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WIN

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

World of Irish Nursing & Midwifery

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Planning for the future

IN FEBRUARY we welcomed the announcement of 2,600 additional acute hospital beds, 4,500 step-down/community beds, three new elective hospitals and an additional €10.9bn capital investment in the health sector as part of the National Development Plan. This is a significant plan for the Irish public health services and if combined with a robust implementation plan for *Sláintecare*, could see the public health service being expanded considerably and becoming more efficient in treatment times as well as reducing waiting times.

Expansion must come with reform, the current structures in the HSE are outdated. Real reform must see the integration of community and hospital structures. Having seven hospital groups and nine community health organisations promotes competing budgetary priorities, lack of integrative working and layers of bureaucratic governance.

Our population health needs have been examined too many times; there are now more expert reports and recommendations to advise on best models of care delivery than ever before. A good blueprint, the *Sláintecare* report, is available and enjoys unique cross-party support. We need to be confident that any change proposal will not be a repeat of the previous reform programmes that resulted in layers of bureaucracy, increased inefficiency, missed care and reductions to the number of frontline employees.

It would be a good start if health service employees were confident in this plan. As employees, nurses and midwives are committed to improving patient services as shown by the expansion of their professional practice and the development of nursing/midwifery-led services over the past 10 years of cutbacks. During that time, INMO members have been very critical of the lack of regard for the evidence linking poorer patient outcomes with reduced nursing/midwifery staffing levels.

The taskforce on nursing staffing in surgical wards has been piloted in 17 of the 270 such wards in public hospitals over the past two years. The preliminary evidence of patient outcome improvement in these sites is very encouraging. The staff morale improvements are reflected in the enthusiasm shown by those involved towards its implementations and continuation as the preferred basis for determining nursing staffing levels and skill mix. The good news is that it works! Now funding is required to ensure its roll-out. It is vital that phase two of the taskforce is continued into ED staffing levels and it must also form the basis for staffing requirements in care of the older person and community care settings.

Any commitment in the plan to expand capacity is entirely dependent on improved staffing. The tools to determine the staffing levels in nursing and midwifery are now available. Recruitment and retention of the required number of nurses and midwives remains the challenge.

This month the INMO will be appearing before the Oireachtas committee reviewing the implementation of the Maternity Strategy. The accepted midwife to birth ratio is one midwife to 29.5 births. The strategy committed to the introduction of this ratio as maternity services evolve through the implementation of the recommendations.

As part of the 2017 funded workforce plan the HSE committed to increasing staff midwifery numbers from the December 2016 census figure by 96 WTE at December 2017. However, the most recent figures presented to the INMO by the HSE in late January 2018 show that the overall number of staff midwives had fallen by 16 WTE in December 2017. While 63 WTE midwives were recruited, the numbers leaving the service were even greater.

If we are serious about improving public health services, we must start by correcting the poor pay for nurses and midwives, underpinned by strong recruitment and retention measures. The evidence shows that appropriate nurse and midwifery staffing levels result in better patient outcomes. This will improve patient outcomes considerably and will instil the badly needed confidence in the population requiring these services.

Phil Ní Sheadhgha
General Secretary, INMO

Worst month ever for overcrowding

Health employers failing to protect health and safety of staff

JANUARY 2018 was the worst ever month for hospital overcrowding since the INMO trolley/ward watch began 14 years ago.

A total of 12,201 people waited on trolleys in emergency departments or on additional beds placed throughout hospitals, during the month of January *(see Table)*.

This is an 18% increase over the numbers in January 2017, which themselves were a record high and is a 128% increase on the numbers recorded in 2007.

The most overcrowded hospital was the Mid-Western Regional Hospital in Limerick which recorded 1,003 admitted patients on trolleys. St Vincent's University Hospital was the most overcrowded in the Eastern region with 559 people on trolleys.

Children's University Hospital, Temple Street, Our Lady's Children's Hospital, Crumlin and the National Children's Hospital, Tallaght recorded an additional 192 children, waiting on trolleys, during January.

INMO general secretary Phil Ní Sheaghdha said: "This is an incredible level of overcrowding and the appalling conditions experienced in emergency departments are now beyond anything we have ever seen. It now amounts to a humanitarian crisis for patients and a risk rich environment for those trying to work in such chaotic conditions."

In February 2016 the employer agreed with the INMO that when one-third of ED trolleys were occupied by inpatients, this was their indicator to take action to protect the health and safety of staff.

Nurses in EDs and throughout hospitals are now working

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

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	Jan 2018
Beaumont Hospital	414	543	661	769	794	574	634	602	710	692	710	386	355
Connolly Hospital, Blanchardstown	259	280	250	286	216	456	378	279	635	595	372	225	363
Mater Hospital	482	433	568	538	531	345	324	356	292	410	481	505	542
Naas General Hospital	441	45	216	355	367	491	194	239	221	369	437	240	516
St Colmcille's Hospital	300	119	76	276	293	235	186	190	n/a	0	n/a	n/a	n/a
St James's Hospital	351	200	211	319	215	150	148	142	101	236	222	229	284
St Vincent's University Hospital	372	351	535	474	509	466	310	470	334	438	598	276	559
Tallaght Hospital	812	219	805	632	528	635	238	181	348	394	337	546	494
Eastern total	3,431	2,190	3,322	3,649	3,453	3,352	2,412	2,459	2,641	3,134	3,157	2,407	3,113
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	47	52	111	123
Cavan General Hospital	408	361	287	196	277	516	316	220	91	71	183	33	63
Cork University Hospital	293	273	413	446	726	695	574	443	361	366	600	667	832
Letterkenny General Hospital	11	428	57	57	43	64	118	42	247	437	110	522	671
Louth County Hospital	41	14	52	62	4	n/a	n/a	n/a	n/a	0	n/a	n/a	n/a
Mayo University Hospital	158	253	168	271	261	144	91	165	256	311	159	70	321
Mercy University Hospital, Cork	197	165	200	155	169	272	117	316	211	170	228	290	355
Mid Western Regional Hospital, Ennis	157	197	28	29	35	127	21	79	0	7	92	46	40
Midland Regional Hospital, Mullingar	38	23	36	54	284	214	295	171	447	374	426	540	635
Midland Regional Hospital, Portlaoise	70	15	60	53	48	111	209	43	140	210	308	477	258
Midland Regional Hospital, Tullamore	40	0	4	32	55	205	186	77	249	219	319	503	556
Monaghan General Hospital	n/a	50	52	29	n/a	n/a	n/a	n/a	n/a	0	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	29
Our Lady of Lourdes Hospital, Drogheda	349	313	290	399	476	455	589	410	462	735	601	469	491
Our Lady's Hospital, Navan	21	164	131	107	31	178	117	85	421	189	69	259	153
Portiuncula Hospital	82	71	115	46	148	79	60	169	119	208	63	379	191
Roscommon County Hospital	79	91	162	165	146	191	n/a	n/a	n/a	0	n/a	n/a	n/a
Sligo University Hospital	94	72	124	143	197	245	108	96	142	191	302	279	439
South Tipperary General Hospital	155	27	134	54	158	52	126	245	294	158	302	556	511
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	n/a	38	130	96	204	239	313	536	615
University Hospital Galway	155	170	286	319	365	523	558	378	602	519	526	618	681
University Hospital Kerry	131	97	133	93	91	93	64	88	93	75	199	187	382
University Hospital Limerick	304	225	118	213	453	404	304	437	564	631	682	793	1,003
University Hospital Waterford	n/a	n/a	n/a	68	95	88	100	138	296	125	430	480	550
Wexford General Hospital	546	162	129	50	226	283	111	106	102	268	196	125	189
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	9,088
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	12,201

Comparison with total figure only:

Increase between 2017 and 2018: 18%
Increase between 2016 and 2018: 31%
Increase between 2015 and 2018: 41%
Increase between 2014 and 2018: 54%
Increase between 2013 and 2018: 95%
Increase between 2012 and 2018: 85%
Increase between 2011 and 2018: 47%
Increase between 2010 and 2018: 58%
Increase between 2009 and 2018: 82%
Increase between 2008 and 2018: 94
Increase between 2007 and 2018: 128%
Increase between 2006 and 2018: 73%

in appalling conditions and according to Ms Ní Sheaghdha: "Health employers have completely fallen down on their statutory obligation to provide a safe place of work."

Ms Ní Sheaghdha also pointed out that Section 8 of the Safety Health and Welfare at Work Act requires employers to carry out risk assessments and put in place mitigating measures to avoid those risks. Section 11 specifically describes the duties of the employer in relation to emergencies and serious and imminent dangers to their staff.

"There was no evidence that any of the employers concerned have carried out risk assessments in any of the hospitals or EDs experiencing such overcrowding," said Ms Ní Sheaghdha.

"INMO members cannot be expected to tolerate such appalling and dangerous working environments and, at this point, many members of the public are openly asking the nurses how they could tolerate such a situation. It seems to us that all standards with regard to fire safety, personal protection, infection control and hygiene have gone out the window and no statutory authority or employer is prepared to look in. In those circumstances the INMO will have to take the necessary steps to protect the safety, health and welfare of our members."

Ms Ní Sheaghdha went on to say: "INMO representatives from all EDs convened for a meeting to consider the crisis situation and how the Organisation can best respond to it. Nurse representatives from all over the country participated in the meeting and the INMO faced calls for action to defend their members and the public."

INMO warns of staffing implications of National Development Plan

WHILE welcoming the health commitments in the National Development Plan announced by government last month, the INMO cautioned that none of them can be realised without significant measures to recruit and retain nurses and midwives.

The health commitments announced include:

- 2,600 additional acute hospital beds
- 4,500 step-down/community beds
- Three new elective hospitals
- An additional €10.9 billion capital investment in the health sector.

INMO general secretary Phil Ní Sheaghdha said: "The commitment to 2,600 acute beds plus an addition 4,500 community beds is entirely dependent on significant reform of our health services."

She pointed out that the report of the Bed Capacity Review has already found that, based on our current health service provision, the Irish health service is short 7,000 acute beds. "Beds alone will not meet the demand and unless the pay and terms and conditions of nurses and midwives are properly addressed in the Public Service Pay Commission Report, the ability to attract and keep nurses and midwives in the Irish public health service will continue to be a major impediment to the delivery of appropriate safe care."

The INMO is seeking early meetings with the Department of Health and the HSE to progress the health elements of the National Development Plan and to discuss the staffing implications for nurses and midwives.

Organisation backs single-tiered health system

LONG an advocate for the introduction of single-tier health system in this country, in February the INMO made a detailed submission to the Independent Review Group examining the removal of private practice from public hospitals.

In the submission the INMO argues a single-tier system would provide the full range of health services, from cradle to grave, with access being solely determined by need and not ability to pay.

The INMO believes the current two-tier health system is deeply flawed and inequitable, with speed of access to services being primarily determined by one's ability to pay or hold private health insurance.

"The two-tier public health service has created instability, inequality of access and dissatisfaction among patients, clients and staff. The commitment to a single-tier health system, where access to care is determined solely by need and not ability to pay, is most welcome," the INMO said in its submission, confirming it will strongly support the removal of private practice from public hospitals.

The Organisation said that the new system must offer, at its core, speedy access and quality assured services to every citizen, if it is to become a cornerstone of Irish society.

In determining the impact of removing the private practice from public hospitals, the Organisation said a number of key areas must be taken in to consideration:

- Equity of access to healthcare services must be prioritised for all in our society, in particular, the most vulnerable sections of society
- Funding arrangements for the acute health services must include an increase in employer PRSI to make up for loss in revenue associated with loss of private bed utilisation
- Adequate staffing, bearing in mind the consequential resources required as a result of the removal of private practice from public services, must at all times be maintained as a priority in ensuring safe patient care.

The full submission can be accessed on **www.inmo.ie**

Opportunity to revert to pre-HRA hours

ALL public sector workers have the opportunity to revert to their pre-Haddington Road Agreement (HRA) hours under a provision of the Public Service Stability Agreement 2018-2020 (PSSA).

This option is available at the commencement and conclusion of the pay agreement, which INMO members voted to accept in September 2017.

This means that individuals may apply to revert to their pre-HRA hours between January and April 2018 or between January and April 2021.

The Public Service Stability Agreement states (at 2.12.1-2): *"It is the view of government that increased productivity measures, including additional working hours, agreed by the parties in the Haddington Road Agreement make a significant and ongoing contribution to a modern public service.*

"However, in recognition of particular work-life balance issues that may arise, it is agreed that an opportunity shall be offered between January 1 and April 1, 2018 and after the expiry of this agreement (January 11-April 1, 2021) to permanently revert to the pre-Haddington Road Agreement hours. Any individuals exercising this option will have their pay reduced commensurately, in line with previous arrangements. The application of this arrangement at the sectoral level will depend on service delivery requirements and business needs."

A circular has issued that will give effect to the above provision (see **www.inmo.ie**). Each application will be considered on a case by case basis and if members require any clarification, please contact the INMO.

The Organisation has received a large number of enquiries on this subject, with a high level of interest in reducing hours. Members should apply for the hours reduction in the normal way via their line management structure. If you have any difficulties, contact your HR department or contact the INMO.

Some members have contacted us via email and social media asking why nurses and midwives must take a reduction in pay to revert to the 37.5 hour week. In the national negotiations last year, the INMO and other unions sought that the HRA hours would be returned but the government and the Department of Health would not agree and this was rejected.

All grades in the public service had their hours increased under HRA. However, it remains the INMO's goal that all nurses and midwives' hours will be the same as allied health professionals. The Organisation has sought such parity in its submission to the Public Service Pay Commission, which is due to report in June. Note, when nurses/midwives achieved a 37.5 hour week in 2007, hours were reduced with no cut in pay, which was the first time any union had achieved that for decades.

The INMO remains firm in its stance that the nursing and midwifery shortages will only be resolved when parity is achieved in the life time of this agreement, in addition to the PSSA wage increases due.

– Tony Fitzpatrick, interim director of industrial relations

WRC ED review agrees set of actions

SEVERAL actions were agreed at the latest ED Agreement review meeting at the Workplace Relations Commission, which took place on Monday, February 12, 2018.

The INMO Emergency Department Nurses Section met on February 6 and developed a priority list of actions to make EDs safer for patients and nurses. The meeting was attended by the INMO senior management team, the president and members of the Executive Council.

The INMO met with Hospital Group CEOs and the Acute Hospital Division and outlined that the record level of overcrowding needed to be addressed as a matter of urgency. The INMO team (general secretary Phil Ní Sheaghdha, deputy general secretary Dave Hughes, and director of industrial relations Tony Fitzpatrick) asked for evidence that each hospital was following the agreed National Escalation Plan. The INMO also pointed out that its members will be taking appropriate action to ensure their own health and safety.

At the WRC oversight meeting on February 12, chaired by John Kelly, the actions below were agreed between the INMO contingent of general secretary Phil Ní Sheaghdha, director of industrial relations Tony Fitzpatrick and IROs Albert Murphy and Lorraine Monaghan, and the HSE, represented by Liam Woods, Robert Kidd, Eileen Whelan, Lindsey Maidment and John Delamere.

Triage escalation

It was agreed that triage escalation will have staffing implications, which would be outlined in a memorandum to the HSE national director of human resources Rosarii Mannion. Robert Kidd, Acute Hospitals Office, agreed to prepare documentation for the funded workforce process, to highlight the need for funding for additional triage posts. Management agreed to circulate the revised triage document.

Transfer of patients from nursing homes

Management said it required more time to examine the issue of patients being transferred from public and private settings to the acute sector. Liam Woods, HSE national director for acute operations, indicated that data identifies that 11,000 deaths take place each year in acute hospitals. The HSE agreed to revert on this by February 21, 2018.

Agency framework

The HSE needed to examine this issue and was to revert to the INMO by February 21.

Security

The INMO demanded that 24/7 security be placed in every emergency department to ensure compliance with the 2002 A&E agreement and the 2016 WRC ED agreement. Management committed to revert on this by February 19.

De-escalation

The INMO requested proof that hospitals are de-escalating after implementing the escalation protocol. The Organisation stated it was unacceptable for hospitals to remain in full capacity protocol for a continuous period. The HSE was to revert on this by February 15.

Recalibration of nursing posts for admitted patients

An exercise last year identified the need for 123 additional nurses to care for admitted patients in ED. The HSE confirmed only 59 have been recruited to date. In addition, the number of vacancies to the established ED complement remains a problem with most departments short staffed. The INMO, HSE, DOH and Prof Jonathan Drennan are to re-engage to recalibrate the numbers needed for admitted patients.

The next WRC ED Agreement review meeting is on March 2.

– Tony Fitzpatrick, interim director of industrial relations

Pathway devised for S39 pay restoration

THE INMO has welcomed the intervention of the Workplace Relations Commission on pay restoration for INMO members working in Section 39 organisations in line with the Public Service Stability Agreement.

The Organisation believes a pathway has now been outlined to ensure that members receive appropriate pay restoration within the S39 sector. The INMO has been pursuing such pay restoration for members working in S39 organisations, lodging claims with local management, and pursuing the matters to the WRC and the Labour Court.

Having confirmed in its recommendations that pay parity exists between individual S39 organisations and the public service, the Labour Court recommended that engagement take place between the INMO, the HSE and the Department of Health to resolve disputes.

The INMO welcomed correspondence issued by the WRC on February 9, 2018, which followed discussions under its auspices between the four unions involved and the Department of Health/HSE.

The WRC letter points out that it was agreed at this meeting that certain organisations, including the workplaces of INMO members, will be prioritised (see **www.inmo.ie** for list of prioritised organisations).

The process that will be followed with regards to pay restoration in S39 organisations is:

- The Department of Health has instructed the HSE to engage with the Section 39 organisations to establish several facts including:
  - whether, when and to what extent reductions in pay rates were applied during the crises in each relevant organisation
  - whether, when and to what extent restoration of pay reductions has happened
  - identify the financial implications for each organisation, considering all sources of funding associated with addressing the issue identified
  - propose an appropriate plan to phase resolution in each case
- The HSE will commence the data gathering exercise immediately and will submit an interim report by March 31, 2018. This exercise will ensure that answers are achieved to points above in respect to the listed organisations
- When the exercise is completed, the HSE will present the results to the Department of Health and the parties may use the services of the WRC in respect of implementation of the outcomes of this exercise
- A specialist third party may be used to audit and corroborate the details. If the parties cannot agree on the appropriate third party, the WRC will nominate this party
- The WRC will assist the parties regarding implementation and an oversight group will be established, including the relevant representative parties and this will be chaired by the WRC.

Cast your vote in INMO elections

Election for 16 Clinical seats on Executive Council – ballot papers enclosed

THIS year is an election year for the INMO Executive Council which will serve for a two-year period 2018-2020.

Enclosed with this journal you will find information on all the candidates who are running for election, including biographical data and each candidate's election manifesto.

Your ballot paper is also enclosed, along with a pre-paid envelope with which to return it.

There is an election in the Clinical category only.

It is very important that each INMO member uses their democratic vote as those elected to the Executive Council will make vital decisions for the Organisation over the next two years.

The closing date for receipt of your ballot paper is **Thursday, March 22 at 5pm.**

Those nominated to the Education, Student and Management seats on the Executive Council did not face competition and so will be deemed elected.

Election of president and vice presidents

A separate election will be held for the positions of:

- President
- First vice-president
- Second vice-president.

This election will be by secret ballot of all voting delegates at the INMO annual delegate conference in Cork, which takes place on May 2-4 *(see page 6)*.

To be eligible for election to the office of President or first or second vice-president, a candidate must be an elected member of the incoming Executive Council and shall have been a member of the outgoing Executive Council for the term immediately preceding the election.

Nominations for the office of President, first and second Vice Presidents, together with the written consent of the nominee, must be submitted in writing to the INMO General Secretary no later than 21 clear days before the annual delegate conference to allow time for notification to delegates.

The closing date for nominations for the three officer positions is **Friday, April 6, 2018 at 5pm.**

Irish Nurses and Midwives Organisation
Cumann Altraí agus Ban Cabhrach na hÉireann
Working Together

EXECUTIVE COUNCIL ELECTION 2018

ELIGIBILITY FOR OFFICE OF PRESIDENT AND VICE-PRESIDENTS (RULE 9)

9.1.1 The President, first Vice-President (Honorary Treasurer) and second Vice-President shall be elected at the 2018 Annual Delegate Conference at which elections are scheduled.

9.1.2 A separate election shall be held for President, first Vice-President and second Vice-President, and such elections shall be by secret ballot of all voting delegates at the Annual Delegate Conference.

9.1.3 The elected candidate must secure an overall majority by exceeding 50% of the eligible votes cast. If no candidate has achieved an overall majority, as aforesaid, then the candidate, or candidates, receiving the lowest vote or votes, if their combined vote is less than the total vote of the highest candidate shall be eliminated and a further ballot shall take place immediately.

9.1.4 If there shall be a tie, another vote shall be taken, and if the result is still a tie, the outcome shall be decided by lot (drawing the name of the successful candidate) by the chairperson of the Standing Orders Committee.

9.2 To be eligible for election to the office of President or Vice-Presidents she/he shall have been an elected member of the incoming Executive Council and shall have been a member of the outgoing Executive Council for the term immediately preceding her/his election.

9.3 **Nominations for the office of President, first and second Vice Presidents, together with their written consent must be submitted in writing to the General Secretary not later than 21 clear days before the Annual Delegate Conference for notification to delegates to that meeting at which the election will take place. (The Closing date for nominations is Friday, April 6, 2018 at 5pm).**

9.4 The President shall preside at the Annual Delegate Conference and Special Delegate Conferences held during the year and at all Executive Council Meetings. In the absence of the President the first Vice-President shall take the Chair; in the absence of the first Vice-President the second Vice-President shall take the Chair.

9.5 The office of President shall not be held by the same person for more than two consecutive terms.

Tony Fitzpatrick, INMO interim director of industrial

Delay in payments in older persons and ID services resolved

AFTER delays by several community health organisations, members working in all CHOs will receive time and one-sixth payments for work between 6-8pm or to the end of shift.

As per a circular of July 2017, time and one-sixth payments were to recommence in older persons and intellectual disability services on July 1, 2017. However, as part of the National Implementation and Verification process, it became apparent in several CHOs that payment had not been applied in compliance with the circular and some CHOs had not paid it in any sector. Non-payment was particularly apparent in CHO 3, 4 and 5.

However, it has now been confirmed to the INMO that all CHO areas will pay the time and one-sixth retrospectively to July 1, 2017. The HSE has also confirmed that section 38 organisations should be paying the time and one-sixth in line with the national circular.

Separately, the National Implementation and Verification Group (NIVG) was due to complete its work with its visit to CHO 8 in Mullingar on February 23, 2018. The group's overall report is then expected in early March 2018.

It is evident that task sharing in older persons and ID services has greatly improved the quality of service provided to clients.

As well as being a quality improvement initiative, it is also ensuring cost savings and cost avoidance for the HSE. The matter before the NIVG is to make a decision with regards to the first 50% retrospection due on payments from July 1, 2017 retrospective to September 2016, which will be addressed in the NVIG report.

In the interim, local implementation groups are to continue to work with trade union involvement, to ensure the full roll out of task sharing within the services.

Storm Ophelia discussions

MATTERS remain outstanding for nurses and midwives who attended work on the day of Storm Ophelia, Monday, October 16, 2017.

Further to the intervention of the trade unions, the HSE issued a clarification covering individuals who were unable to attend work for safety reasons, stating they were not required to take annual leave or any other form of leave in respect of the hours which they were unable to work.

However, matters outstanding relate to how those individual staff members who provide essential services and attended work on that day would be treated with regards to time back. The INMO and other unions was scheduled to meet with the HSE on February 20, 2018 in an attempt to resolve this matter. See next month's *WIN* for update.

Job descriptions breaching national agreements

THE INMO was meeting with the HSE on February 22, 2018 on the issue of posts being advertised with job descriptions at variance with the nationally agreed criteria and job descriptions.

For example, there is an essential requirement for the 'head of bed management' to be a registered nurse, as set out in the Labour Court Recommendation 18123 that settled a dispute with regard to the grade of the head of bed management function. Labour Court Recommendation 18123 and the agreed job description at that time clearly outlines that nursing is an essential requirement for the job. However, a number of advertisements have been placed recently where this stipulation was not included.

The INMO is meeting with the HSE to ensure that all future advertisements comply with the LRC and the INMO HSE agreement on same.

In addition, posts have been advertised at CNM2 level that have included the requirement for the individual to take on the 'person in charge' role. Again, this is at variance with the nationally agreed job description for clinical nurse manager 2. The INMO is pursuing the issue of appropriate grading of persons in charge with the HSE and this will also be discussed at the meeting.

In the interim, the INMO is seeking confirmation that all HSE employers and Section 38 organisations will not advertise CNM2 posts requiring the individual to take on the 'person in charge' role. See next month's *WIN* for an update.

INMO pursuing claim for bereavement leave parity

THE INMO is pursuing an increase in bereavement leave within the health sector to reflect changes implemented last year across the civil service and local government.

A circular issued in the civil service in January 2017 which increased bereavement leave to 20 days in the case of the death of a spouse/partner. This has also been applied in local government. However, to date the HSE and the Department of Health have refused to amend the bereavement leave entitlement in the health service.

Two conciliation conferences have taken place on the issue under the Workplace Relations Commission. At the most recent conciliation, management agreed to provide to the INMO and the staff panel its costings on the €11 million it states it will cost to increase the bereavement leave entitlement. The unions have now received this costing from the HSE and the matter is to return to conciliation at the WRC on March 21, 2018.

relations, reports on current national IR issues

Progress on Children's Hospital issues

AS A result of concerns raised by the INMO at the Employee Relations Working Group for the National Children's Hospital, several subgroups are to be established immediately.

The INMO's concerns included the future operating model of the hospital and a subgroup is to be established to deal with this. The INMO is firmly of the view that the development of this model is crucial to understanding the place of nursing and midwifery going forward.

While a symposium is being held to outline the future operating models to staff, management has clearly stated that the model being presented is not finalised and the working group will deal with issues that arise for staff regarding its contents.

Separately, a contractual subgroup is being established to address matters related to integration.

The INMO also raised concerns relating to the advertisement of certain posts. A recruitment strategy subgroup will deal with this and management has committed to providing a list of posts to facilitate early consultation and that the designation of posts will be discussed in the subgroup prior to being advertised.

It is planned that within the recruitment strategy subgroup, a framework will be agreed on how posts will be advertised, with a preference for confined competition, but with the potential for transfers to posts in certain circumstances.

The INMO shared, with management, previous framework agreements negotiated in locations where services were reconfigured. The Organisation believes staff currently working in Crumlin, Temple Street and Tallaght, should have the opportunity to express an interest in posts being developed, prior to these posts going to external competition.

Action on Joint Declaration for CPD/life long learning

THE Joint Declaration on Continuous Professional Development and Life Long Learning was agreed between the EPSU (European Public Service Union) and HOSPEEM (European Hospital and Healthcare Employers' Association) in November 2016.

The content of the Joint Declaration required that employers would support individuals in CPD and life long learning in order to enhance and improve their health service.

The HSE is a co-signature of the Joint Declaration and a working group is to be established with its first meeting due to take place on February 28, 2018. While the terms of reference have not been finalised, the unions are seeking that commitments made in the Joint Declaration are followed through by the HSE to ensure that staff working within the health service have appropriate support both financially and in terms of time, to partake in continuing professional development and life long learning.

INMO ID Steering Group commences its work

THE inaugural meeting of the INMO Steering Group for the Intellectual Disability Sector took place at INMO headquarters on February 12, 2018.

This meeting was attended by members of the RNID Section and other practitioners, as well as members of the Executive Council and INMO officers.

The first meeting examined the current issues for members working within the ID sector. The issues that came to the fore included:

- Medication management
- Role of the RNID and other nurses in the ID sector
- Models of care
- The imposition of the PIC role on middle nurse managers
- RNID and the nursing role with children in disability services
- Staffing and skill mix
- Nurse management and governance structures in Section 38 organisations
- Professional identity of the RNID
- Decongregation and the reconfiguration of services
- RNID and nursing staff role in preschool education and within the school system
- Developing ANP and CNS roles within the ID sector.

All these issues were discussed and relevant research is currently being examined ahead of the next meeting of the steering group, which is scheduled to take place on March 5, 2018. Members working within the ID sector who would like to participate in the steering group may express an interest by contacting Jude Maher, Tel: 01 6640603.

Operating departments under focus

AS DIRECTOR of industrial relations, I met with the Operating Department Nurses Section on February 19, 2018 to discuss current issues within theatre departments throughout the country.

Issues of concern to members include staffing levels, excessive on-call, inadequate sleep time, the numbers of staff on call, unacceptable risk due to excessive activity out of hours, staff turnover within theatre departments, inadequate controls around theatre activity and the unavailability of intensive care beds resulting in intensive care patients being cared for in the recovery area of theatre for excessive periods. It is clear from the discussion that many areas are not complying with Department of Health Circular 33/2003 regarding on-call arrangements.

The INMO is carrying out an in-depth examination of the matters and will be initiating contact with INMO reps in theatre departments throughout the country. Members working within theatre departments who have concerns about staffing, workloads, excessive on-call or have quality and risk concerns, are asked to contact the INMO via their local rep, to ensure that the Organisation has a comprehensive picture of the situation in all theatre departments.

It is important that members use internal risk management processes to highlight any risk concerns they may have. Contact your INMO rep if you require assistance with this.

– Tony Fitzpatrick

Innovation or exploitation?

The 'gig economy' is little better than the hiring fairs of old, where workers were exploited in the name of profit, writes **Dave Hughes**

THERE are two private member Bills passing through Dáil Eireann at the moment relating to precarious work practices (or the 'gig economy' – to use the latest buzzword for such if-and-when-type work).

The 'gig economy' is where workers are engaged by a company and are only paid for when they work. A common example of this is individuals engaged by a delivery company to deliver fast food. This type of employment also increasingly exists in healthcare. Some private providers are engaging home helps and nursing staff on arrangements where they are only paid for the time spent with the client. Individuals are finding themselves assigned to clients for periods of 40-60 minutes and then periods in other homes with no paid time to travel between homes. This means an individual could spend an eight to 10-hour day working for the same employer in different homes but only be paid for half that time. This practice is also growing in the retail trade.

This is not new, it is simply the latest version of employers exploiting a labour surplus in order to force down pay. For individuals subjected to such employment arrangements, it is highly insecure with no idea of how many hours they will have from week to week and little prospect of security for rent and other living expenses.

Precarious work can take different forms. According to a recent Congress report, *Insecure and uncertain: precarious work in the Republic of Ireland and Northern Ireland,* temporary employees can easily find themselves in precarious employment because, apart from the fact that they have no guarantee of work continuing, their contracts are generally easier to terminate than permanent contracts.

Bogus self-employment is the trend generally described as the 'gig economy'. While legitimate self-employed operators can be single-handed without employees, trends suggest that such self-employment contracts are, in fact, workers who have no employees and whose entire work is controlled by the employer.

One in four (25%) of the self-employed without employees work in the construction sector. A further 17% work in banking and finance, and 14% are in the transport and communications sector. Overall, 44% of self-employed contracts, without employees, are in unskilled work rather than skilled trade occupations.

The picture that emerges is that while self-employment is perfectly legitimate for those who choose it and carry a skill or profession for which demand matches or outstrips supply, in situations where there are more workers for a particular type of work than the demand, then self-employment or if-and-when-type contracts apply. With this is the likelihood that they are simply measures to exploit the surplus workers and avoid employment law and high labour costs.

The phrase 'gig economy' makes such employment sound trendy. However, the classic understanding of the word 'gig' does not apply. It is not the likes of a music gig or a jockey being paid 'per gig' by a trainer who is not his usual employer. However, to describe delivering pizza or working in a shop for short periods as a gig and being paid minimum wages, is not a reasonable understanding of gig or freelance type employment.

Genuine freelance or self-employed workers tend to be skilled and offer their services to a range of employments at a premium rate, which allows them to provide for the benefits that employees get through their contracts, such as paid holidays and control over their time.

For employees working for a single employer, to suggest that they are in any way similar to a freelancer or a self-employed contractor who can work for many employers, usually rings an alarm bell that advantage is being taken of the employees concerned.

Such employment practices are certainly not new. If one looks back in history to agriculture and dock work, it was common to have the hiring fair where the workers queued up and the employer picked from the crowd those they would engage for a day's labour. In the docks it was trade union organisation that ultimately brought some regulation and fairness to that system and the button system was the mechanism used by workers to try to establish some fairness around the distribution of the available labour among the masses looking for it. The button system was essentially a seniority system where the employer could not dispense with the services of a particular docker because they did not like them, but had to allocate work based on the service already given. Therefore, those who had more regular employment had some level of protection and some opportunity to plan and provide for their lives.

Industrial relations and history tell us that while new tags like 'gig economy' are put on such practices, they really are nothing more than the old hiring fairs where the surplus of labour was used to keep labour costs at a minimum and profits maximised. This is done at the expense of the worker and it only survives where the supply of labour with a particular skill outstrips demand for that skill. The market, therefore, is part of the solution.

Unfortunately, when it comes to public service employment the market works only one way. So while nursing, in the past, and teaching, particularly at third level, have been impacted by precarious contracts of employment, now that both are in short supply one would expect that market rules would apply and that market rates of pay would apply to these professions to address the supply shortages.

Pay Commission

The test before the Public Service Pay Commission, which has the power to recommend to government that it adjusts pay in line with market reality, is to see whether market principles can apply to public service pay. The alternative, which has existed for more than three decades in this country, is the highly regulated system where the relative earnings of all employees are stabilised to avoid leapfrogging.

While that system made some sense in the past, a public service that is in short supply of particular skills, such as nursing and midwifery, needs the flexibility to adjust itself and allow those groups to improve their pay and conditions so that the health service can retain and recruit what it needs to provide a comprehensive health service.

INMO seeks injury grant for RNIDs injured at work

THE INMO attended negotiations with the HSE and funded agencies to ensure that nurses working in intellectual disability services who are injured at work access an Injury Grant, rather than be placed on the Sick Pay Scheme.

On foot of an adjudication officer's decision, the INMO argued that nurses employed in ID services should access the preferential Injury Grant rather than having their income maintained on the Sick Pay Scheme.

The employers committed to reverting to the INMO within two weeks of the talks.

*Tony Fitzpatrick (left) and **Philip McAnenly** seeking Injury Grant rather than Sick Pay Scheme for nurses injured while working in the intellectual disability services*

The INMO negotiating team comprised Tony Fitzpatrick, director of industrial relations, Colette Mullin, information executive, and, Philip McAnenly, IRO.

Update

- ***Bandon Community Hospital:*** Following a Labour Court hearing on February 7, Bandon Community Hospital is now entering a Joint Review Group to examine staffing levels for the new building at the hospital. This group, which comprises two union officials and HSE representatives, will review the staffing levels for the new build, based on the evidence provided by the HSE and union side. Following this, a recommendation will be issued on staffing levels for the new building. As an interim arrangement which arose from the Labour Court hearing, all parties have agreed to the opening of an initial 12 beds in the new build, albeit under protest, while the review takes place.

– Liam Conway, INMO IRO

- ***St Ita's Community Hospital, Newcastlewest:*** A dispute remains between the INMO and the HSE on proposals to open additional beds in St Ita's Community Hospital when the service is struggling to maintain appropriate nurse staffing levels for current residents. The INMO referred the dispute to the Workplace Relations Commission with a date for the initial hearing scheduled for March 13.

– Mary Fogarty, INMO IRO

Widespread members' concern about ongoing unsafe conditions in EDs

MEETINGS are ongoing between management at Tallaght Hospital and the INMO regarding INMO members' ongoing concerns in the adult emergency department and more recently also in the paediatric emergency department.

The adult ED remains severely overcrowded with intolerable workloads and workplace conditions for nursing staff. The hospital has experienced increased demand on its services since January with the resulting increase in ED admitted patients.

The INMO has also met management regarding members' concerns for staffing levels in the paediatric ED. This department sees on average the same number of emergency attendances as Our Lady's Children's Hospital, Crumlin, yet has significantly less WTE nursing staff.

As a result of these meetings, the hospital has submitted a business case to the Children's Hospital Group for additional WTEs to bring the ED on a par with Crumlin Hospital.

Waterford University Hospital

Meanwhile, Waterford University Hospital continues to experience serious levels of overcrowding in its emergency department despite the opening of an additional 19 beds in January.

The INMO has engaged in a series of meetings with management in the hospital and has been advised of a patient flow initiative for this additional capacity commencing in early March.

INMO members are extremely concerned about the ongoing levels of overcrowding and the impact of this on patient safety as well as on their ability to practise safely.

– Joe Hoolan, INMO IRO

HSE called on to explain its logic for staff cuts

The INMO, led by director of industrial relations Tony Fitzpatrick, attended the latest Workplace Relations Commission hearing on February 8, 2018 regarding the proposed slashing of 23 WTE healthcare professional posts in St Finbarr's Hospital, Cork.

The HSE intended to operate the same service with a reduction in 18 WTE nursing posts and five healthcare assistants. The INMO sought for the HSE management to provide its methodology and logic behind its proposed staffing cuts. The WRC adjourned with the HSE to provide its methodology and logic, or to allow for an independent review of the staffing levels within the hospital.

INMO members are united and will resist this proposal as they know the importance of the service provided by St Finbarr's staff to the people of Cork, particularly in relation to patient flow and patient journeys within the city.

– Liam Conway, INMO IRO

Section round up

Conferences

Please ensure that you have booked your place at the forthcoming conferences taking place later this month:

- March 12 – National Care Of The Older Person Section conference taking place in the Midland Park Hotel, Portlaoise. Go to **www.inmoprofessional.ie** or contact the INMO at Tel: 01-6640616 to book your place.
- March 22 – the RNID Section annual conference is taking place in the Midland Park Hotel, Portlaoise. Go to **www.inmoprofessional.ie** or contact the INMO at Tel: 01-6640616 to book your place.
- April 20-21 – The Operating Department Nurses' Conference is taking place at the Tullamore Court Hotel. Entries for the poster competition close on March 23 – please ensure you have your poster submitted to be in with a chance of winning part of the €1,000 prize fund.

Welcome to new officers

AS ALL the AGMs have now taken place, we would like to take this opportunity to sincerely thank all our outgoing national section officers for the dedication they have shown during the course of their terms of office. We never take your hard work and commitment for granted, and we are extremely grateful to each and every one of you for the time you have put into making your national section successful.

We also wish to welcome the new incoming officers, thank you for taking up the position, and we very much look forward to working closely with you in continuing to deliver on your section's vision.

Care of the Older Person Section planning for 2018

PLANS for the year ahead were put in place at the recent National Care of the Older Person Section AGM, which took place at INMO HQ in late January. These will include holding a session on documentation in June at INMO HQ and a session on diabetes in September that will be held in the INMO Cork office.

The motion for ADC was debated and selected. Those in attendance also chose the two delegates to represent the Section at the conference in May.

Final plans are also underway for the Section's annual conference taking place on 13 March in Portlaoise. It has been five years since the Section's first conference there, and they look forward to welcoming you back.

Attendees at the National Care of the Older Person Conference which took place on January 23 at INMO HQ

Go to: **inmoprofessional.ie** to book your place, or you do so by phoning the INMO at Tel: 01 6640616.

Busy year ahead for Retired Section

THE INMO's Retired Section has a busy year ahead, with many social events planned. Whether you have recently retired, or have been part of this vibrant group for a number of years, they are a wonderful group and offer a really nice way of staying in touch with your nursing and midwifery colleagues.

Forthcoming section meetings include:

- Thursday, April 26 at 11am at INMO HQ
- Thursday, September 6 at 11am, INMO HQ.

Social Events:

- Tuesday, March 6 – Richmond Barracks, off Bulfin Road, Inchicore, Dublin 8. Contact Geraldine Sweeney at Tel: 087 2794701
- Sunday, April 15 – Spring Break with McGinley's Travel. To book your place phone Annette McGinley at Tel: 074 9135201 – or queries to Myra Garahan at Tel: 01 8384407
- Tuesday, May 15 – Tour of Mary Aikenhead Heritage Centre (Museum), Our Lady's Hospice, Harold's Cross, Dublin 6 Contact: Ann Igoe by email to: a.igoe123@gmail.com
- Tuesday, June 12 – Visit Skerries Mills and possibly Lambay Island, tides permitting. Contact: Ann Igoe by email to: a.igoe123@gmail.com
- Tuesday, July 10 – Visit to New Ross, Dunbrody and Ros Tapestry. Entrance Fee: Group Rate €6pp, Individual - €7. Contact Margaret Nordell at Tel: 087 6167774
- Sunday, August 12 – Visit to Moynalty Festival (near Kells) – Courtesy bus from Kells to venue. Contact: Myra Garahan at Tel: 01 8384407. Nathan Carter will be performing on the day
- October 7-10 – Proposed break to Midleton Park Hotel, Glebe, Midleton, Co Cork – October 7-10 (three nights) Bed and breakfast plus dinner on each evening, one day trip by coach to local regional attractions. €210 per person sharing a twin/double room or €240 per single room
- Tuesday, November 6 – The Little Museum of Dublin, 15 St Stephen's Green, Dublin – Contact Geraldine Sweeney at Tel: 087 2794701.

Members are reminded to check the website for updates and additions.

Date for your diary

The OHN Annual conference will be taking place on Wednesday, September 12
The Annual Telephone Triage Conference will be taking place on Wednesday, October 3
The All Ireland Midwifery Conference will be taking place in Dublin on Thursday, October 18

Full details will be available in forthcoming issues of WIN

Nursing Now campaign engages global power

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

NURSING NOW is a campaign focused on raising the status and profile of nursing globally and maximising the contribution that nursing makes to universal health coverage, women's empowerment and economic development.

Nursing Now is a programme of the Burdett Trust for Nursing and is a three-year global campaign launched in London on 27 February 2018 by the Duchess of Cambridge.

Nursing Now is run by a campaign board made up of nurses and non-nurses from 16 different countries. It is a privilege that Janet Davies, CEO/general secretary, Royal College of Nursing, nominated me to the board to represent the European Region. Therefore, I will serve on the board with the endorsement of the RCN while representing the INMO and the European Federation of Nurses Associations as president on behalf of three million nurses across Europe.

Nurses are at the heart of most health teams, playing a crucial role in health promotion, disease prevention and treatment. As the health professionals who are closest to the community, they have a particular role in developing new models of community-based care and support local efforts to promote health and prevent disease.

Nursing Now is based on the findings of the *Triple Impact* report, which concluded that as well as improving health globally, empowering nurses would contribute to improved gender equality – as the vast majority of nurses are still women – and build stronger economies.

Global goals: *INMO director of professional development Elizabeth Adams, who is also president of the European Federation of Nurses Associations, is pictured with Lord Nigel Crisp, co-chair of the Nursing Now campaign, who is also independent crossbench member of the House of Lords and co-chair of the All-Party Parliamentary Group on Global Health*

Under the leadership of co-chairs Lord Crisp and Prof Sheila Tlou, and alternate chair Baroness Mary Watkins, the Nursing Now global campaign will build on the unique position of nurses as the health professionals who are at the heart of every health system, provide continuity of care for their patients and are part of their local community. The campaign aims to raise the status and profile of nursing globally so that it can make an even greater contribution to improving health and wellbeing.

With the first board meeting in January 2018 and the official launch of the Campaign on February 27, there is a real opportunity to position nursing more centrally to health policy and ensure that nurses can use their skills, education and training to their full capacity. The campaign seeks to:

- Influence policy and decision makers by demonstrating what nurses can achieve and advocating for specific objectives and goals
- Create a grassroots movement among the global nursing workforce to generate energy, boost morale and encourage recruitment.

Nursing Now will run to the end of 2020 – the 200th anniversary of Florence Nightingale's birth and a year when nurses will be celebrated worldwide. The board

through the campaign, aims to improve perceptions of nurses, enhance their influence and maximise their contributions to ensuring that everyone everywhere has access to health and healthcare. There are many organisations worldwide playing powerful roles in developing nursing and midwifery. Our aim is to complement and support them – bringing nursing to the forefront of thinking on global health and enabling nurses to do even more in improving health globally.

Our focus is on nursing but it also includes midwifery where the two professions overlap – and many nurses are also midwives. We recognise that midwives face the same pressures as nurses and that their extraordinarily valuable role needs to be strengthened and supported if universal health coverage (UHC) is to become a reality.

Goals

By the end of 2020, we want to see the following goals achieved:

- Greater investment in improving education, professional development, standards, regulation and employment conditions for nurses
  - all countries have plans for developing nursing and midwifery
  - increased investment in all aspects of nursing and midwifery
  - more nurses in training and employment, with clear progress in eliminating the global shortfall of nine million nurses and midwives by 2030
- Increased and improved dissemination of effective and innovative practice in nursing
  - Nursing organisations collectively support a coordinated global portal of effective practice and innovation used by nurses and policy makers around the world
- Greater influence for nurses and midwives on global and national health policy, as part of broader efforts to ensure health workforces are more involved in decision-making
  - All global and national policies on health and healthcare acknowledge the role of nursing in achieving their goals and include plans for the development of nursing
  - All national plans for delivering UHC make specific proposals to enhance and develop the role of nurses as the health professionals closest to the community
- More nurses in leadership positions and more opportunities for development at all levels
  - At least 75% of countries have a chief nursing officer/chief government nurse as part of their most senior management team in health
  - More senior leadership programmes for nurses
  - The establishment of a global nursing leadership network
- More evidence for policy and decision makers about – where nursing can have the greatest impact, what is stopping nurses from reaching their full potential and how to address these obstacles
  - A landmark study on the economic impact of nursing is published
  - More articles on nursing's impact in peer-reviewed journals
  - A coordinated global network on research on nursing is established.

The Campaign will work with the World Health Organization, United Nations Women and other bodies to ensure that its activities are linked with the global health workforce strategy and the five-year action plan of the Commission on Health Employment and Economic Growth, in addition to other global strategies.

Running until the end of 2020, the Nursing Now campaign aims to improve perceptions of nurses, enhance their influence and maximise their contributions to ensuring that everyone everywhere has access to health and healthcare. The campaign invites you to participate and seeks your commitment to giving nurses more recognition, investment and influence, to sign up to support the campaign. The new website with further information is available at: **www.nursingnow.org/** The Nursing Now's social media toolkit to help get others interested and involved is developed (see **http://www.nursingnow.org/social-media-toolkit/**), and you can follow the campaign's progress on Twitter and Facebook.

Nursing Now also plans to showcase supporter-led events, case studies, education, funding opportunities and much more. You are welcome to share your plans (logon to: **http://www.nursingnow.org/share-your-plans/**) to champion nursing and they will be added to the campaign's global activity map (**http://www.nursingnow.org/global-activity-map/**).

Further information

Background information on how this has evolved is available at: **www.nursingnow.org** and you can subscribe to the newsletter and register for updates in addition to actively participating in the campaign.

Elizabeth Adams is INMO director of professional development

Nursing Now campaign leadership

Co-chair: Lord Nigel Crisp

Lord Nigel Crisp is an independent cross-bench member of the House of Lords where he co-chairs the All-Party Parliamentary Group on Global Health. He was chief executive of the NHS in England from 2000-2006 and has subsequently worked and written extensively on global health with a focus on Africa. His main current interests are global health partnerships, health creation and nursing.

Alternate chair: Baroness Mary Watkins

Prof Watkins is a nurse academic who has held university posts, non-executive roles in the NHS and not-for-profit sectors. In December 2015, she was appointed as a Crossbench member of the House of Lords as Baroness Watkins of Tavistock. She has published extensively and presented at conferences contributing to debates on subjects ranging from nursing, the cost of social housing for NHS workers, public health and social care.

Co-chair: Prof Sheila Tlou

Prof Tlou is former UNAIDS Director of the Regional Support Team for Eastern and Southern Africa, and former Member of Parliament and Minister of Health of Botswana. She is also former professor of nursing at the University of Botswana and director of the WHO Collaborating Centre for Nursing and Midwifery Development in Primary Health Care for Anglophone Africa. As Minister of Health, she led a very successful AIDS prevention, treatment, care and support programme. She holds a PhD in nursing science from the University of Illinois, Chicago, and has membership of the American Academy of Nursing and the US National Academy of Medicine.

Restored Richmond hosts inaugural event

Eighty years to the day that the Richmond Hospital hosted an INO postgraduate course, the newly refurbished facility saw its inaugural education programme take place. **Alison Moore** reports

IT WAS fitting that the inaugural education programme hosted in the INMO's Richmond Education and Events Centre should be facilitated by speakers from the Organisation itself under the title of 'Perspectives on nursing and midwifery for 2018'. Elizabeth Adams, INMO director of professional development and the Richmond Education and Events Centre, who has project managed the whole development, introduced the programme by reminding those present that it was down to the vision and courage of the members of the INMO that the development had been possible.

"It is fabulous that this is a members' building and that nurses and midwives own it. It is wonderful that the previous Executive Council made the decision to purchase the building and that the Executive Council that followed also supported the refurbishment," Ms Adams told those present.

She guided the audience through a presentation that detailed the history of the site from 1688 through to the refurbishment journey that the building has been through since the INMO took ownership of it in late 2013.

The purchase and refurbishment of the Richmond has been the largest capital project that the INMO has taken on. Ms Adams explained that the vision was to provide a members' building that offered a relaxing learning environment with state-of-the-art IT facilities. There is a tandem goal for the building to generate revenue – through venue hire – that will help to secure the INMO's finances into the future.

Over the course of the development, more than 5,000 contractors worked onsite with up to 220 there in a given week.

Ms Adams explained that there were many obstacles encountered in the refurbishment, such as a lack of fireproofing and use of lead in the roofing which caused delays to the project but, ultimately, all of these were overcome and the INMO and its members are now the owners of a truly remarkable building.

INMO president Martina Harkin-Kelly referred to the purchase of the building for €2.9 million during the height of austerity and lauded everyone who was part of the decision process in doing so, including the membership, which she observed was "always consulted at each step of the process".

Ms Harkin-Kelly said that the Richmond Education and Event Centre was committed to supporting nurses and midwives to determine their professional requirements to ensure the delivery of effective clinical outcomes for patients and service users alike.

"The Richmond will be the hub, and working core of our regional offices ensuring that connectivity is maintained to our peripheral membership," she added.

Phil Ní Sheaghdha, INMO general secretary, gave a presentation on 'Nursing and midwifery; the role and contribution of trade unions'; Edward Mathews, INMO director of regulation and social policy, spoke on 'Access to and management of health records; and Steve Pitman, the new INMO head of education and professional development, outlined "A future vision for continuing education for nurses and midwives.

Following the presentations there was an afternoon tea in the Victorian Tea rooms for those in attendance.

Pictured at the inaugural education programme held in the INMO's newly refurbished Richmond Education and Event Centre were: *(opposite page top: Elizabeth Adams; director of Professional development and the Richmond Education and Events Centre; (bottom) The new lecture theatre. (This page clockwise): Edward Mathews, director of regulation and social policy, Martina Harkin Kelly, president; Steve Pitman, head of education and professional development; Phil Ni Sheaghdha, general secretary; the Victorian Tea Room with INMO members enjoying the launch; Michelle Russell, nurse consultant; and Neal Donohue, student and new graduate officer; and (l-r) Marie O'Brien, Executive Council; Eileen Lawrence, secretary to staff panel of trade unions, National Joint Council; and Anne Harney, Executive Council*

The Richmond

A glorious restoration and legacy for the INMO

A truly remarkable renovation: *The Richmond Education and Event Centre, pictured above as it is now in 2018, and as it was during the renovation process (below)*

The Auditorium mid-renovation in 2017 and as it looks completed today. Each seat has access to a power socket and USB

The banqueting hall during renovation and as it is today

The Richmond's formal dining room

One of the beautifully restored staircases

The completed parlour/sitting room

Restoration of the entrance hall in progress

The education room

Elizabeth Adams oversaw the whole project from start to finish

'Education should light a fire'

Steve Pitman, new head of education and professional development, is set to ensure that INMO Professional's CPD programmes are collaborative, motivational and inspiring. Interview by **Tara Horan**

WITH the opening of the Richmond Education and Event Centre, INMO Professional is entering a new era in its provision of continuing education for nurses and midwives.

To help drive this forward, Steve Pitman was recently appointed to the new post of head of education and professional development with the Organisation, and is now assisting Elizabeth Adams, director of professional development and the Richmond Education and Event Centre, to build on the solid base of 100 CPD programmes currently offered by INMO Professional.

"This is an immense opportunity for the INMO. It has invested a huge amount in terms of the Richmond and I feel privileged that I can come in at this point in time. It is an ideal opportunity to relook at the education offerings of INMO Professional, in line with its strategic priorities and its mission," said Mr Pitman.

'The scheme'

"For me the main area is to sustain and develop the CPD programmes, particularly with the changes coming with the competency assurance scheme that is likely to be clarified by the NMBI in the next year."

The competency assurance scheme has been on the cards since the enactment of the Nurses and Midwives Act 2011 and is now expected to be up and running in the next two to three years.

"This process has been ongoing since the Act was signed in 2011. The NMBI is engaging in a consultation process and will provide greater clarity and guidance in 2018 about the agreed 'scheme' for revalidation. It is expected that this process should kick in in the early 2020s. This will require nurses and midwives to refocus on CPD and life-long learning."

To get an idea of what the scheme for nurses and midwives could potentially look like, Mr Pitman suggested looking at the process already in place for some of the CORU health and social care professions. It is likely that the revalidation process will evolve over time to enable nurses and midwives to become accustomed to the new scheme in line with the experience of the nursing and midwifery professions in other countries.

"Continuing professional development is based on the idea of life-long learning. Learning doesn't stop after your degree programme or your training; it is something that you are motivated to follow for the betterment of yourself but also in terms of your progression as a professional," Mr Pitman said.

"We have moved away from the idea of education as people coming into lecture theatres as empty vessels to be just filled up with information. That's just pre-programmed learning offering information. I believe education should be collaborative; education should be motivational; education should be inspiring; it should light a fire underneath the individual to move forward and to learn more."

INMO Professional is poised to play a major role to help members with the scheme. "We have a bedrock already in terms of 100 CPD programmes. It'll just mean making sure these remain attractive to nurses and midwives, and ensure that we are meeting their needs."

The central function of INMO Professional will always be to provide education to the Organisation's membership, however, Mr Pitman sees an opportunity to explore collaboration with other healthcare professions and where it is deemed advantageous to members to consider joint programmes, such as in patient safety, quality and process improvement. "This would more closely mirror the reality for nurses and midwives participating in and leading cross disciplinary teams throughout the health service," he said.

"At the heart of my job is exploring the further needs of members and the wider market. I can see plenty of potential, with around 65,000 nurses and midwives on the register in Ireland. Current academic programmes across the country take 20-30 individuals, so collectively they make only a small inroad into the 65,000. The market for education in the healthcare workforce is significant within Ireland with over 100,000 employees just in the HSE," Mr Pitman said. "All in all I'm biting at the bit to get really stuck into developing the CPD programmes here in the Richmond, as well as around the country."

Leadership

Developing healthcare courses, particularly in the area of leadership, has been central to Mr Pitman's work in recent years. For the past 10 years he has worked in the RCSI Institute of Leadership, as programme

director for the second year of its MSc programmes, which focus on participants completing an organisational development project. He also had responsibility for delivering modules on leadership, change and positive organisational behaviour. Mr Pitman has experience leading and delivering programmes in Ireland, Dubai, Bahrain and Jordan.

Technology

While a strong advocate for face-to-face education where relationships can be built, Mr Pitman sees the potential of developing technology to facilitate learning. This would include online/distance learning, webinars for participants to log into, and learning management systems to make sure that people can access and communicate about education programmes.

"What I have in mind is a one-stop shop in terms of education for nurses, midwives and others. It's important to keep an eye on changes in terms of technology; virtual reality and artificial intelligence are going to be big issues over the next 15 years in the care of older people, for example. We need to stay ahead of the curve, rather than just responding in 10 years time.

"A good example of this is in Trinity College at the moment where they have been researching the use of a robot as an assistant carer for people with disabilities or dementia, or older people. What it does is essentially keep the person company, talk to them and remind them about things – turn off lights, tell them to have meals and so on. It can even have an element of interactive conversation with them.

"What we need to explore is how will such innovations affect healthcare and, in particular nursing and midwifery and education. While the caring role of nurses and midwives will never be replaced, there's a prediction that some professionals will have to reimagine themselves as much of their work will be done by artificial intelligence.

"Simulation also is a growing area in education, where people can be in a safe environment which is both highly challenging and highly supportive – where they can try things out, make mistakes and thereby develop their skills. There's a huge opportunity there for clinical practice and health and management practice as well.

"For the moment however, the short-term priorities for us is to bed down in the Richmond – to get the centre up and running, to transfer the programmes across, and to welcome the members into the wonderful building. After that we can start to explore opportunities for getting accredited academic programmes and also to explore the options around learning management systems and the use of e-portfolios," he said.

Learning management systems

"One of the big challenges for learning management systems, in the context of CPD, is content and how it is developed or sourced. This is something that we would need to consider, as to whether it is developed and authored within the Organisation or if the content is developed by others and then made accessible via learning management systems."

He points to the recent partnership with the Royal College of Midwives in which INMO midwife members will have access to RCM online content. "The level of resources offered by the RCM is something that the INMO would not be able to produce on it own over a short time period," he said, pointing to other examples of excellent content, such as *Nursing Times* online and the Australian Nursing and Midwifery Federation CPD.

Preventing burnout

Getting down to business already, this month Mr Pitman will be facilitating a new INMO Professional programme designed specifically for nurses and midwives exploring the nature of burnout and work engagement. The prevention of burnout can be achieved by focusing on engagement, organisational assessment and the early signs of unmanageable stress and burnout.

"As well as introducing the key focus of concepts related to burnout and work engagement, this programme will help participants to develop an understanding of approaches to promoting engagement and creating a more fulfilling workplace."

The 'Understanding and managing burnout and work engagement' programme is currently offered in three locations around the country – in the Richmond and in the INMO Cork and Limerick Offices.

For further details on this programme and the many and varied other programmes currently offered by the INMO Professional, *see pages 32-40* of this issue of WIN or long on to **inmoprofessional.ie**

Road to INMO Professional

STEVE PITMAN grew up in the industrial area of Newport, South Wales, where trade unionism is very much part of the culture.

"The Labour movement was embedded within the culture of the people of South Wales and is something which is central to my personal philosophy. I have a very strong draw to the public health services as well."

From Wales, Steve trained as an RGN in north London, where he met his Irish wife on their first day of training. He then worked in the Leicester Royal Infirmary and later for a community mental health team as an assistant psychologist. He has a degree in social psychology (Loughborough University), psychology of health (Bristol University), work and organisational psychology (DCU) and a postgraduate certificate in leadership in health professions education (RCSI). Steve also has experience as an executive coach and holds a higher diploma in coaching from Kingstown College.

After a spell in Wales at the Royal Gwent Hospital, he moved to Ireland where he worked in the Adelaide Hospital and later Tallaght Hospital. In Tallaght he was clinical nurse manager for practice development and then nurse practice development co-ordinator. From there he moved to the NMPDU in the Eastern Regional Health Authority as a project officer examining why midwives were leaving the Dublin maternity hospitals. After that he moved to an academic role in the Faculty of Nursing and Midwifery in the RCSI as programme co-ordinator for the MSc in nursing programme. For the past 10 years he has worked in the RCSI Institute of Leadership as programme director for the MSc Year 2 programmes in Ireland and at times in Dubai and Bahrain.

Steve has been a trade unionist and supporter of the labour movement throughout his career. He joined the INMO when he moved to Ireland before transferring to IFUT when he started working in academia.

Q and A Bulletin Board

With INMO interim director of industrial relations Tony Fitzpatrick

Query from member

I am a PHN, is it mandatory to provide a weekend on-call service? Can you clarify if this is done on a voluntary basis?

Reply

You are correct, there is no requirement to work at the weekend. The Department of Health circular letter, November 19, 1975 and indeed subsequent circular, May 30, 1980 (S100/38), outlined that the public health nurse has a five-day week and PHNs have first option on weekend working. However, the circular clearly records that PHNs can opt out of weekend work and that this would not affect their career prospects.

Furthermore, regarding a dispute involving HSE West and the then Irish Nurses Organisation, the Labour Court (LCR 18972) provided further clarity, and concurred with the INMO's interpretation of the circular, that community registered nurses, and locum public health nurses in the Sligo/Leitrim area were not obliged to provide a planned 'on-call service' at weekends, over and above their contracted hours of Monday to Friday. The Court stated, "they may opt to work a planned essential service at weekends, paid at the agreed fixed rates."

In 2008, a Framework Agreement was established between the unions and the HSE with regard to an extension of the working day. Since December 2008, all contracts issued to PHNs and CRGNs reference this agreement, however this agreement does not require them to work weekends or an extended day. This clause would only be invoked if the HSE decided to change the service to a Monday to Sunday service. Such a change would require engagement and consultation with the INMO nationally and would require increased resources.

In conclusion, PHNs and CRGNs are only required to work Monday to Friday. There is no requirement on them to provide a weekend essential call service, but they can do so voluntarily while retaining the option to opt out. Should you require any further information, please contact your local representative or your local industrial relations officer.

Query from member

I am currently working a 39-hour week. I would like to revert to the pre Haddington Road hours (37.5). Will this affect my pay and annual leave entitlements? I have over 10 years' service and I am on the long-service increment.

Reply

Based on the LSI €45,248, the following is a breakdown of how this reduction in hours will affect your pay and leave entitlements:

- 39-hour week – weekly amount = €867.15
- 37.5-hour week – weekly amount = €833.80
- This will mean a loss of €33 per week in pay.

Annual leave entitlement for more than 10 years' service as a staff nurse is 27 days for a 39-hour week. A reduction in hours to 37.5 would mean a loss of one day's annual leave. For example, as you work a 39-hour week, you are entitled to 27 days' annual leave. If you choose to revert to a 37.5-hour week, your annual leave allowance would reduce to 26 days. This is calculated using the following criteria: 27 (full time) divide by 39 (number of weeks in the year) multiply by 37.5 (reduced hours) = 26 days.

Therefore, should you choose to revert to the pre-Haddington Road hours, there will be a loss of one day's annual leave and a loss of €33.35 per week in pay. However, you will work 10 days fewer in the year.

Should you have any further queries, please contact your local INMO representative or the INMO Information Office at Tel: 01 6640610/19.

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

INMO

- 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

Urinary tract infection in children

In the latest clinical update in this series, **Amanda Greenall, Stephanie Laidlaw** and **Gerry Morrow** examine the diagnosis and management of UTI in children

A URINARY tract infection (UTI) is an illness caused by micro-organisms in the urinary tract. A UTI can be classed as upper or lower depending on which areas of the urinary tract are affected. A lower UTI (cystitis) affects the bladder and urethra and an upper UTI (pyelonephritis) affects the renal pelvis and kidneys. If it is not possible to differentiate which areas of the urinary tract are involved, a UTI is classified as undifferentiated.[1]

The most common bacterial cause of UTI in children/young people is *Escherichia coli,* which is thought to cause 85-90% of paediatric UTIs. Other common causal bacteria of paediatric UTIs are *Proteus mirabillis, Staphylococcus saprophyticus,* and *Pseudomonas* species. Rare causes of UTI in children/young people include adenovirus infections and candida UTI, which can occur in people who are immunosuppressed.[2]

By the age of seven, at least 8% of girls and 2% of boys will have had a UTI. In a UK study, systematic urine sampling carried out in 6,079 children under five years presenting in primary care with acute illness showed that laboratory criteria for UTI were met in 339 (5.6%) of the samples.[2,3,4]

Children with a higher risk of developing a UTI include those aged below one year, those of female sex or Caucasian race, those with no history of breastfeeding, immunosuppression and those with a voiding dysfunction. Although females have a higher risk of developing a UTI than males, within the first three months of life UTI is generally more common in boys than in girls. Children who have previously been treated for a UTI have a higher risk of developing a UTI; recurrence has been noted in approximately 78% of girls and 71% of boys with a UTI within the first year of life, and 45% of girls and 39% of boys with a UTI after one year of age.[2,4]

Vesicoureteral reflux (VUR) – the reflux of urine from the bladder into a ureter – can be unilateral or bilateral. VUR is graded numerically to reflect its severity. Mild reflux is confined to the ureter; in the most severe grade, the ureter and urinary collection system are grossly dilated, and the reflux extends into the kidneys. Approximately 33% of febrile infants and children in whom a UTI is diagnosed have VUR, and it is bilateral in about half of these cases.[2,4]

If treated with antibiotics, the prognosis after childhood UTI is generally excellent. Girls are more likely than boys to have a recurrent UTI. In addition, girls tend to have more recurrences, and their recurrence rate increases with age. Infants and children with VUR are more likely to have recurrent UTIs. Rarely, long-term complications can occur.[4]

Estimates of complication rates of UTI in children are limited by several methodological problems, however possible complications include, renal scarring/damage, hypertension, bacteriuria and hypertension in pregnancy, and renal insufficiency and failure. A systematic review of the risk of renal scarring in children with a first UTI found that around 15% of children had evidence of renal scarring on a follow-up DMSA scan five to 24 months later.[5] Renal scarring is almost always preceded by an upper UTI, although not all upper UTIs are followed by renal scarring.[4]

Diagnosis of UTI in infants and children

In all infants/children with suspected UTI, the risk of serious illness should be assessed. All those presenting with an unexplained fever of 38°C or higher should have their urine analysed by culture and microscopy within 24 hours. For all those presenting with fever, a measurement of temperature, heart rate, respiratory rate and capillary refill time should be carried out.

To assess the risk of serious illness in an infant or child, carry out an examination, including measurement of temperature, respiratory rate, heart rate and capillary refill time. Observe effort of breathing, and pay attention to the colour of the skin, lips and tongue, and the appearance of mucous membranes. Symptoms or signs that indicate a high risk of serious illness in children under five years of age include: temperature of ≥38°C in an infant under three months of age; pale/mottled/ashen/blue skin, lips or tongue; no response to social cues; appearing ill to a healthcare professional; not waking or rousing; weak high-pitched cry; grunting; respiratory rate of >60 breaths per minute; moderate or severe chest indrawing; reduced skin turgor; and a bulging fontanelle.

For infants younger than three months of age, a UTI should be suspected if there is fever, vomiting, lethargy and/or irritability. Poor feeding and failure to thrive may also be observed. Less common symptoms include abdominal pain, jaundice, haematuria and/or offensive urine. For pre-verbal infants older than three months of age, suspect a UTI if there is fever. Abdominal pain, loin tenderness, vomiting and/or poor feeding may also be present. Less common symptoms include lethargy, irritability, haematuria, offensive urine and/or failure to thrive. If UTI is suspected in an infant/child older than three months, but younger than three years of age, a dipstick analysis should be performed. If both leukocyte esterase and nitrite are negative, do not send a urine sample for microscopy and culture unless symptoms suggest acute upper UTI and/or UTI is recurrent, and/or clinical symptoms and dipstick tests do not correlate, and/or the child is assessed as high to intermediate risk of serious illness.

For children who can verbalise, suspect UTI if there is frequency and/or dysuria. Dysfunctional voiding, changes to continence, abdominal pain, and/or loin tenderness may also be present. Less common symptoms include fever, malaise, vomiting, haematuria, offensive urine

and/or cloudy urine. If UTI is suspected a dipstick analysis should be performed. If both leukocyte esterase and nitrite are negative a differential diagnosis should be considered. If either leukocyte esterase or nitrite are positive, urine should be sent for microscopy and culture. If both leukocyte esterase and nitrite are positive and the child has a high/intermediate risk of serious illness, and/or symptoms suggest acute upper UTI, and/or UTI is recurrent, and/or clinical symptoms and dipstick analysis do not correlate, a urine sample should be sent for microscopy and culture.

A diagnosis of acute upper UTI should be made if the child presents with a fever of ≥38°C and bacteriuria or in children with a fever <38°C with loin pain/tenderness and bacteriuria. All children who have bacteriuria but no systemic symptoms or signs should be considered to have a lower UTI.

When assessing an infant or child with UTI, ask about factors that may indicate recurrent infection and/or an underlying pathology. These factors include poor urine flow, history of suspected or confirmed UTI, recurrent fever of uncertain origin, antenatally-diagnosed renal abnormality, family history of VUR, constipation, dysfunctional voiding, enlarged bladder, abdominal mass, spinal lesion, poor growth and high blood pressure.

Differential diagnoses include vulvovaginitis or vaginal foreign body, Kawasaki disease, voiding dysfunction, sepsis with no urinary tract source, threadworms and meningitis. Although it is rare, clinicians should be alert to the possibility of child abuse when a child presents with urinary symptoms – consider sexual abuse if a boy or girl has dysuria or anogenital discomfort that is persistent or recurrent and does not have a medical explanation.[1,2,6]

Management

If the infant or child has been assessed at high risk of serious illness, refer urgently to secondary care. All infants younger than three months with suspected UTI should be referred immediately to the care of a paediatric specialist, for urine analysis and treatment with parenteral antibiotics.

For infants and children three months or older with acute upper UTI consider referral to a paediatric specialist. Use clinical judgement to determine whether this is necessary, considering factors such as the child's age, the presence of vomiting, the number of facts suggestive of risk of serious illness, signs of inadequate fluid intake, and factors that might affect a carer's ability to look after an ill child at home. If referral is deemed unnecessary, treat with oral antibiotics for seven to 10 days. If culture results show that the causative organism is resistant to the initially prescribed antibiotic, switch to an alternative.

For infants and children three months or older with a lower UTI, treat with oral antibiotics for three days, according to local guidelines and the results of the urine culture, if available. Trimethoprim, nitrofurantoin, a cephalosporin or amoxicillin may be suitable. If culture results subsequently show that the causative organism is resistant to the initially prescribed antibiotic, switch to an alternative.

For all infants/children being managed in primary care, advise the parents or carers to bring the child for reassessment if still unwell after 24-48 hours. An urgent referral for ultrasound of the urinary tract during the acute UTI should be arranged for all children with atypical infection.

Self-care advice should be provided to the parents/carers outlining the importance of completing any course of treatment, the use of paracetamol for pain relief and the importance of adequate fluid intake. All children with UTI should have ready access to clean toilets when required and should not be expected to delay voiding. Ensure parents are aware of the possibility of UTI recurring and the need to seek prompt treatment from a healthcare professional should this occur.[1,2,4,7]

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

References (full reference list available from the Prodigy 'Urinary tract infection – children' topic at above website)

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CPD Quiz

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

1. Symptoms of UTI in children include:
A) Fever
B) Abdominal Pain
C) Skin Rash
D) Dysuria

2. What do the differential diagnoses for UTI in children include?
A) Gastroenteritis
B) Voiding dysfunction
C) Otitis media
D) Threadworms

3. Which bacteria is the most common cause of UTI in children?
A) *Proteus mirabilis*
B) *Staphylococcus saprophyticus*
C) *Serratia marcescens*
D) *Escherichia coli*

4. Complications of UTI in children include:
A) Growth delay
B) Renal scarring
C) Hearing loss
D) Hypertension

5. What percentage of girls will have had a UTI by the age of 7 year?
A) 15%
B) 8%
C) 50%
D) 90%

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

Clarity informatics

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

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

Effective communication for reps

INMO organiser **Albert Murphy** shares tips for public speaking and details of upcoming rep training courses

ONE of the most important aspects of being an INMO representative is the ability to communicate effectively. The public speaking session in the basic rep course has proven to be rewarding for participants. The module provides methods for overcoming individual reticence for speaking in public and is a popular part of the course.

The participants on the course are asked to pick a topic to speak about for three minutes. At the training course in Limerick in January there were powerful speeches from the participants including a very moving personal experience of supporting an individual with dementia and a case of a nurse who left Ireland, became a midwife and went on to nurse in Africa in a time of famine. All of the courses produce surprises but here is some advice for people who are going to speak on behalf of our members.

Public speaking tips

- Preparation is essential for any public speech
- Speak on a subject you are familiar with
- Powerpoint or even old-fashioned speaking cards are a good way to structure and organise your speech
- Speeches should have a beginning, a middle and an end, and make sure that you get your point across early in the speech and again at the end
- Avoid using excessive statistics and telling jokes
- More importantly finish your speech by ending on a quote or, even better, a punch-line. Then your audience is more likely to remember your speech.

Upcoming courses

For the past three years the INMO has intensified its training of reps in the north west and I am delighted to confirm that there will be basic rep training courses on March 7 and 8 in the Mount Errigal Hotel. This will be followed by an advanced rep course on March 27 and 28 in the same venue. The INMO is keen to establish a network of representatives in the north west, if you are interested in doing either of these courses, please do not hesitate to contact, Martina Dunne at email: martina.dunne@inmo.ie or Tel: 01 6640624.

Training courses have also been organised for April in Tralee and Cork in June, 2018.

Lunchtime courses

The INMO also provides short-duration courses for members. These include courses on: statement writing; the new sick leave scheme; and members' rights and entitlements. If you are interested in organising a course, do not hesitate to contact Albert Murphy at email: albert.murphy@inmo.ie or Tel: 01 6640637.

Albert Murphy is INMO industrial relations officer/organiser

INMO

REP TRAINING

Would you like to become an INMO workplace leader?

Date	Course	Venue
March 7 & 8	Basic	Mount Errigal Hotel, Letterkenny
March 27 & 28	Advanced	Mount Errigal Hotel, Letterkenny
April 10 & 11	Basic	Manor West Hotel, Tralee
June 12 & 13	Basic	INMO Cork

For all enquiries email: martina.dunne@inmo.ie

Taking care of ourselves

INMO student and new graduate officer, **Neal Donohue**, discusses the importance of looking after yourself as well as your patients

IT DOESN'T take a student nurse or midwife long to recognise the following symptoms: increased heartbeat, swiftness of breath, dry mouth, upset stomach and sweaty palms. No, I am not referring to the assessment of a patient. I refer to the initial physical symptoms of stress that become a common experience for many nurses and midwives. Prolonged and excessive experiences of stressful situations can lead to fatigue and depression, and can result in higher incidences of cardiovascular disease.

Support

I have had the experience of meeting many inspiring, energetic and optimistic nurses and midwives who love their jobs. It is refreshing to meet newly qualified nurses, or student nurses, and listen to their plans and hopes for the future. We need to protect this resource, by supporting the new generations of nurses and midwives.

In recent years, the crisis in healthcare has been discussed, contemplated and reported on to a point where the word crisis has almost lost its meaning. Just look at this year's INMO trolley watch figures. Crisis is now the everyday experience for the staff working in all areas of healthcare, where resources in the form of funding and staffing are stretched beyond belief.

This is a harsh reality for our society, and it weighs heavily in the thoughts of every nurse and midwife involved.

Right now, we need the new generations of nurses and midwives to shoulder the burden. Will newly qualified graduates stay in Ireland just because they are needed? To attract the hundreds of students who will qualify this year, the issue of pay needs to be addressed. However, pay alone is not enough to keep them here. We need safer, more worker friendly environments for future generations of nurses and midwives, which will in turn ensure a better health service for our society.

Stress

Long hours, working in difficult conditions, being overworked and underpaid naturally leads to stress.

Work-related stress is an occupational hazard. According to the European Agency for Health and Safety at Work (2000) "Work-related stress is experienced when the demands of the work environment exceed the employees' ability to cope with (or control) them."

Therefore, contrary to the belief of my barber, STRESSED is not simply DESSERTS backwards. The risk factors for stress in the workplace include:

- Too much work or insufficient time
- Complex hierarchies of authority
- Working in isolation or bullying and harassment
- Shift work
- Dealing with life-threatening injuries, illnesses and patient deaths
- The threat of violence and aggression.

Does any of this sound familiar? Like all occupational hazards, we must report the risk to successfully manage it. For student nurses and midwives as well as new graduates it is important to be aware that while we are here to help others, we too need to be taken care of.

Responsibility

The Safety, Health and Welfare at Work Act 2005, requires employers to put in place systems of work which protect employees from hazards which could lead to mental or physical ill health. There is an obligation on employers to risk assess all known hazards including psychosocial hazards, which might lead to stress.

Despite employers having this responsibility, under section 13 of the Safety, Health and Welfare Act 2005 we too as workers have a responsibility in reporting risks to the employer. Do we support a culture of reporting? We talk about stressful situations, we even say 'something should be done', but how many risk assessments are done every year on the occupational hazard of stress?

Records

One of the most common phrases I have heard since I began my nursing career is 'if you didn't write it, then it didn't happen'. All staff need to be familiar with the HSE Policy for Prevention and Management of Stress, as well as the Health, Safety and Welfare at Work act 2005.

As students and new graduates, you also need to document the risks and report them. Change the culture and change the workplace. In all areas of healthcare, we can use this legislation to effect change, but it is only as good as the paper it is written on.

To all the student nurses and midwives, and to all the new graduates, before you take care of someone else, make sure you are taking care of yourself. It is admirable to want to help others, but healthy boundaries are essential. Take your breaks, finish on time, and give yourself the same compassion that you show to your patients.

For information on available support visit: **www.yourmentalhealth.ie** and **www.jigsaw.ie**

Counselling services are available to students in college or university, and all workers in the HSE can avail of the employee assistance programme through occupational health.

If you have any queries you can contact me by email: neal.donohue@INMO.ie or by phone at Tel: 01 6640628.

Quality & Safety

A column by Maureen Flynn

Clinical Handover: An Inter-disciplinary Education Programme

THIS month's column introduces *Clinical Handover: An Inter-disciplinary Education Programme*[1] a quality improvement initiative supported by the Nursing and Midwifery Planning and Development Units (NMPDUs), Dublin South, Kildare, Wicklow (DSKW) and the Midlands region.

Context

As part of this initiative, an existing training programme, '*Shift Handover, A Training Programme for Nurses and Healthcare Assistants*[2] was revised to reflect recommendations of the National Clinical Guideline (NCG) on Communication.[3]

Why it is important

Clinical handover refers to the 'transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis'.[3]

While clinical handover has been identified as an essential step in the provision of safe quality care, it also provides the opportunity for healthcare professionals to work together to optimise patient safety. However, the handover process is also recognised as a potential opportunity for error to occur if not completed in a structured, standardised format. Risks associated with clinical handover are high and include missed, incorrect or delayed treatment and may adversely affect the relationship between patients, staff and the healthcare system.[2]

Clinical Handover: An Inter-disciplinary Education Programme[1] facilitates nursing, midwifery and healthcare assistant staff within all clinical settings to implement best practice clinical handover processes. It may also be adapted to suit other staff disciplines and to incorporate particular needs of individual clinical areas using the 'flexible standardisation' approach. The programme supports the utilisation of recognised communication tools to inform clinical handover as recommended by the NCG on Communication (Clinical Handover) in Acute and Children's Hospital Services.[3] These tools include ISBAR$_3$ to support inter-departmental and shift clinical handovers and ISBAR to support communication in relation to a deteriorating patient. ISBAR$_3$ supports the exchange of information under the headings 'Identify, Situation, Background, Recommendation, Read-back and Risk' while ISBAR includes 'Identify, Situation, Background and Recommendation'.

How to use the Programme

Incorporating reflection, discussion and group work, the four-hour education programme is facilitator-led and delivered within the clinical setting. It includes video recordings of scenarios that illustrate examples of best and existing practices providing a practical demonstration of the principles of using a structured, standardised approach to clinical handover. Use of role play and vignettes provide participants the opportunity to consolidate the knowledge obtained and reflect on clinical handover processes. Video recordings are supported by a facilitator resource manual, participant workbook, the NCG and other national resources, eg. the 'Safety Pause' guidance developed by the Quality Improvement Division.[4] Other local resources may also be used as part of the 'flexible standardisation' approach as required such as patient communication boards and handover templates. The programme has received NMBI Category 1 Approval and has been awarded four CEUs.

Benefits

These include increasing our knowledge and skill resulting in:

- Provision of safer quality person centred care minimising the risks of error and/or omission in clinical handover of care
- Implementation of a structured approach to clinical handover which enhances communication and facilitates the exchange of focused relevant patient information
- Our practice therefore meets best practice standards as identified within the NCG on Communication.[3]

More information

The programme is accessible at **www.hse.ie/clinicalhandover** and further details can be obtained by contacting Denise Doolan NMPD Officer, NMPDU, Dublin South, Kildare and Wicklow by email at denise.doolan@hse.ie.

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

Acknowledgements: Thank you to members of the ONMSD, NMPDU DSKW and Midlands and the staff who participated in the video recordings for their support in the development of this education programme.

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Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
Quality Improvement Division

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

Tús Áite do Shábháilteacht Othar
Patient Safety First

Key role of nutrition in cancer survival rates

Up to 80% of cancer patients unintentionally lose weight, which can have a devastating impact on their quality of life and ultimately leads to poor survival rates

UNINTENTIONAL weight loss in cancer patients can have a devastating impact on quality of life and ability to tolerate chemotherapy, ultimately leading to poor survival rates, according to Aoife Ryan, dietitian and lecturer in nutritional sciences at UCC.

The seriousness of this issue is illustrated by the fact that one in five cancer deaths is caused from wasting, not from cancer. The wastage affects not just the muscles involved in movement, but also the muscles involved in breathing and in the heart. Dr Ryan says, unfortunately, there is no safe drug to prevent or reverse this or to safely stimulate appetite.

"It seems it is almost the norm to lose weight once you develop cancer. Ten years ago it was thought patients were losing fat. Now we can use their CT scans to measure exactly what patients are losing and we are gaining a huge understanding that weight loss is actually rapid loss of muscle."

A great example of how the roles of nutritionists and food scientists can help cancer patients can be seen from current research at UCC into the development of innovative protein gels, dietary drinks and appetite-increasing supplements to assist cancer patients who are experiencing involuntary and at times life-threatening weight loss. Cancer patients often develop sarcopenia, which is most commonly seen in very elderly people.

Research into nutritional status and quality of life

Dr Ryan and a team of nutritional scientists at UCC have performed a detailed study of the nutritional status and quality of life in ambulatory Irish cancer patients attending for chemotherapy at Cork University Hospital and the Mercy University Hospital.

In a study which has been ongoing since 2011, 1,020 patients have been recruited to date. "We have looked at over 1,000 patients having chemotherapy here in Cork and only 4% of them look underweight. We rarely see obviously wasted cancer patients any more. Nowadays they look normal or overweight but, underneath that fat, there is very little muscle. Over 40% have sarcopenia and these patients live about half as long as people who maintain their muscle," says Dr Ryan.

Dr Aoife Ryan, dietitian and lecturer in nutritional sciences at UCC, viewing a CT scan of a cancer patient

It is known that protein intake is of fundamental importance in this regard, and so the team is looking at ways to increase this intake and also to address why patients are losing weight in the first place.

"They are losing weight because cancer causes huge amounts of inflammation in their bodies. So can we dampen down inflammation which would cause them to stop losing weight? If they are weight stable they will live longer."

Towards this goal, Dr Ryan has spent more than 12 years studying the fish oil, EPA, which is found in salmon, mackerel and herring. Unfortunately, most people eat very little of this. To provide new means of incorporating EPA into the diet, nutritionists at UCC have joined forces with food scientists to put a high dose of fish oil into a nutritional drink.

Dr Ryan says the results to date have been encouraging. "Several clinical trials have shown that, if we give patients with cancer calories, protein and a very high dose of a fish oil, that it will dampen down inflammation and they will lose less muscle. Keeping patients active through exercise is also hugely important."

Food science

As part of this work, Dr Ryan develops products in conjunction with colleagues, including Dr Shane Crowley and Prof Alan Kelly of the School of Food and Nutritional Sciences at UCC. Prof Kelly says this work is a perfect example of where a complementary relationship between nutrition and food science can deliver hugely important outcomes.

"Food scientists have the skills to develop products the design of which has been informed by the nutritional understanding of what food does to the body and, in this case, the particular issues of cancer patients are what we hope to solve. But there might be other considerations to do with the texture or the structure, for example in terms of chewing and swallowing and digestibility or flavour," says Prof Kelly.

"So the food scientist looks at how we design the product and how we mask flavour. Any product is ingredients plus a process we apply to it, so food scientists will find the right ingredients for the product properties that are needed and work out a way to turn these into a desirable, safe and high-quality product."

High protein gels for cancer patients

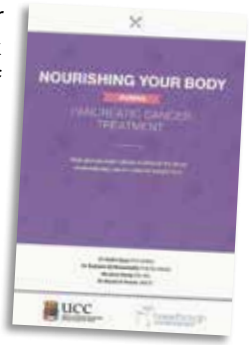
Food scientists at UCC are also developing high protein gels for cancer patients, based on the fact that people undergoing chemotherapy often suffer from metallic tastes in their mouths, so they have taste challenges as well as appetite challenges.

The gels would be tasteless and could be added into food without affecting texture and yet deliver critical nutrients and taste sensations tailored to the sensory perceptions of a cancer patient.

Furthermore, scientists at UCC working as part of the national Food for Health Ireland consortium have also found small peptides released from proteins from milk that can mimic the action of hunger hormones in the body. Initial studies in animals conducted at UCC showed increased food intake when given these peptides.

Dr Ryan says they have now encapsulated the peptides for trials in healthy humans to examine bioactivity and these may eventually be trialled in diseased populations, including cancer. "They take it in a capsule and it is released in the small intestine. And then it has actions there where we think it will stimulate appetite. If trials are positive it would represent a safe way of stimulating appetite," Dr Ryan says.

New evidence-based pancreatic cancer cookbook



Meanwhile, Breakthrough Cancer Research and University College Cork have launched the third in their series of cookbooks for cancer patients. The *Nourishing Your Body during Pancreatic Cancer Treatment* cookbook is specifically aimed at patients undergoing treatment for pancreatic cancer and is available free of charge to cancer patients throughout Ireland.

Following their two previous cookbooks – *Good Nutrition for Cancer Recovery for Patients Recovering from Treatment* and *Eating Well with Swallowing Difficulties in Cancer* for patients suffering from mouth, throat, neck, oesophagus and stomach cancers – the same team of oncologists, dietitians and chefs based in UCC and Cork Institute of Technology (CIT), developed this new cookbook with more than 90 recipes. The team includes Dr Aoife Ryan and Dr Eadaoin Ní Bhuachalla from UCC, with input from Dr Derek Power, consultant medical oncologist, Cork and Mercy University Hospitals, Cork, and Jane Healy and Anne O'Connor, lecturers in the Culinary Arts in CIT.

More than 9,000 copies of the book are available free of charge to cancer patients through their hospitals; a free e-book is also available from **www.breakthroughcancerresearch.ie**, along with a hard copy version for a €5 donation to cover postage.

Inhaler technique: It's everyone's job

Ruth Morrow discusses the importance of choosing the appropriate inhaler device for each patient and then for healthcare professionals continuing to monitor usage technique at every opportunity

INHALER technique is an essential skill for patients and nurses to ensure optimum and accurate delivery of medication to the lungs. Ever since the development of the metered dose inhaler (MDI) 40 years ago, errors have been reported with technique.[1]

Over the years, multiple devices have been developed in an attempt to overcome these errors and improve drug deposition to the lungs. Both the GOLD (2017) and GINA (2016) guidelines strongly recommend educating, assessing and reviewing the patient's inhaler technique at every opportunity.[2,3] This article seeks to explore issues with inhaler technique including common errors and the different techniques for MDIs, dry powder devices (DPIs), breath actuate devices and soft mist inhalers.

Inhaled medications

Inhaled medications are essential for treating asthma and COPD, among other respiratory conditions such as fibrosis. The big advantage of using inhaled medication is that the drug reaches the lungs directly to where it is needed with little systemic absorption, thereby lowering the risk of side effects when compared with oral or intravenous administration. On the other hand, inhaled medication is not suitable for everyone, particularly those with poor inspiratory effort, poor dexterity, learning difficulties or cognitive impairment.

A recent systematic review of inhaler technique involving 54,354 adults and children with either asthma or COPD investigated the extent and prevalence of inhaler use.[1] The review assessed the most common errors made by patients; the percentage demonstrating correct, acceptable or poor technique; and thirdly the change in outcomes over time. The overall results demonstrated a prevalence of correct inhaler technique in 31% of adults and children, acceptable technique in 41% and poor technique in 31%. The most frequent errors reported were incorrect preparation of the device, errors in co-ordination, incorrect speed or depth of inspiration, and not holding the breath after inhalation.[1] In the same study, there were difficulties reported in firing the MDI and breathing from the chamber.

Each inhaled device has specific characteristics for its use and care, and therefore it can be confusing for patients if they are on different devices. Every effort should be made to ensure that patients are prescribed the same device for all their inhaled medications. However, this may not be possible depending on the drugs required to be delivered. In recent times, this has proved easier as there has been a surge of inhaled devices on the market that can be used in combination.

Good inhaler technique is essential:

- To optimise drug deposition into the lungs
- To manage treatment failure
- To improve symptoms
- To prevent inappropriate escalation of treatment
- To avoid side effects, such as hoarseness or dysphonia.

Poor inhaler technique is associated with poor asthma control, frequent emergency department and GP visits, increased admission to hospital, increase in the levels of morbidity and mortality, increased costs, and inappropriate escalation of treatment.[4] In COPD, poor inhaler technique can lead to poorly controlled COPD. In a study by Rogliani et al it was demonstrated each device has its pros and cons, with age, cognitive status, visual acuity, manual dexterity, manual strength and ability to co-ordinate the inhaler all having an influence on whether the patient can use the inhaler.[5]

Types of inhaled medication

Basically, there are five ways to deliver inhaled medication: aerosol devices, breath activated devices, DPIs, soft mist inhalers, and nebuliser. For the purpose of this article, aerosol devices, breath actuated devices, DPIs and the soft mist inhaler will be addressed. The technique for each group will be discussed later in the article.

Inhaler dose vs delivered dose

Drug deposition within the lungs is dependent on the size of the drug particles. Particle size of more than 5 microns are deposited in the mouth and oropharynx. Particles measuring 2-5 microns are deposited in the upper and central airways and particles less than 2 microns are deposited in the peripheral airways and alveoli.[6]

The drug dose stated on the label is not the dose that is actually delivered to the lungs. The nominal dose is the dose that is stated on the label. The emitted dose is the amount released from the mouthpiece and the fine particle dose is the amount of drug released that is 5 microns or less in diameter that is deposited in the lungs.

Considerations when choosing a device

A number of issues need to be considered when deciding on the appropriate device for a patient. Experience and research has shown that involving the patient in choosing the device aids better adherence.[7] What the patient wants from their inhaler, the drug formulary, the range of devices, the range of therapies and the cost of the medication are all considerations which health professionals should take into account.

From the patient's perspective, the medication needs to fit into their lifestyle. Their ability to use the device and the presence of physical or sensory impairment can impact on a patient's ability or willingness to use a device.

Inspiratory effort

For the drug to be optimally delivered to the lungs, adequate inspiratory effort is required. This can be checked by using an in-check dial device to ensure the patient has sufficient inspiratory effort for the drug to reach the airways. A minimum inspiratory effort of 30 litres/min is required for optimal deposition. Some devices require higher inspiratory effort. Poor inspiratory effort will result in poor control of symptoms and an increased risk in side effects as the drug is deposited in the mouth and oropharynx.

Starting inhaled medication – check list

- Inhaler should not be prescribed unless the patient has been shown how to use it
- If the medication is to be repeated, inhaler technique should be reassessed
- Demonstrate inhaler technique using placebo devices, which are available from all pharmaceutical companies
- Do not switch inhaler unless the patient's technique has been reviewed and assessed
- Advise patient about storage and maintenance of inhaler device.

Common errors in inhaler technique

The errors with inhaler technique can be categorised as: errors with the device, errors with patient, and errors with the health professional.[8] Cultural barriers also exist with inhaler use. In some populations, the use of an inhaler is seen as improper or impolite, and oral medications may be preferred.[9]

Errors with the device include:

- Incorrect preparation of the device
- Poor inspiratory effort
- Using different devices to deliver different drugs – where possible the devices should be the same
- Poor dexterity – inhaler aid devices are available to assist patients with reduced dexterity
- Poor co-ordination of actuation and inspiration

Errors with the patient include:

- Reduced dexterity which may affect the patient's ability to actuate the device
- Learning difficulties or cognitive impairment
- Inhaling too fast or too slow for the device
- Inappropriate device for the patient's lifestyle

Errors with the health professional include:

- Not explaining to the patient how to use the device
- Not demonstrating the inhaler technique
- Not checking inhaler technique at every opportunity
- Inadequate assessment of the patient's inspiratory effort to ensure the device is appropriate
- Inadequate assessment of the patient's ability to use the device correctly.

Evidence indicates that patients who express a preference for a particular device are more likely to use their inhaler correctly and are easier to teach correct inhaler technique.[6]

Inhaler technique

Basically, there are two inhalation techniques for using inhaled devices – slow and steady for MDIs, breath actuated devices and soft mist devices, and quick and deep for DPIs .

Meter dose inhaler – step by step

1. Remove the cap
2. Shake the inhaler
3. Breathe out gently
4. Put the mouthpiece in the mouth and at the start of inspiration and press the canister down
5. Breathe in steadily and deeply
6. Hold the breath for 10 seconds or as long as possible
7. Wait a few seconds before repeating steps two to six
8. Replace the cap.

To increase the deposition of the drug in the lungs with the MDI, a spacer can be used. This will also make actuation of the device easier for the patient.

Inhaler technique using a spacer device

All spacers have static charge which attracts the medication to the spacer walls, thus reducing the amount of medication available for deposition to the lungs. The static charge can be reduced by washing the spacer in warm soapy water, soaking it for a few minutes and letting the spacer 'drip-dry'. This will last for four weeks and the spacer does not need to be washed more frequently.

Spacers can be large volume (eg. Volumatic) or small volume (eg. Aerochamber or Free Breath spacer). Spacers can be used by either the multiple breath technique (tidal breathing for five to six breaths) or the single breath technique (a single breath is inhaled after actuation of the device and the breath is held for 10 seconds). Spacer devices need to be changed according to the manufacturer's instructions.

Breath actuated devices – step by step

1. Shake the inhaler
2. Hold the inhaler upright and open the cap
3. Breathe out gently. Keep inhaler upright
4. Put the mouthpiece in the mouth and close the lips and teeth around the mouthpiece, taking care not to block the air holes on the top of the inhaler
5. Breathe in steadily through the mouthpiece and continue to inhale when the medication is released
6. Hold the breath for about 10 seconds
7. After use hold the inhaler upright and close the cap
8. For a second dose, wait a few seconds before repeating steps one to six.

Dry powder devices

Each dry powder device (Diskus, Elipta, Breezhaler, Turbohaler, Genuair) all have specific instructions prior to use. For the inhalation of the drug, the patient:

1. Breathes out fully, away from the device
2. Puts the mouthpiece fully into the mouth closing the lips around the mouthpiece
3. Takes a breath in deeply and quickly
4. Holds the breath for 10 seconds.

Soft mist device

This device requires loading and priming by the pharmacist prior to dispensing to the patient. For daily use the patient:

1. Holds the soft mist inhaler upright with the cap closed
2. Turns the base in the direction of the red arrows until the inhaler clicks
3. Opens the cap
4. Breathes out fully and closes lips around the mouthpiece without covering air vents
5. Points the inhaler to back of the throat
6. While taking a slow deep breath through the mouth, presses the dose release button and continues to breathe for as long as possible
7. Holds breath for 10 seconds or for as long as possible.

Written instructions on inhaler technique are readily available for all inhalers, which should be given to patients. All inhalers have specific care and maintenance and patients need to be educated about this to ensure medication is delivered in its optimum state. Information with regard to care and maintenance is provided by the manufacturers.

Conclusion

This article has reviewed the importance of choosing the appropriate inhaler device for the patient. The concepts of inhaled medication and optimal inspiratory effort have been explored. Common errors in inhaler technique have been discussed. Finally, inhaler technique for MDI, breath actuated devices, soft mist inhalers and dry powder devices has been addressed.

Ruth Morrow is an ANP in primary care and a registered nurse prescriber in practice in Leitrim

References on request from nursing@medmedia.ie (Quote: WIN 2018; 26(2): 55-56)

Improving glycaemic control in type 2 diabetes

Early initiation of pharmacological therapy is associated with improved glycaemic control and reduced long-term complications in type 2 diabetes, writes **Poochellam Muthalagu**

Part one of a two-part article

TYPE 2 diabetes is a chronic metabolic disorder that results from either insulin resistance and/or insulin deficiency. This type of diabetes represents 90% of all diabetes cases and the current epidemic in type 2 diabetes is largely seen in an ageing population and with obesity.

The focus in managing type 2 diabetes is on putting the patient at the centre of care and the requirement of constant monitoring and treatment throughout the patient's life. The treatment involves several aspects, such as self-care measures, lifestyle changes and in most cases alteration of medications.

Prevalence

Approximately 422 million people worldwide have diabetes, which translates into almost one in every 11 people having the condition. In Ireland 3.3% of women and 4.3% of men had diabetes in 1980. This rose to 5.1% of women and 7.3% of men in 2015.[1]

Screening and diagnosis

Integrated type 2 diabetes care[2] recommends that testing for diabetes should be considered in all adults who are overweight (BMI ≥ 25kg/m^2) and who have one or more additional risk factors as listed below:

- Physical inactivity
- First-degree relative with diabetes
- Are hypertensive (≥ 140/90mmHg) or on therapy for hypertension
- Dyslipidaemia – HDL < 0.9 and/or triglycerides > 2.82
- Have established arterial disease (IHD, CVA, PVD)
- High-risk ethnicity (eg. African, Asian, Hispanic, etc.)
- Members of the Travelling community
- Have delivered a baby weighing > 4.1kg or have a history of gestational diabetes
- On previous testing had impaired glucose tolerance (IGT) or impaired fasting glucose (IFG)
- Have other clinical conditions associated with insulin resistance (eg. polycystic ovary syndrome, acanthosis nigricans, long-term steroid use or severe obesity).

In the absence of the above additional risk factors, it is recommended that overweight adults age 45 and older get screened for type 2 diabetes at least every three years.[2]

In 2011, the WHO approved HbA1c as a diagnostic test for diabetes. To aid screening and early detection of diabetes, HbA1c can now also be used to diagnose pre-diabetes *(see Table 1)*.

Table 1: Criteria for diabetes diagnosis

FPG ≥ 7.0mmol/L (126mg/dL)* Fasting is defined as no caloric intake for ≥ 8 hours		
Two-hour PG ≥ 11.1mmol/L (200mg/dL) during OGTT (75g)* Using a glucose load containing the equivalent of 75g anhydrous glucose dissolved in water		
A1C ≥ 48mmol/mol (6.5%)* Performed in a lab using NGSP-certified method and standardised to DCCT assay		
Random PG ≥ 11.1mmol/L (200mg/dL) In individuals with symptoms of hyperglycaemia or hyperglycaemic crisis		
If no clear clinical diagnosis, test should be repeated using a new blood sample		
**In absence of unequivocal hyperglycaemia, result to be confirmed by repeat testing*		
Categories of increased risk of diabetes (pre-diabetes)		
FPG	Two-hour PG	A1c
5.6-6.9mmol/L (100-125mg/dL) Impaired fasting glucose (IFG)	7.8-11.0mmol/L (140-199mg/dL) Impaired glucose tolerance (IGT)	39-46mmol/mol (5.7-6.4%)
For all tests, risk is continuous, extending below lower limit of range and becoming disproportionately greater at higher ends of range		

Pathophysiology

Insulin insensitivity in muscle and liver associated with β-cell failure represent the crucial defects in diabetes. In addition to muscle, liver and β-cells, α-cells (hyperglucagonaemia), adipocytes (accelerated lipolysis), gastrointestinal tract (incretin deficiency/resistance), kidney (increased glucose reabsorption), and brain (insulin resistance and neurotransmitter dysregulation) play important roles in the development of glucose intolerance and later type 2 diabetes.

Management strategies for diabetes

The management approach below is based on guidelines from the American Diabetes Association (ADA),[3] the National

Institute for Health and Care Excellence (NICE)[4] and the ICGP's most recent guidelines.[2]

As diabetes is seen across the lifespan, co-ordination between primary care teams and secondary care providers is crucial as patients transition through different stages of life. An effective framework for improving the quality of diabetes care needs to be in place in collaboration with multidisciplinary teams. The main objectives for primary care providers should be to prioritise prevention, diagnosis, initial management and continuing care:

- Primary care teams should manage timely and appropriate intensification of lifestyle and/or pharmacological therapy for patients who have not achieved beneficial levels of glucose, blood pressure or lipid control
- Optimal diabetes management requires an organised, systematic approach and involves a co-ordinated team of dedicated healthcare professionals
- Primary care providers should focus on treatment intensification when treatment goals are not met. This has been associated with improvement in A1c, hypertension and hyperlipidaemia
- Patient adherence should be addressed to avoid barriers such as complexity, multiple daily dosing, cost and side-effects. Treatment adherence should be improved by simplifying a complex treatment regimen.

For primary care of diabetes, the 2016 ICGP *Guide to integrated type 2 diabetes care*[2] provides a good national integrated model of care to illustrate the care pathway for people with type 2 diabetes *(see Table 2)*.

Approach to hyperglycaemia management

Lifestyle optimisation

Lifestyle and nutrition counselling is essential for patients with prediabetes or new-onset diabetes to slow the progression of type 2 diabetes.[5] Clinical trials have shown that calorie restriction is typically the primary method for weight loss. Patients who are overweight or obese could see multiple health benefits, including significant improvement in HbA1c, systolic and diastolic blood pressure, high-density lipoprotein cholesterol (HDL-C), and triglycerides, by losing just 5-10% of body weight.[6]

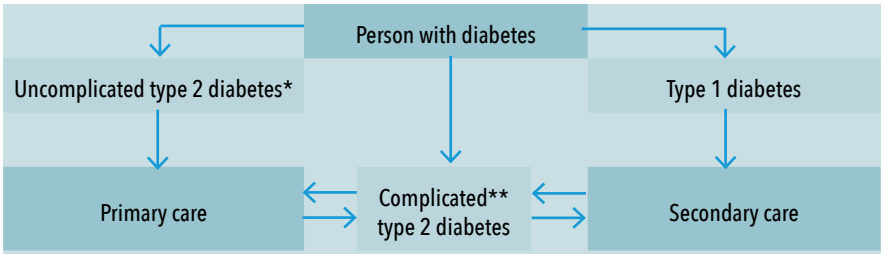
In addition to calorie intake restriction, the American Association of Clinical Endocrinologists/American College of Endocrinology (AACE/ACE) guidelines recommend a diet largely focused on vegetables and polyunsaturated fatty acids, such as those found in fatty fish (eg. salmon, mackerel and trout) and monounsaturated fats (eg. olive oil). Trans-saturated fats should be avoided.[7]

Foundations of care

Individuals with diabetes are advised on self-management and encouraged to follow a healthy eating pattern with appropriate portion sizes to achieve and maintain body weight goals, individualised glycaemic targets, blood pressure control and lipid goals. All adults with diabetes are advised to undertake at least 150 minutes of moderate-intensity aerobic activity over at least three days/week or resistance training at least twice weekly. Smoking cessation is encouraged in all patients with type 2 diabetes.

Poochellam Muthalagu is a consultant endocrine physician at Cavan General Hospital

Table 2: National integrated model of care



***Uncomplicated patients with type 2 diabetes are defined as follows:**
Type 2 diabetes patients not on insulin but on diet only or on two glucose lowering agents (not insulin) with a HbA1c (< 58mmol/mol) in patients with:

- Low risk or moderate risk diabetic feet
- No active diabetic eye disease
- Controlled CV risk factors
- Normal hypoglycaemia awareness
- Patients with type 2 diabetes and satisfactory renal function defined as a serum creatinine < 150umol/L or eGFR > 60mL/min or albuminuria < 70mmol/mL or PCR < 100mg/mmol
- No symptoms of autonomic neuropathy (with the exception of erectile dysfunction)

****Complicated type 2 diabetes patients who will be managed between primary and secondary care:**
These patients will have at least one visit per year in secondary care, 'the annual review', or will be seen more frequently according to the severity of the diabetes-related complication and will have visits up to twice a year in primary care at four-monthly intervals.

- Type 2 diabetes patients requiring insulin*
- Failing HbA1c (> 58mmol/mol) on two or more glucose-lowering agents (not insulin)
- Active or history of foot ulcer
- History of lower limb amputation
- High risk foot (as per national model of foot care)
- Renal failure (creatinine > 150umol/L or eGFR < 60ml/min)
- Albuminuria with normal serum creatinine (ACR on two occasions > 70mmol/mL or PCR > 100mg/mmol)
- Painful peripheral neuritis
- Symptoms of autonomic neuropathy (except for erectile dysfunction)
- Diabetic eye disease with active proliferative retinopathy/maculopathy or recent laser therapy (last 24 months)
- Uncontrolled CV risk factors (refractory hypertension or dyslipidaemia)
- Steroid induced hyperglycaemia (can be referred back once off steroids or blood glucose levels settle)
- Recurrent hypoglycaemia
- Hypoglycaemia unawareness
- Weight loss + osmotic symptoms +/- ketones

**Patients with type 2 diabetes on insulin may be managed appropriately in the community depending on local primary care expertise or availability of integrated care diabetes nurse specialist*

Part two of this article will feature in WIN April and will focus on pharmacological therapy

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Irish thriller with echoes of a dark past

"THE hole they dug was not deep, less than three feet. A milky white flour bag encased the little body, firmly tied with the strings of a soiled, once white apron. Three small faces watched from the third floor window, eyes black with terror. The child in the middle spoke without turning his head. 'I wonder which one of us will be next?' "

So opens the prologue, dated January 31, 1976, of *The Missing Ones* by Irish author Patricia Gibney. The first chapter jumps forward to December 2014, where we meet the central character of the novel, detective inspector Lottie Parker.

A woman's body is discovered in a cathedral, having been garrotted, and hours later a man is found hanging from a tree outside his home. Detective Parker is called in to lead the investigation. Both bodies have the same distinctive tattoo on their legs. It soon becomes evident that the pair are connected, but how?

The evidence leads Detective Parker to St Angela's, a former children's home in the fictional midlands town of Ragmullin where all the action takes place. St Angela's also has a link to a dark time in Parker's own family history, making the case increasingly personal.

Meanwhile DI Parker, still struggling from

the recent death of her husband and trying to find the balance between her demanding career and raising her three somewhat troubled children, is using both alcohol and benzos to get through the day. While she has an awareness of her increasing dependency, she is not yet ready to face it.

As DI Parker begins to link the current victims to unsolved murders from decades past, two teenage boys go missing. She must close in on the killer before they strike again, but in doing so is she putting her own children in terrifying danger?

As DI Parker and DS Mark Boyd, with whom she has a complicated but affectionate personal relationship, start digging they discover that the first two victims both had connections to the planning department of the local council as well as to a big shot developer. Both were also placed in St Angela's as children in the 1970s.

The action sees Parker defying her chief's direct order and takes off for Rome to view the records from St Angela's that had been mysteriously shipped to the Vatican archives. What they uncover is meticulously-documented years of child exploitation and abuse that the local bishop not only knew about but did nothing to stop.

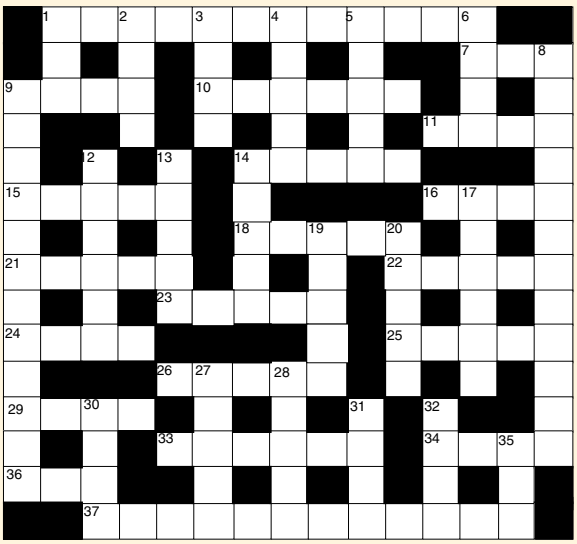
The Missing Ones is a real page turner with echoes of the scandals that affected the Catholic Church in Ireland over recent years. Parker is a flawed but likeable character. If you order this on Kindle you will soon return for the next books in the DI Lottie Parker series.

- Alison Moore

The Missing Ones by Patricia Gibney is published for Kindle by Bookouture and is available on Amazon.co.uk for 99p STG. It is also published in paperback by Sphere. ISBN: 9780751572186 RRP €12.99

Crossword Competition

WIN A €30 BOOK TOKEN



Name:

Address

Across
1 Will these cardiac drugs get in the way of only one Greek character? (4,8)
7 Spherical symbol of monarchy (3)
9 Mountain top found on a cap? (4)
10 Quake (6)
11 & 15a Constellation - the Little Bear (4,5)
14 Legate (5)
15 See 11 across
16 Cosmetic procedure for Sherwood Forest's friar? (4)
18 Seabirds (5)
21 A collection or bunch (5)
22 A great number - of savages? (5)
23 Large instrument? To one character, it's a monster! (5)
24 Grew older (4)
25 & 31d White beast wandering in a paler orb (5,4)
26 Proscribe broken bread (5)
29 Observation game or a secret agent from a certain computer and phone company? (1,3)
33 The county town of Kerry (6)
34 Pelvic joints (4)
36 Tool with which to break the law (3)
37 When you put fifty on, put five hundred on a card game, as this may to be falling down! (6,6)

Down
1 Cricket extra (3)
2 Remove (4)
3 City on the river Avon (4)
4 Large sea area (5)
5 Japanese city associated with a climate change protocol (5)
6 Sharp-tasting (4)
8 Make the rake scribble about such hedgerow fruit (12)
9 In preparation for a first issue! (5,7)
12 Ozone's useful if you want forty winks (6)
13 Mathematical chart (5)
14, 28d & 35d This American writer earned a gallop around (5,5,3)
17 Disorderly, lawless (6)
19 Stratum (5)
20 Retail outlets (5)
27 Was mistaken (5)
28 See 14 down
30 Tug (4)
31 See 25 across
32 Part of dreariest Huddersfield – how dull it sounds! (4)
35 See 14 down

The prize will go to the first correct entry opened
Closing date: Tuesday, March 20, 2018
Post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin

February crossword solution

Across: 1 Unscrupulous 7 Log 9 Cent 10 Sister-in-law 11 Here 14 Cease 15 Bayou 16 Fuss 18 Malmo 21 Llama 22 Felon 24 Crew 25 Exact 26 Apply 29 Cock 33 Hobble 34 Edgy 36 Dab 37 Half-marathon

Down: 1 Use 2 Site 3 Rush 4 Passe 5 Leeds 6 Sloe gin 8 Gray's Anatomy 9 Carbolic acid 12 Gyrate 13 Dubai 14 Camel 17 Unload 19 Lowly 20 Offer 27 Proof 28 Libra 30 Cobh 31 Hera 32 Mesh

The winner of the February crossword is:

Carolyn Kelleher
Dun Laoghaire
Co Dublin

Protecting your home

Marc Evans offers advice on ensuring you have the right level of home insurance cover

THE start of the year is a great time to plan for the year ahead, set goals and get organised. Top of that list should be making sure you have the insurance cover in place to keep your most prized assets protected.

Choosing the right type and level of cover to protect your home can seem daunting, with so many variations and terms that might not be familiar. While getting cover for a reasonable premium is important, it is essential to get the cover you need. Some things to consider when shopping around:

Prepare for the weather

Consider the increased risk posed by frequent storms and harsh weather conditions at this time of year. Areas not traditionally exposed to flood risks could end up impacted in times of extreme weather; therefore it is important to check that all potential risks are covered on your policy, including flood.

To reduce your likelihood of claiming, check your gutters are clear of leaf debris and are in a state of good repair. Check doors and windows are secure and can withstand intense weather. Also, ensure there are no loose items around your home that could be damaged or cause damage in high winds.

Take stock of your contents

It is important to insure your contents for their replacement value. If you are taking out cover or reviewing the amounts insured, consider each room and its contents. An easy way to look at it; anything you would take with you if you left the home. After the Christmas period, it may be easier to realise the volume of both new and old contents items, which you might not have included. Items stored in the attic and garage or new gifts may affect your required sum insured.

For valuable items that you frequently take out of the home, such as jewellery, you should consider separate specific 'all risks' cover. There are two ways of applying this benefit to your policy:

- 'Unspecified items' can be applied to your policy to cover a number of items up to a certain value, eg. a number of items of jewellery worth less than €1,000 each, could be insured under the 'unspecified items' benefit
- Alternatively, for a particularly valuable item, this can be covered under 'specified items' for their full value, eg. an engagement ring worth €5,000.

There are different terms and conditions on this benefit, so it is important to discuss this fully with your adviser when choosing to add this to your policy.

Be security conscious

You should take measures to ensure your home is kept safe. Having regularly maintained smoke and burglar alarms throughout your home will reduce risk and also often reduce your premium. Do not broadcast your plans for a break away from the weather too widely. Social media accounts being tracked by thieves can provide a notification of an empty house and vulnerable contents items.

Consider your excess

The excess is the amount you are required to pay, should you make a claim on your home insurance. Some insurers allow you to modify this amount, which will have an impact on your premium. The higher your excess the lower the premium but the more you will have to pay should a claim occur.

Checklist of benefits

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

Check the list

Policy features and benefits will differ by insurer. Use the checklist above when reviewing your quotes to see what exactly you are getting for your premium and to determine which aspects of cover are most important to you:

With so many demands on time, energy and finances at this time of year, home insurance should not be put on the long finger. Having adequate insurance provides you with peace of mind and a feeling of security that lasts the whole year.

You can avail of a discount offering two months free when you buy a new home insurance policy with Cornmarket before April 30, 2018 and your policy starts before May 31, 2018.[1] The offer is subject to a minimum premium of €335.52. For more information call our team of home insurance experts at Tel: 01 408 6202.

Marc Evans is a director of Cornmarket Group Financial Services Ltd.

1. Discount applies in year one only and is inclusive of government levy. Only one discount can be used with each eligible proposal. 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. A member of the Irish Life Group Ltd. which is part of the Great-West Lifeco Group of companies. Telephone calls may be recorded for quality control and training purposes.

HPRA issues warning on validity of food intolerance testing

THE Health Products Regulatory Authority (HPRA) has warned the public that there is no scientifically valid test to diagnose food intolerance and that products being promoted as such should not be used.

According to the HPRA, food intolerance tests cannot diagnose food intolerance conditions and people should not act on the results of such tests without expert advice from a healthcare professional.

Due to an increased availability of these tests in recent years, the HPRA carried out a scientific review of them in order to assess their validity. It confirmed that 'there is no single test to diagnose food intolerance', and advised people not to rely on the results of these test kits alone, and not to remove certain food groups from their diet.

"If anyone is suffering from gastrointestinal issues or believes they could be intolerant of a certain type of food, they should consult a doctor or dietician. Attempting to self-diagnose a suspected food intolerance using a test kit alone could potentially result in a delay in identifying and treating other medical conditions," the HPRA warned.

According to the Authority's CEO, Dr Lorraine Nolan, the only safe and valid way to diagnose food intolerance is to eliminate foods following clinical advice, and then reintroduce the suspected foods on a phased basis to determine if any symptoms return.

She noted that food intolerance is a term that has emerged to describe various unpleasant conditions, such as indigestion and bloating, that can occur after eating certain foods. She insisted that people should not rely on the results of these test kits, regardless of how they are labelled or promoted.

"Any examination relating to a person's ability to digest or tolerate foods should be made in careful consultation with a doctor or dietician. It should not be based on these tests alone as to do so could lead to a misdiagnosis or the removal of important nutrients in the diet.

"Removing a range of foods from your diet without expert advice on how this should be managed can result in nutritional deficiencies among vulnerable populations and impaired growth in children, which can have important long-term health consequences," said Ms Nolan.

The HPRA's review included the most commonly used test kits in Ireland, such as immunoglobulin G (IgG) tests.

It found that these tests do not diagnose intolerance to a certain food type, but instead detect previous exposure to a food. While this information may be used to show foods a person has consumed in the recent past, it does not indicate intolerance.

The various tests examined as part of this review are currently available through certain nutritional, food intolerance and health centres, as well as via some pharmacies. In light of this, the Pharmaceutical Society of Ireland has informed pharmacists that they should not offer food intolerance testing services to their customers. It also reviewed test kits that people can use in their own home such as those available via the internet and those offering a postal based service.

Meanwhile, the HPRA emphasised that there is a clear distinction between food intolerance and food allergies. It stressed that food intolerance tests have no role whatsoever in the diagnosis of a food allergy.

A tribute to Jack & Jill nursing team

AFTER nine wonderful years, working on PR for the Jack & Jill Children's Foundation, I've called it a day but I wanted to note the respect and admiration I have for this champion team of nurses who deliver a unique, quality, flexible, child and family-centred home nursing care service, 365 days a year.

In 20 years, 2,300 families have been supported by the Jack & Jill nurses since the charity was established. Mary Joe Guilfoyle was the first, pioneer nurse recruited by founder Jonathan Irwin and she is still a member of the team.

For me, getting to know the 12-strong nursing team, via their monthly meetings, was a baptism of fire. The level of noise, energy and intensity at such meetings was greater than the banking or business meetings I'd had.

My job was to shine a light on the impact of Jack & Jill's home nursing service to raise awareness and funds that were essential to keep the charity going. Once convinced of the rationale of doing PR, the nurses were fully on board, but always stressed that these were families who did not want sympathy or sensational headlines.

The core Jack & Jill nursing team, the 12 apostles as I called them, mobilise an extensive congregation of community nurses. Families describe these Jack & Jill nurses as a life line. They take time to listen and advise. They are advocates to have in their corner, as parents battle for every little support for their child from the health system.

So, my gift to my nursing friends is publish this, a tribute to this wonderful team of nurses who demonstrate the very best in the world of Irish nursing.

– Carmel Doyle

ALCI Spring Study Day 2018

THE Association of Lactation Consultants of Ireland (ALCI) is delighted to announce that its spring study day will take place this year on March 10 at the HSE-RCSI Building at University Hospital Waterford.

The day begins with Dr Justin Roche who will present case studies from his Infant Feeding Centre. Then physiotherapist Patricia Weldon will address mothers' experiences with breastfeeding difficulty. Claire Bulfin, International Board of Lactation Consultant Examiners (IBLCE), will share the most frequently asked questions on the HSE website **Breastfeeding.ie** The final session will entail a workshop involving various case studies of ethical dilemmas.

The event is for ALCI members only, but all are welcome to join or renew online. Handouts, lunch and refreshments are included in the registration fee of €40, email: info@alcireland.ie for information.

March

Tuesday 13
National Care of the Older Person Section Conference. Midland Park Hotel, Portlaoise. For further details contact jean.carroll@inmo.ie

Thursday 22
RNID Section Conference. Midland Park Hotel, Portlaoise. Contact jean.carroll@inmo.ie for further details. *See also page 18*

April

Tuesday 3
Emergency Department Nurses Section Meeting. 11am INMO HQ. Presentation by Edward Matthews. Contact jean.carroll@inmo.ie for further details

Tuesday 3
Dublin East Coast Branch Meeting. Clonskeagh Hospital. 7pm. Contact ann.obrien@inmo.ie, Tel: 01 6640600 for further details

Tuesday 3
Leinster Nurses Golfing Society New members wanted. Annual membership is €30. Contact Margaret Sheridan at Tel: 087 2719885 or Anne Tynan at Tel: 086 1700028

Monday 9
Nurse Midwife Education Section 11.30am. Contact jean.carroll@inmo.ie for further details

Saturday 14
PHN Section Meeting. INMO HQ 11am. Contact jean.carroll@inmo.ie for further details

Saturday 14
School Nurses Section Meeting. Follow up on documentation workshop. INMO HQ. 10.30am. For further details contact jean.carroll@inmo.ie

Saturday 14
Radiology Nurses Section Meeting. INMO HQ. 11am. For further details contact jean.carroll@inmo.ie

Monday 16
National Children's Nurses Section Meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie for further details

Tuesday 17
Student Allocation Liaison Officers Meeting. INMO HQ. 12pm. Contact jean.carroll@inmo.ie for further details

Wednesday 18
RNID Section Meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie for further details

Friday 20
ODN Section Meeting. Tullamore Court Hotel. 6pm. Contact jean.carroll@inmo.ie for further details

Friday 20 - Saturday 21
ODN Section annual conference *See page 20* for full details

Thursday 26
Retired Nurses Section Meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie for further details

May

Wednesday 2 - Friday 4
INMO annual delegate conference The Clayton Hotel, Silver Springs, Cork. *See page 6* for full details

Wednesday 15
Retired Section Social outing. Tour of Mary Aikenhead Heritage Centre. Our Lady's Hospice, Dublin 6. Contact: Ann Igoe - a.igoe123@gmail.com

Thursday 17
CPC Section This year's seminar organised by the Clinical Placement Co-ordinators Section will take place in the Richmond Education and Event Centre. Don't forget to avail of the early bird rate of €70 prior to 30 April. Contact marian.godley@inmo.ie for further details

Wednesday 23
Telephone Triage Section Meeting. INMO Limerick office. Workshop on mental health issues. Bookings essential. Contact jean.carroll@inmo.ie for further details

Wednesday 23
Orthopaedic Nurses Section Meeting in UHG. 11am. Contact jean.carroll@inmo.ie for further details.

INMO Membership Fees 2016

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

Condolences

- It is with deep sadness the general secretary Phil Ni Sheaghdha, president Martina Harkin-Kelly, Executive Council and all INMO staff learned of the sad loss of Keady Clifford, a colleague working in Cork University Hospital. We wish to express deep sympathy to the parents, family, friends and colleagues of Keady at this difficult time. The INMO wishes to offer support to the INMO members and colleagues of Keady. We have set up a dedicated counselling helpline at Tel: 1850 670 407. Our thoughts are with Keady's family and many friends during this difficult time of loss. *Ar Dheis Dé go raibh a h-Anam*.
- The INMO Limerick Branch extends deepest sympathy to Claire O'Grady, ADON, St John's Hospital, Limerick, on the recent loss of her mother Mary Hassett. May she rest in peace.

Retirement

- The Limerick Branch wishes the very best to Kath Burke CNM2 and INMO representative St Camillus's Hospital on her recent early retirement. Kath, may you have many years of happiness.