscheme

As an INMO member, you are entitled to access 'INMO Groupscheme – an exclusive savings and discounts portal that offers you a chance to save money on hundreds of well-known brands and retailers in Ireland, such as Supervalu, Debenhams, Topaz, Expedia, Argos, Sketchers, Dyson, Eason, Wagamama and Captain America's.

In 2016, there were almost 20,000 unique engagements with the INMO Groupscheme site and their retail partners and we will be launching a competition for members who register and log in to the site during the months of March and April, with the winners to be announced at the ADC in May.

The INMO Groupscheme recently underwent a mini transformation to enhance the user experience and allow for new offers to be included such as LearnPlus, a free online education and learning service from leading universities

and specialist organisations.

A new cinema offer is also being launched within the next month, offering up to 40% off cinema tickets as well as new and exclusive deals for INMO members. Registered members will receive information on this directly. For those members not yet registered, remember:

- The scheme gives you the opportunity to spend and save via printed vouchers, online portals, shopping cards, cashback functionality or short-term deals
 - The website is fully secure, data compliant, and enabled to process online payments (your credit card details are never stored)
 - Updates to offers and discounts are automatically emailed to you.
- New offers, brands, retailers, and discounts are added on an hourly basis. Thousands of INMO members are already



registered and are saving hundreds of euros on travel, insurance, fashion and clothing and everyday household expenditure.

To register for INMO groupscheme go to www.inmo.ie/inmogroupscheme and click on 'register now' or if you have previously registered, you can click on 'log in'. Members will be emailed twice a week with details of new offers and reminders about existing offers.

Oncology nurses congress focuses on balancing healthcare needs

MORE than 500 oncology nurses from all over Europe and beyond gathered in Dublin on October 17-18, 2016 to share their knowledge and develop their skills at the EONS-10 Congress.

The hugely successful event, hosted by the Irish Association for Nurses in Oncology (IANO) and the Irish Cancer Society, took place alongside the 18th International Psycho Oncology Society Congress.

European Oncology Nursing Society president, Prof Daniel Kelly, and scientific committee chair, Prof Mary Wells, welcomed everyone to the landmark congress, which was then opened by Minister for Health Simon Harris.

The overall theme of EONS-10 was 'Balancing healthcare needs in a changing context', allowing for a close examination of the physical and psychosocial care needs of patients and their families in the context of demographic change and constant advances in diagnosis and treatment of cancer.

Meinir Krishnasamy, professor of cancer nursing at the University of Melbourne, Australia, addressed many of these important themes in her keynote speech.

The congress offered delegates a fan-



Pictured at the EONS-10 Congress in October were (l-r): Dr Brendan Noonan, IANO NEC member; Aoife McNamara, IANO NEC member; Prof Daniel Kelly, EONS president; and Eileen O'Donovan, IANO NEC member. The 10th European Oncology Nursing Society Congress saw more than 500 oncology nurses gather to listen to a wide range of sessions and attend workshops centred around the theme of balancing healthcare needs in a changing context

tastic opportunity to network with nurse leaders and colleagues from around the world and benefit from a packed scientific and educational programme.

Participants could choose from a wide range of sessions and workshops on topics such as supporting parents with cancer who have young children, care dependence in patients with cancer and establishing

priorities for cancer nursing research, with speakers from Sweden, Turkey, Italy and The Netherlands among others.

Cancer nurses and other key members of the multi-professional team discussed the care needs of patients and their families and the challenges that nurses face in providing comprehensive care in a fast changing world.

Improving access to epilepsy care

ACADEMICS at Trinity College have conducted first of its kind research in Ireland as to whether specialist nurses can provide added value disease management and cost-effective care for thousands of epilepsy patients in Ireland.

Epilepsy is the most common neurological condition. Epilepsy Ireland estimates that of the more than 37,000 people who have the condition in Ireland, there are approximately 12,000-15,000 people with breakthrough seizures who require regular contact with secondary and tertiary hospital services.

The research, which is funded by Epilepsy Ireland and the Health Research

Board, comes at a time when the model of emergency care in Ireland is under immense and sustained pressure.

The findings from this research, their implications for epilepsy care in Ireland, the lessons that could be learned for management of other chronic conditions and the impact this could have on the health system in Ireland were discussed at the launch of the SENSE report on February 1 at the School of Nursing and Midwifery, Trinity College Dublin.

Despite overwhelming evidence that early and accurate diagnosis of epilepsy and responsive care from a skilled multidisciplinary team improves health outcomes

for people with the condition, many deficiencies in care provision have been identified throughout the years.

As part of a plan to improve access to expert epilepsy care and the quality of care across the healthcare environment, the National Clinical Programme for Epilepsy (NCPE), which was set up by the HSE, recommended in 2014 that all people with epilepsy in Ireland have access to an epilepsy nurse specialist (ESN).

In the past decade, 16 ESNs were recruited by the NCPE. This research examined the role of the ESN and its impact on patients with epilepsy, on other healthcare staff and on service outcomes.

Eliminating mother to child HIV

THAILAND has become the first Asian country to eliminate mother to child transmission of HIV, thanks to a pragmatic multisector response backed by strong political commitment and heavy government investment, a study published in *Paediatrics and International Child Health* has reported.

Such an early, concerted response allowed the country to successfully address the four prongs of the recommended World Health Organization elimination strategy. As a result, mother to child transmission rates were reduced from 20-40% in the mid-1990s to 1.9% in 2015 (surpassing the WHO elimination target of < 2%).

The WHO strategy focuses on the following four prongs: primary prevention of HIV in women of childbearing age, prevention of unintended pregnancies in women living with HIV, prevention of HIV transmission from a HIV-infected woman to her infant, and provision of appropriate treatment, care and support to women and children living with HIV.

In Thailand, initiatives to promote condom use, provide information about the risk of transmission and introduce testing for pregnant and postpartum women were successfully implemented. For example, the 100% Condom Programme, which promotes 100% condom use by male patrons of commercial sex workers, has played a crucial role in preventing HIV infection in women of reproductive age.

Assessment highlights importance of feeding breast milk to pre-term babies

A NEW report has provided overwhelming evidence reaffirming the importance of feeding breastmilk to infants in the neonatal intensive care unit (NICU).

If every pre-term infant in the UK is fed breastmilk in hospital, the health and financial implications are irrefutable. According to a new study published by the *Springer Health Economics Review*, feeding breast milk to these infants could prevent 238 deaths and save the NHS STG £30.1 million each year.

Economists at York Health Economics Consortium from the University of York conducted a systematic, independent assessment of the value of human milk to pre-term babies. They analysed the most robust clinical studies available, with data from over 50,000 infants.

The results show the minimum health

and financial impact of institutionalised NICU breast milk feeding in the UK. It is a clear call to government and the NHS to integrate breastmilk feeding into the standard healthcare cost model.

Breastfeeding often not only prevents illnesses like sudden infant death syndrome, necrotising enterocolitis and sepsis in the first year of life but it also reduces the probability of coronary heart disease, obesity and neurodevelopmental impairment as the baby grows and matures.

The new model is universally relevant. It was applied first to the UK system, where quality standards are high and the national healthcare figures are thoroughly documented and considering 10% of the global population is born prematurely, the logical next step would be to apply this model in other countries.



Pictured at the Hugh Lane Gallery in Dublin were Cystic Fibrosis Ireland ambassadors, Jenny Dixon and Chef Adrian, who launched a new fundraising appeal, 65 Roses Day, to raise money for the development of dedicated healthcare facilities, research, counselling and grant supports for people with cystic fibrosis. 65 Roses Days will take Place on April 13 as part of Cystic Fibrosis National Awareness Week and volunteers will take to the streets and shopping centres across Ireland selling purple roses to raise €100,000 for cystic fibrosis services. Members of the public can support the fundraiser by buying a purple rose for €2, completing a 65 roses challenge, texting 65 Roses to 50300 or by donating online at www.65roseday.ie

March

Wednesday 8

Care of the Older Person Section conference. Limerick Strand Hotel. Contact jean.carroll@inmo.ie or Tel: 01 6640648. See page 42 for further details

Friday and Saturday March 10/11 Irish Student Health Association (ISHA) annual conference. Radisson Blu Galway. For further information contact joan.broderick@iadt.ie or Tel: 01 2394760

Thursday March 23

Retired Nurses and Midwives Section trip to Newbridge House, Donabate. Email: geraldinmcsweeney@gmail.com

Friday 24 and Saturday 25 ODN Section conference and meeting. Crowne Plaza Hotel, Santry, Dublin 9. Log onto www.inmoprofessional.ie or contact jean.carroll@inmo.ie or Tel: 01 6640648

Thursday March 30

CPC Section study day. Log onto www.inmoprofessional.ie or email: marian.godley@inmo.ie to book your place.

April

Saturday 8

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

Saturday 8

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

May

Wednesday 10

OHN Section conference. Cork. log on to www.inmoprofessional.ie or contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 13

School Nurses Section meeting. Portlaoise Heritage Hotel, Town Centre, Portlaoise. 10.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Tuesday 16

Student Allocations Liaisons Group meeting. INMO HQ. From 12.30pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 27

CNM/CMM Section meeting. Limerick. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Tuesday 30

Telephone Triage Section meeting. Limerick. Session on pregnancy complications and mindfulness. 10am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Upcoming events

- ❖ The Irish Stoma Care and Colorectal Nurses Association study day will take place on Friday, March 24, 2017 at the Mater Misericordiae University Hospital, Dublin. For further information email: stomacare@mater.ie
- ❖ The members-only spring study day for the Association of Lactation Consultants in Ireland will take place on Saturday, March 25, 2017 in the Coombe Women and Infants University Hospital, Dublin 8. Visit www.alcireland.ie/join-alc/i/ to register
- ❖ The St Luke's Home/Northridge House, Education and Research Centre annual conference will take place on April 6, 2017 in the Radisson Blu Hotel, Little Island, Cork. Bookings can be made online at www.northridgehouse.ie or Tel: 021 4536551. Closing date for registration is Friday, March 31, 2017
- ❖ The Irish Nephrology Nurses Association workshop will take place on April 28, 2017 in City North Hotel and Conference Centre, Co Meath. For further details Tel: 01 809 2513 or email: harveymcdonnell@beaumont.ie or helendunne@beaumont.ie
- ❖ The Irish Nurses and Midwives Golf Society outing will take place on Friday, May 19, 2017 in Portumna Golf Club. Cost €50. Booking from April 3, 2017, email: portumnagc@eircom.net. Bookings will only be confirmed on receipt of payment within five days to Bernie Kilmartin or Marie Kelly, Portumna Golf Club, Ennis Road, Portumna, Co Galway. For further details contact Bernie Kilmartin at Tel: 087 6787395 or Michael Ryan at Tel: 090 9741059
- ❖ The second National Paediatric Children's Nurse Specialist Seminar, entitled 'Paediatric specialist nursing – a changing landscape' will take place in AMNCH Auditorium, Tallaght Hospital on Thursday, May 25, 2017 from 8.30am to 4.30pm. Admission is free. Tel: 01 4142846, Bleep: 7186, email: patricia.gaule@amnch.ie

INMO Professional Development Centre Library Opening Hours

March
Monday-Thursday: 8.30am-5pm
Friday: 8.30am-4.30pm

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

INMO Membership Fees 2017

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

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