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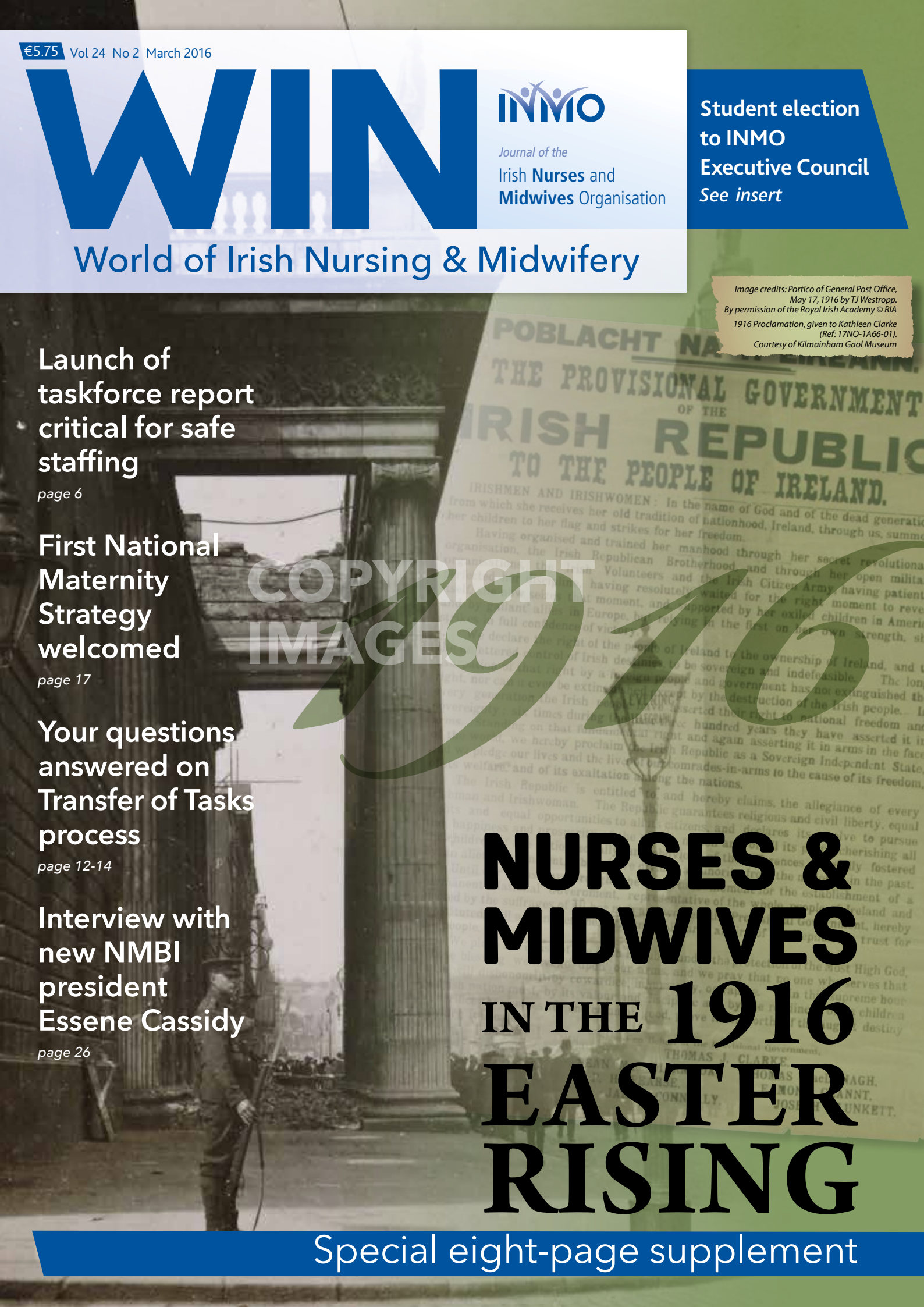
WIN

World of Irish Nursing & Midwifery

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

Student election to INMO Executive Council
See insert



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1916 Proclamation, given to Kathleen Clarke (Ref: 17NO-1A66-01). Courtesy of Kilmainham Gaol Museum

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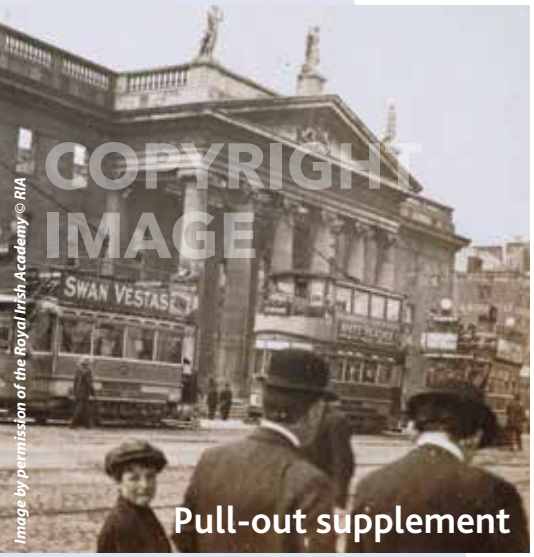
NURSES & MIDWIVES IN THE 1916 EASTER RISING

Special eight-page supplement



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One hundred years on

AS YOU are reading this editorial the country will have voted, elected our TDs, and we may, or may not, have a government to lead the 32nd Dáil. I am writing this on the eve of the election and it would appear, from opinion polls, that any new government will involve a coalition of a number of interests.

In fairness to the recent election campaign, whether you found it exciting or not, it did involve on this occasion, a significant degree of focus on our health service, its current difficulties and how they might be resolved. It should also be noted that the INMO's Trolley/Ward Watch is now used, on a daily basis, effectively as a barometer of the state of the health service, as we count and make public, the number of admitted patients on trolleys in inappropriate areas across our hospitals.

Indeed the INMO's Trolley/Ward Watch is now an integral part of media coverage of our health service, and I want to thank all of our members in emergency departments and hospitals who supply us with these figures on a daily basis.

Against this backdrop it is good to see the increased attention given to health by political parties. Indeed, any consideration of all the various health manifestos would indicate an increased awareness of the severity of the current difficulties, but sadly no obvious agreement on how they can be addressed.

It is not automatically clear, from all of the policy statements on health, what the medium and long-term commitment towards funding of our public health service will be. It would still appear that the budget for health will continue to be determined on an annual basis. This is both disappointing and contrary to what is required.

The debate on healthcare and, in particular, how we fund our public health service, is also taking place against the backdrop of recent figures from the Central Statistics Office (CSO). These indicated that in this country, we spend more than our European neighbours on health, when you combine public/private expenditure including all charges and levies. In bringing forward this information it is very important to remember that the combination, of both public and private spend, is not readily comparable to the total public spend that might arise in a single tiered health system. The public service must provide all services while the private system is heavily focused on elective/planned work.

However, at the same time, it has to be acknowledged that the latest CSO figures, and the level of insight they provide with regard to Irish expenditure on health, compared to our European neighbours, provides information which cannot be ignored.

They certainly challenge everyone, who cares about our public health system, to redouble the effort to ensure we have a universal healthcare service which is efficient, effective and which treats everyone equally, with access being determined by need.

All of this reinforces the need for a national debate, leading to a national consensus, on how our health service should be structured, funded and accessed. The INMO, based on experience and the current situation, is calling again for the incoming government, of whatever combination, to initiate this national debate. We must look beyond the normal five year horizon, to determine how we want our health service to serve us both now and for the next 25 years.

In this issue we are also commemorating the role of nurses/midwives in the Easter Rising of 1916. I sincerely believe you will find the supplement, written by our own Mark Loughrey, to be interesting and insightful with regard to how nurses and midwives, and hospitals, played their part over those traumatic days.

One hundred years on from that rising, we continue to have many challenges. Let us hope that, in memory of those who went before us, we now make the correct decisions, particularly with regard to health, so that every citizen in this country will always receive world class care.

Liam Doran
General Secretary, INMO

Launch of taskforce report a critical step in ensuring safe staffing on wards

A RADICAL new approach to nurse staffing levels on medical and surgical wards was launched last month by Minister for Health Leo Varadkar and Chief Nursing Officer Dr Siobhan O'Halloran, with the publication of the interim report of the Taskforce on Staffing and Skill Mix for Nursing.

This taskforce was established in response to the INMO's Safe Staffing Campaign, which was launched in May 2014 in response to the dramatic reduction in nurse staffing levels on inpatient wards arising from the ban on recruitment.

In drawing up its interim report, the taskforce focused on the need to introduce agreed measures, which will determine patient acuity and need, to ensure a consistent, adequate and safe nursing workforce is available at all times. This is a step change in determining nurse staffing levels in the interests of patients, their care and their return to wellbeing.

The taskforce recommendations, and its approach to determining staffing levels, will avoid any repeat of recent years when reductions took place without any assessment of impact on patients, or on the nursing staff and their ability to provide safe care.

The INMO has welcomed the commitment to move to the next stage of the process, in piloting the interim recommendations in a number of medical and surgical wards nationwide. The INMO will ensure that the recommendations are applied and any learning from their application is reflected when the pilot programme reports back to the national taskforce.

For many years the INMO has sought that nurse staffing on inpatient wards would be determined by nursing staff, following measurement of patient need and acuity. The taskforce recommendations bring members a significant step closer to this reality. This will see nurse management, particularly the clinical nurse manager 2 (ward sisters), properly empowered to maintain safe staffing levels, and nursing practice on their wards.

At the launch of the interim staffing report were (l-r): Dr Philippa Ryan Withero, deputy chief nursing officer; Dr Siobhan O'Halloran, chief nursing officer; Minister for Health Leo Varadkar; and Liam Doran, INMO general secretary

INMO general secretary, and staffing taskforce member, Liam Doran said: "This is a very positive day for nursing in Ireland. The taskforce work, and its recommendations, offer the opportunity to move away from staffing levels determined solely by finances, to being consistently determined by patient need and acuity as applied by nursing staff. That is the way forward. It will, in future, prevent the dramatic reduction in nurse staffing levels which has taken place in recent years, without any measure of the negative impact on patients or staff as a result.

"The recent loss of nursing staff has, in turn, left us in the current situation where we have inadequate numbers of nurses to safely staff wards. The taskforce recommendations provide the opportunity to ensure that all wards are safely and consistently staffed. This will aid recruitment and retention of nursing staff because they will have staffing levels allowing them to practise safely, which is every nurse's goal and objective."

Report's €2m pilot scheme set to get underway

THE framework drawn up by the taskforce is now set to be piloted in three acute hospitals in general and specialist medical and surgical inpatient units.

€2 million has been allocated in funding to allow the project to be piloted this year. The interim report sets out the framework for the pilot, including a method to calculate a safe nurse staffing and skill mix for acute hospitals. In particular, it recommends replacing the 'one size fits all' approach with a range of factors when calculating safe nurse staffing and skill mix.

The ultimate goal is to stabilise the nursing workforce, raise care for patients, and make hospitals a healthier work environment for staff.

The framework identifies four core assumptions to be used in calculating the number and type of nurses to be deployed on any given ward:

- Individual patient need should be measured to identify the actual demand for nursing care, through acuity and dependency measurement
- The skill mix within the nursing team as a whole in addition to the nursing hours required to meet patient need should be assessed to determine the optimum skill mix and number to provide safe, effective and efficient care
- Monitoring the ward and organisational culture are important indicators of effective leadership that can influence the ward and organisational climate
- The monitoring of patient outcomes of quality and safety, along with day to day measurement of safety triggers such as nursing care left undone, to provide a mechanism for immediate response to patient safety concerns in addition to their longer term management across hospitals. The framework also recommends changes at organisational level to ensure continuous monitoring of staffing levels within hospitals and across hospital groups.

A pilot implementation group has been established, with the INMO represented by President Claire Mahon, to plan and co-ordinate the testing throughout 2016. On completion of the pilot, the taskforce will prepare a final report and recommendations.

Pictured with INMO student nurse and midwife members welcoming news of the significant restoration of their pay last month were (front row, middle): Claire Mahon, INMO president; Kathleen Lynch, Minister of State at Department of Health with special responsibility for Primary Care, Mental Health and Disability; and Liam Doran, INMO general secretary

INMO wins restoration of student pay

Incremental credit also restored for future nursing/midwifery graduates

THE INMO and other nursing unions have secured significant restoration of the pay of student nurses/midwives when they are undertaking the rostered placement, during which they replace staff nurses/midwives and work the full roster.

The revised arrangements also provide for the restoration of incremental credit, on graduation, for this 36 week period resulting in the new graduate moving to the second point of the scale (worth over €2,000) after 16 weeks.

In 2011/12 the government chose to unilaterally reduce the pay of fourth year students, who are working full-time on wards/units, leaving them in a situation where they were getting less than the minimum wage at €6.86 an hour. In addition, the government withdrew granting of incremental credit for this period, which only further penalised the graduating nurse/midwife. This service was recognised in the UK, which provided a further impetus for emigration.

The revised arrangements, to come into place from March 1, 2016, provide for:

- During the 36 week clinical placement the pay of the fourth year shall equal 70% of the staff nurse scale, or €9.48 an hour
- 16 weeks after graduation the newly registered nurse/midwife will move to the second point of the scale (€29,497), which represents an increase of over €2,000
- The new arrangements also provide for a further review and discussions on the outstanding issue of granting retrospective incremental credit for the graduate classes of 2011-2015. The INMO will continue to pursue this demand in the interest of recruiting and retaining these highly valued, and scarce, registered nurses and midwives to the Irish healthcare system.

INMO general secretary Liam Doran said: "The INMO welcomes this restoration as it moves some way to correct a serious wrong done to young nurses and midwives in 2011/12. We also acknowledge the recognition, by Ministers Kathleen Lynch, Brendan Howlin and Leo Varadkar, that this issue had to be addressed and that paying young nurses/midwives less than the minimum wage was wrong and could not be continued.

"The INMO will continue to pursue the outstanding issue of granting incremental credit to recent graduates. We believe that this is necessary in our continuing efforts to recruit, and retain, young graduate nurses/midwives to our health service, which remains severely understaffed".

Pilot sites chosen for taskforce staffing initiative

THE Taskforce on Staffing and Skill Mix for Nursing has chosen the three pilot hospitals that will undertake an initial study using the framework on some of its medical/surgical wards.

Beaumont Hospital, Our Lady of Lourdes Hospital, Drogheda and St Columcille's Hospital, Loughlinstown will be the sites where the initial pilot, running over the next six to eight months, takes place.

As we went to press, discussions were continuing with the directors of nursing in these three locations to put in place the necessary arrangements to commence the study, which includes:

- A 100% supervisory role for the CNM2 on each ward
- Permanent staff on the ward
- An inbuilt complement of 21% for annual leave/other leave
- Special training on the taskforce framework (which utilises the nursing hours per patient day method) for staff on the ward and senior nursing staff within the hospital.

It is expected that the pilot studies, which will also be subject to external research to confirm the improvements in environment for patients and staff, will run until the third quarter of this year.

The findings of the pilot studies will be fed back to the National Taskforce, which will then complete its deliberations and issue a final report in December 2016. This will allow the ongoing roll out of the staffing method to all medical/surgical wards, to be included in the estimates for 2017.

INMO general secretary Liam Doran said: "The INMO welcomes the next step in implementing the taskforce work by choosing the three pilot sites. INMO president Claire Mahon is now on the national implementation group and our members locally, together with the relevant IRO, will be on the local implementation group in each hospital to oversee the pilot study.

"This whole initiative flows from the INMO's Safe Staffing Campaign. It is our continued belief that we must utilise evidence based best practice to greatly improve the staffing levels on our medical and surgical wards, which have been so depleted in the past four to five years.

"The Organisation will work closely with the pilot sites to ensure that all of the resources necessary to fully utilise the framework are available to the three locations. This will ensure that the environment, for both patients and staff, is greatly improved arising from consistent staffing levels based on patient need."

ED members accept revised proposals

Implementation of all measures now key to addressing overcrowding

INMO members working in the country's 26 emergency departments have voted to accept revised proposals to address ED overcrowding, brought forward by the Workplace Relations Commission (WRC).

This acceptance, by 71% in favour to 29% against, followed the rejection of previous proposals by ED members as they felt that they did not address the critical issues of confidence and clinical risk and they were not convinced they would be implemented, on a 24/7 basis, by health service management.

The INMO is now monitoring to ensure that the agreement now in place between the HSE and the Organisation is implemented, in full, on an ongoing basis in the interests of patients and staff in EDs throughout the country.

In particular the INMO will now insist that all of the hospital and group level structures, involving engagement between hospital management and INMO ED members, continues, on a weekly basis. This is necessary to ensure continuous implementation of the, now agreed, System Wide Escalation Policy which places the pressures on EDs at the centre of all health service activity.

In accepting these revised proposals, INMO members reaffirmed that this dispute was always about patient care and ensuring a safe working environment which must minimise overcrowding and maximise the ability of nurses to practise safely with manageable workloads.

The INMO has consistently said this was not a 'traditional' dispute as it always centred on the needs of patients and the requirement of nursing staff to work in an environment where they could deliver safe care and where management was constantly working to ensure overcrowding was minimised.

In addition to the specific requirements, now stipulated in the HSE/INMO agreement, the Organisation will continue to work with all stakeholders to implement the 80 plus recommendations of the Emergency Department Taskforce published in April 2015.

The INMO pointed out that this Taskforce was accepted by all stakeholders, across the health service, including health service unions. The Organisation is looking forward to the implementation of all changes necessary to ensure the needs of the emergency department are central to all activity across the healthcare system.

INMO general secretary Liam Doran said: "The acceptance of these proposals by our members re-affirms their absolute commitment to their patients and to ensuring that they can deliver safe care to the sick and vulnerable people presenting to them. Our members constantly stated, in all of the information meetings held ahead of the ballot, that this was never about pay and conditions but it was all about ensuring the unacceptable situation, in emergency departments, was prioritised, by management."

"We will continue, in the interests of our members and the patients they care for, to lead the campaign, seeking the implementation of this agreement, and also the need for additional beds, staff and services right across the healthcare system".

As we went to press, the Workplace Relations Commission has convened the first review of the agreement, involving the INMO/HSE/Department of Health for Monday, March 14, 2016.

In order to prepare for this review, the INMO has convened a further national meeting of ED reps which will take place on Wednesday March 9, in INMO HQ.

INMO trolley and ward watch January – February 16, 2016

Hospital	2015	2016
Beaumont Hospital	1,298	1,246
Connolly Hospital, Blanchardstown	1,045	568
Mater Misericordiae University Hospital	782	789
Naas General Hospital	709	795
St Colmcille's Hospital	n/a	n/a
St James's Hospital	440	332
St Vincent's University Hospital	856	1,099
Tallaght Hospital	732	675
Eastern	**5,862**	**5,504**
Bantry General Hospital	97	118
Cavan General Hospital	132	292
Cork University Hospital	682	1,055
Kerry General Hospital	165	308
Letterkenny General Hospital	837	200
Louth County Hospital	n/a	n/a
Mayo General Hospital	512	331
Mercy University Hospital, Cork	406	387
Mid Western Regional Hospital, Ennis	9	144
Midland Regional Hospital, Mullingar	755	785
Midland Regional Hospital, Portlaoise	383	456
Midland Regional Hospital, Tullamore	436	521
Monaghan General Hospital	n/a	n/a
Nenagh General Hospital	15	55
Our Lady of Lourdes Hospital, Drogheda	1,306	1,015
Our Lady's Hospital, Navan	268	101
Portiuncula Hospital	369	73
Roscommon County Hospital	n/a	n/a
Sligo Regional Hospital	333	440
South Tipperary General Hospital	362	506
St Luke's Hospital, Kilkenny	459	543
University Hospital Galway	991	958
University Hospital Limerick	1,214	1,214
University Hospital Waterford	282	706
Wexford General Hospital	524	236
Country total	**10,537**	**10,444**
NATIONAL TOTAL	**16,399**	**15,948**

Comparison with total figure only: Decrease between 2015 and 2016: –3%

Exercise your vote in Seanad elections

NURSES and midwives who are graduates of NUI colleges or TCD are among those privileged to have a second vote available to them for the election of six of the senators who will serve in the new Seanad when it is formed.

The people of Ireland voted to retain the Seanad as the Upper House of the Oireachtas, rejecting the political parties' efforts to abolish it. The Irish people have given graduates of the universities concerned a special privilege, which should be appreciated and used constructively. The register of electors for the Seanad is published each June and the current register, which will be used for the Seanad elections now in progress, was published in June 2015.

On graduation, each nurse or midwife is given the prescribed form to register for Seanad elections. However, a graduate is entitled to register at any stage up to the end of February to be included on the June register for that year.

TCD academic graduates may verify their inclusion on the register at any time at the Seanad Electoral Office located in that academic registry or by contacting the office by email at: academic.registry@tcd.ie

The NUI constituency comprises graduates from NUI Colleges in Dublin, Cork, Galway and Maynooth. Additionally, graduates of St Angela's College, Sligo are eligible as a constituency. Copies of the register are available at the libraries of the various institutions and also at the reception of the NUI offices, 49 Merrion Square, Dublin 2.

As mentioned, Irish people have decreed that it is worthwhile having an upper house, even if political parties felt it was a superfluous institution. The intent of the people was surely that there would be some supervision of the activities of the elected politicians in the Dáil. It can be argued that the outgoing group of senators gave great service by closely scrutinising all legislation and the activities of Dáil Eireann.

Indeed, some of the best known senators to have occupied seats in the house are those occupying the university seats, such as senators David Norris and John Crown.

The right of nurses and midwives to participate in such a privileged vote, which is not available to the majority of Irish citizens, was hard fought and won in that it is directly related to the achievement of degree status for the professions. That degree status came out of the implementation of the Commission on Nursing recommendation of 1998 following an industrial campaign led by the INMO on a range of grievances held by the professions through the ages. Ultimately, the Commission's report was implemented following the 1999 dispute and the first degree status nurses emerged from the colleges in 2004.

Based on a motion to the INMO annual delegate conference in 2015, the Executive Council has called for nominations in respect of the university panel of the Seanad.

Nurses and midwives are encouraged to support any candidate selected and give a nurse or midwife a voice in Seanad Eireann, speaking for the public health service. It would be a fitting achievement at this point to elect an INMO member to such a position.

One way or another, graduates with the entitlement to vote in the Seanad should use their vote and make the people's decision to keep an upper house a democratic reality.

– Dave Hughes, INMO deputy general secretary

Annual Delegate Conference 2016

The INEC, Killarney Convention Centre
Killarney, Co Kerry
Wednesday to Friday, May 4-6, 2016

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

HOTEL RESERVATIONS FOR ANNUAL DELEGATE CONFERENCE 2016

This year the accommodation will be provided in **The Gleneagle Hotel** and **The Brehon Hotel, Killarney, Co. Kerry**. Three nights B&B accommodation will be reserved for all nominated delegates, from **Wednesday, May 4, 2016 until Saturday, May 7, 2016, inclusive.**

Accommodation is available on a shared basis only. The INMO will not be responsible for any expenses incurred by delegates, other than the agreed package negotiated with the hotels. Delegates who wish to have a single room will be asked to pay the single person supplement. ***Delegates who are unable to arrive on the Wednesday evening, or who are departing earlier than the Saturday morning, May 7, 2016, must inform the hotel and Oona Sugrue. ADC Co-ordinator, as early as possible, but no later than Tuesday, May 3, 2016.***

Following your Branch/Section Annual General Meeting, when ADC delegates are nominated, Branch and Section Secretaries should reserve the required accommodation for their appointed delegates, clearly indicating the number of nights required by delegates, by sending the official INMO Booking form direct to:

Central Reservations, The Gleneagle Hotel, Muckross Road, Killarney, Co. Kerry prior to Thursday, March 31, 2016

All reservations for both The Gleneagle and The Brehon Hotels, Killarney will be made through the Central Reservations Team. All rooms will be allocated on a first-come, first-served basis. Confirmation of hotel bookings will be made direct to the Branch/Section Secretaries, by The Reservations Team in The Gleneagle Hotel.

For all enquiries regarding Annual Delegate Conference, please contact Oona Sugrue, INMO HQ
Tel: 01 664 0636 Email: oona.sugrue@inmo.ie

Transfer of tasks agreed under LRA

Premium pay to be fully restored for 6-8pm period

AS PART of the Lansdowne Road Agreement, the INMO, SIPTU Nursing and the IMO sought that the role of the nurse would be expanded to incorporate involvement by nursing/midwifery grades in undertaking four specified tasks. These are:

- Intravenous cannulation
- Emergency phlebotomy; currently carried out by non consultant hospital doctors
- Intravenous drug administration – first dose
- Nurse/midwife led delegated discharge of patients.

Agreement was dependent on training being provided and agreed staffing levels being in place in order for nurses/midwives to take on these tasks in a safe manner. The INMO, SIPTU Nursing and the IMO engaged in intensive discussions in October and November, 2015. Included in this proposal was the restoration of premium pay of time plus one sixth, which was removed under the Haddington Road Agreement (HRA).

On February 10, the INMO, along with other nursing unions signed off this agreement by the Department of Public Expenditure and Reform and the Department of Health. This means:

- It is accepted that improving patient care is one of the central aims of the proposal and that there will be benefits to patients beyond the acute hospital setting
- It is agreed and accepted that these tasks cannot be the sole responsibility of any one single grade and that nursing/midwifery practice should expand to incorporate them
- The full restoration of nursing/midwifery premium pay of time plus one sixth that was removed from nurses/midwives under the HRA. This equates to a 2% increase in salary and will be paid on July 1, 2016 and backdated to January 1, 2016.

INMO director of industrial relations Phil Ní Sheaghdha said: "This agreement will provide an enhanced service to patients and allow for some improvement in treatment times, ultimately leading to greater efficiency and shorter treatment times for patients. The agreement also provides an opportunity for nurses/midwives to expand their role to incorporate these specific tasks.

"Nurses/midwives will not be the only grade responsible for these tasks, however, they will have opportunities to expand their practice in these areas as staffing levels and appropriate training allows. Nurses and midwives have been expanding their practice in these areas of care in many countries and this has resulted in benefits to patient outcomes. Irish nurses and midwives are perfectly placed to deliver this significant reform to the Irish health service which can only be to the benefit of the patients for whom they provide care."

Phil Ní Sheaghdha, INMO director of industrial relations: *"Nurses and midwives are perfectly placed to deliver this significant reform to the Irish health service which can only be to the benefit of the patients for whom they provide care"*

With regard to time and one sixth, which was removed from nurses/midwives working the period of 6pm to 8pm, Ms Ní Sheaghdha said: "The INMO and other nursing unions have been campaigning to have this restored since that time. This agreement provides for the restoration of time and one sixth to the nurse/midwife which was removed under the HRA."

The next steps are:

- A circular letter will issue from the Department of Health to the HSE, instructing it to commence the process
- The HSE will then issue a circular letter to its own service providers advising them of the agreement and the nature of it
- A meeting with the unions will then take place as the timeframe has now been altered, due to the delay in Department of Public Expenditure and Reform sign off
- A request has been made to the directors of nursing/midwifery by the HSE director of human resources for a joint briefing with the INMO, which needs to take place
- Agreement on the independent chair of the national process
- Set up of local hospital implementation groups will only happen when all of the above steps are in place.

It is anticipated that this will take at least three weeks, if not longer, and at that point, the INMO will notify members of the agreement to set up local hospital groups on this issue. The most important point for our members is that the premium pay which was removed will be restored retrospectively to January 2016 on verification, and that the task can only be transferred in an orderly manner in accordance with the framework agreement.

- *See opposite for questions and answers on this LRA agreement, which can be cut out to keep and copied for your INMO colleagues. Local INMO IROs are also available to clarify any issues in relation to this agreement*

INMO member elected NMBI president

INMO member Essene Cassidy was elected president of the Nursing and Midwifery Board of Ireland (NMBI) at a meeting of the board last month.

INMO president Claire Mahon, the Executive Council, general secretary Liam Doran, members and staff of the Organisation extended their congratulations to Ms Cassidy on her election and send her best wishes for her term as NMBI president.

Mr Doran said the Organisation looked forward to working with Ms Cassidy and her fellow board members, in the task of ensuring that nurses and midwives have a strong regulatory body which best protects the public by ensuring that the professions can practise safely and to the highest standards.

The INMO also extended its congratulations to INMO member Lorraine Clarke-Bishop, who was elected to the Education seat on the NMBI board following the elections in November.

• *See interview, page 26*

LANSDOWNE ROAD AGREEMENT (LRA)

Q&A on Transfer of Tasks

Q1. Has the 'Transfer of Tasks' process agreed under the HRA and LRA concluded?

A. Yes, a lengthy process of negotiation has resulted in an agreement that will enable an orderly transfer of the four identified tasks, *when* staffing levels are agreed and training has taken place.

Q2. What are the four tasks?

A. It is agreed between the parties that the following tasks, including their intrinsic elements, will transfer in accordance with this Agreement from medical staff to nursing/midwifery:

1. Intravenous cannulation, including in the appropriate setting:

- Peripheral cannulation in adults
- Peripheral cannulation in children, which is subject to additional specific protocols and arrangements

Advanced treatments, some of which require specific medications and additional protocols and attendance of a doctor.

2. Phlebotomy

This is currently carried out by NCHDs as distinct from general routine phlebotomy, which is the responsibility of specifically trained and employed phlebotomy staff. This task includes, in the appropriate setting:

- Venepuncture in adults
- Venepuncture in children

3. Intravenous drug administration – first dose; including in the appropriate setting:

- Medication management
- Basic life support training
- Safe use of any medical devices and vascular access devices (VADs) used in order to safely administer IV therapy
- Theoretical knowledge of the medication prescribed in that clinical area (subject to local policy)
- Anaphylaxis treatment.

4. Nurse led delegated discharge of patients.

Q3. Will nurses/midwives be the only grades undertaking these tasks?

A. No, it is agreed and accepted that these tasks cannot be the sole responsibility of any one grade but that nursing/midwifery practice should expand to incorporate them. This should not de-skill medical staff and it is important that they maintain some involvement in order to ensure this does not occur. The appropriate measures required to ensure this occurs will be determined by the clinical director. Nothing in this Agreement diminishes the responsibility of each qualified and trained health professional to carry out such procedures, within their scope of practice, when necessary for patient care or safety.

Q4. What happens in relation to sectors outside the acute hospital?

A. It is agreed that in the context of the implementation of this Agreement in relation to sectors outside the acute hospital sector that engagement will occur between the relevant parties with regard to these tasks and appropriate measures to allow for their implementation in sectors outside the acute hospital settings. Immediate discussions between the HSE and nursing unions will take place in order to agree appropriate arrangements and protocols for change in the relevant sectors.

Q5. Does this mean four different tasks might apply outside of the acute hospital setting?

A. No, the tasks remain the same. However, it may be some time before the service can be adapted and protocols developed to allow nurses and midwives expand practice in locations outside the acute sector. The agreement is specific that if this is the case the requirement in the first instance is for engagement to discuss this process.

Q6. What training will be provided?

A. A detailed document setting out training requirements was agreed as part of this process. It clearly sets out that staffing levels have to be in place to allow nurses/midwives expand practice in these areas. It also sets out the standard requirements in respect of nursing practice in accordance with Nursing and Midwifery Board of Ireland scope of practice guidelines, which are available at **www.nmbi.ie**

Q7. Will this training be working time?

A. Yes, it will be agreed with the director of HR HSE that any classroom training will be working time, and IT based training, which can be undertaken outside of the hospital, will be considered working time also. In a side letter between the chairperson and the INMO director of industrial relations, it states:

"I refer to the paragraph contained in the Transfer of Tasks Agreement concluded on December 1, 2015, which reads as follows:

'The local management group as indicated above will put in place initial and ongoing support arrangements for the provision of training in the relevant tasks, including sufficient appropriate training time'.The Agreement also states that an agreed circular letter will issue to each location, outlining the requirement to prioritise this matter and ensure that the necessary actions are undertaken with immediate effect. I wish to confirm that the HSE will agree to include confirmation that nurses undertaking relevant training in relation to such tasks, as set out in Appendix 1 to the Agreement, will be facilitated with offsite personal training time of not less than two days."

Q8. How will the process begin?

A. A national overseeing group will be set up immediately. The Department of Health, the HSE and trade unions will have a representation on this group and it will be independently chaired. The INMO director of industrial relations will be the INMO representative. This group will be responsible for confirming the terms of this Agreement have been complied with.

Also, they will have the ability to meet individual hospitals if required if difficulties arise. The independent chair will have the final authority in respect of any dispute.

Q9. How will this be organised in the local hospital?

A. There will be a joint local implementation group made up of the chief operating officer, medical director and director of nursing, a representative of the INMO, SIPTU Nursing and the IMO. There will be joint chairs agreed locally at the outset. In order to ensure implementation within the agreed timescales.

Q10. What if staffing levels are disputed?

A. In accordance with the Agreement:

- The local management group as indicated above will put in place initial and ongoing support arrangements for the provision of training in the relevant tasks, including sufficient appropriate training time
- The local management team will prepare a proposal for any additional requirements in relation to staffing, including skill-mix in line with nationally agreed ratios. This will be discussed at the local implementation group. In drawing up this proposal, local managers will prioritise these requirements within pay bill management and control processes and associated accountability requirements. Consideration will also include overall benefits, efficiencies and ongoing savings accruing from the changes as set out above
- Any dispute over this (or any other) aspect relating to implementation will be referred without delay to the National Implementation Group for determination
- The INMO, SIPTU Nursing and the IMO will ensure that, where appropriate, training is provided and adequate staffing levels are in place (subject to above), union members will co-operate fully with the transfer
- Delegation of responsibility for relevant tasks to the appropriate grades in each location will be communicated in writing to the appropriate staff including an indication of the commencement date.

Q11. What if agreement on staffing cannot be reached at local level?

A. The parties would then refer the issues in dispute to the national implementation group. The national group would then either:

a) Meet the local group at hospital level; or

b) Examine the issues raised in correspondence.

Either way the national group would endeavour to assist the parties at local level reach agreement. If this is not possible the independent chair of the national group can make a recommendation which would be accepted by the parties.

Q12. Will time and one sixth be restored as set out in the HRA if transfer of tasks occurs?

A. Yes, the Agreement states that on verification of the training being provided, evidence of tasks transferring and no obstacles being created the payment which was in place prior to the HRA for hours worked between 6pm and 8pm will be reinstated.

Q13. When will payment commence?

A. As soon as the verification has been completed, which should be no later than July 1, 2016 and the payment at that stage will be backdated to January 1, 2016.

Q14. What if the evidence is not there that tasks have transferred but this is not due to staff refusal, but due to training or staffing not being provided?

A. The Agreement is specific that staff cannot be disadvantaged if circumstances outside their control prevent implementation of the Agreement.

Q15. Is the payment of time and one sixth pensionable?

A. Yes it is, as are all other premium payments made.

Q16. Is this payment for the transfer of these tasks?

A. No, the HRA is specific that time and one sixth could be restored to those who work the period 6pm to 8pm by savings generated from changes to work practices including transferring certain duties to nurses/midwives from medical staff. The value of the role of the nurse/midwife following the expansion of the role in this way would then have to be examined as clearly the role would have changed via this process.

Q17. Will this lead to a better service for patients?

A. Yes, the whole point is that interventions such as these can be delivered earlier and in a more timely fashion when led by nursing/midwifery staff. The benefits to patients of these developments are well documented as:

- Earlier treatment and better outcomes for patients
- Consistently delivering on safety targets
- Reduced levels of infection
- Enhances patient recovery which lessens patient stay in acute hospitals
- Reduces bed occupancy by earlier discharge leading to better bed utilisation, and improves patient flow throughout the hospital.

Q18. What benefits would arise outside the acute hospital?

A. The benefits outside of the acute hospital are potentially very important in changing the way health care is delivered. This can lead to a lesser dependency on the acute hospital and ultimately a greater degree of authority and autonomy for the nurses/midwives working in these sectors.

Q19. Why should nurses and midwives take on these tasks?

A. There are a number of benefits to the formal expansion of the role of nurse/midwife in this orderly way;

- The reality is that some of these tasks are being undertaken by nurses and midwives already. However, this is not governed by a national agreement and therefore it is being rolled out in an ad hoc manner without definite agreement between nursing and medical staff in various locations
- Nurses and midwives scope of practice will incorporate these tasks and this will become part of the review of the emerging changed role of the nurse/midwife
- Once staffing levels allow and the nurse/midwife is educated and deemed competent, they will have the authority to undertake these expanded roles within the workplace. This ultimately will increase the profile and general authority of the nursing/midwifery grades and lead to a greater level of satisfaction in respect of the performance of the role in acute hospitals and in services in long-term care/community settings
- This orderly process, governed by agreed rules, will determine the pace and extent of the process. This is safer and fairer than the ad hoc transfer that is occurring in some locations now
- The role and function of nurses and midwives by expanding and changing in this manner will need to be reviewed at the completion of the process with a view to assessing the benefit and extent of this change
- The Haddington Road Agreement and the Lansdowne Road Agreement "Provided for the re-instalment of payment between 6pm and 8pm (time and one sixth). On transfer of these tasks, the Agreement now confirms that this will occur and be paid to all nurses/midwives in all sectors, where it applied prior to July 2013.

INMO welcomes launch of Ireland's first National Maternity Strategy

Full implementation of recommendations now top priority

WELCOMING the launch of Ireland's first National Maternity Strategy by Minister for Health Leo Varadkar last month, the INMO said its full implementation must now be a top priority.

'Creating a Better Future Together: National Maternity Strategy 2016-2026' maps out how Ireland can improve maternity and neonatal care in the years ahead, ensuring that it is safe, standardised, of high-quality and offers a better experience and more choice to women and families.

The INMO Midwives Section particularly welcomes the recognition within the strategy, of the need to give pregnant women appropriate and informed choices, supported by access to the correct level of care and support for their individual needs.

Midwife members also welcome the recognition within the strategy of their role in the natural childbirth experience. In particular, they welcome the recognition of midwives leading and delivering care within the multidisciplinary framework for delivering the care pathway, intended for normal risk mothers and babies (supported care).

The INMO fully endorses the recommendations within the strategy for the development of a community midwifery service. This development will see hospital midwives going out into the community, to provide antenatal and postnatal care, which represents a hugely positive development for mothers and babies, bringing the service to them rather than requiring them to come into a hospital for care and support.

The INMO notes the intention to establish a National Women and Infants Health Programme to drive forward the implementation of the strategy. The Organisation looks forward to working with this programme, to implement in the shortest possible timeframe, all of the recommendations itemised leading to a positive transformation of maternity services in Ireland.

In the short term the INMO will seek a meeting with the Department of Health, with a view to agreeing the necessary measures, particularly on workforce planning, including an analysis of training requirements needed to ensure the provision of additional midwives required to facilitate the full implementation of this strategy.

INMO Executive Council member and member of the Maternity Strategy Steering Group, Mary Gorman said: "This strategy, which was formulated after detailed discussion involving all partners in maternity care, represents a step change in our approach to pregnancy and childbirth. The recommendations place the mother and child at the centre of all services and will require all members of the multidisciplinary team to alter existing approaches to facilitate new models of care, totally sympathetic to the mother and newborn baby".

INMO general secretary, Liam Doran, said: "The INMO acknowledges the dedicated work of the steering group, leading to the launch of this forward-looking strategy. The

INMO and particularly the Midwives Section, commits itself to work with all concerned to deliver upon the strategy's recommendations. The collective goal must be to ensure excellent standards of care, in the environment chosen by the mother, based on their needs and preferences.

"The recognition of the role of midwives within the new pathways of care is very welcome. Our midwife members look forward to embracing this change and providing these new models of care and choice for women".

The National Maternity Strategy 2016-2026 can be found on: **www.health.gov.ie**

Safe staffing agreed for Coombe delivery suite

FOLLOWING extensive negotiations at the Workplace Relations Commission, the INMO and the Coombe Women's Hospital management agreed safe skill mix levels in the delivery suite, which in turn allows rotation of staff to recommence in the hospital.

A dispute arose following proposals by management to redeploy two-thirds of senior midwives out of the delivery suite, over a very short time frame, which, in the view of INMO members would have led to an unsafe clinical environment for mothers and infants.

During protracted negotiations, over a number of days at the WRC, hospital management accepted that in addition to two CMM2s, three senior midwives must be on duty on a 24/7 basis. This means that the delivery suite roster must have a minimum of 16.5 WTEs senior midwives in place before rotation of senior midwives can take place.

Agreement was also reached on the criteria to define the role of a senior midwife. A CMM3 and CMM2 group would examine if midwives meet this criteria. An internal appeal mechanism was also agreed if agreement could not be reached. This appeal procedure would have the final say on the matter.

Speaking on the issue, INMO IRO Joe Hoolan said: "Our members showed great leadership and determination in demanding safe skill mix on this unit at all times. Through their efforts and unified approach, their unit will now have the appropriate skill mix of CMMs and senior midwives which allows support to other staff and enhances safe mother and infant care on the delivery suite".

Spotlight on Third Level Student Health Nurses Section

Last year saw a continued focus and resurgence of the Third Level Student Health Nurses Section, which aims to consolidate and support nurses employed in third level educational institutions. We aim to ensure the delivery of best practice to promote and advance student health. The section promotes agreed professional standards of nursing practice in accordance with the guidelines set down by the Nursing and Midwifery Board of Ireland. We are a source of expertise on nursing practice in areas of student health and facilitate continuing education and professional development. This is an invaluable support network for those employed in the area of student health.

Our educational officer liaised with members regularly throughout 2015, enabling members to keep up-to-date with recent developments and provided information relating to the Professional Development Centre at the INMO. Participation was encouraged in important online surveys. The education officer assisted with organisation and booking of expert speakers who provided education and professional updates on infectious diseases/skin conditions, oral contraceptives and mindfulness and meditation for holistic nursing.

Section Officers

Chairperson

Alice Meagher
Alice.meagher@lit.ie

Vice chairperson

Deirdre Adamson
ahealth@dit.ie

Secretary

Laura Tully
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Education officer

Michelle Cresswell
michelle.cresswell@ittdublin.ie

Treasurer

Orlagh Fleming
orlagh.fleming@ittdublin.ie

Affiliation Form for INMO Section Membership

Name:_____

INMO membership No:_____

Home Address:_____

_____

_____

Tel (work):_____

Tel (home/mobile):_____

Email:_____

Place of employment:_____

Job title:_____

Second section option (to obtain information only):

_____

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

Tick ONE relevant Section you wish to affiliate with

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

Section roundup

Telephone Triage Section

THE next Telephone Triage meeting, which will be held on April 12 in the Heritage Hotel, Portlaoise, will include a session on preparing for HIQA. Booking is essential and the session will be accredited. Log on to **www.inmoprofessional.ie** to book your place or contact the INMO at Tel: 01 664 0600

School Nurses Section

A SESSION on medication management in the school setting will be held at the next School Nurses Section meeting on April 16.

Members of the Section are invited to attend this informative event which will be held in the Heritage Hotel, Portlaoise. If you are working in a school setting and have colleagues also working in this setting, please ensure that they are aligned to their national section by contacting the INMO at email: membership@inmo.ie

Call for ODNs to enter annual poster competition

AS THE ODN Section conference approaches, submissions are now welcome for the Section's annual poster competition *(see page 66)*.

This year's conference, the theme of which is 'perioperative nurses – the vital link for excellence in patient care', will be held on April 15 and 16 in the Clarion Hotel, Liffey Valley, Dublin.

The poster competition is sponsored by Tekno Surgical and has a total prize fund of €1,000, which may be awarded to multiple winners, depending on the entries.

Posters must be original work and an abstracts on the posters will be included in the printed conference proceedings.

The closing dates for poster entries is Friday, March 25 and entrants are required to have their poster erected prior to the opening of the conference on Friday, April 15.

Entrants must also be available at peak viewing times throughout the conference to meet with the judges.

Members are encouraged to submit a poster as this is a great opportunity to share your work with your perioperative colleagues.

There is a reduced conference fee of 50% for members who enter the poster competition (one reduction per poster entered).

For full criteria and guidelines email: helen.oconnell@inmo.ie or log onto **www.inmo.ie** for further details.

ED nurses urged to get involved in Section

THE Emergency Department Nurses Section, which is in the process of being re-established, is set to give members the opportunity to link up with colleagues from across the country for ongoing specialised networking, information sharing and support.

Members can connect with fellow nurses and midwives through the INMO national section network, where there are currently 25 active sections.

A meeting has been organised for Monday, March 7, 2016 from 12pm to 2pm in INMO HQ.

During this meeting, a committee will be elected to run the section and set out goals for the coming year.

All ED nurses are welcome to attend this meeting.

Violence in the health sector – a broader view

The Fifth International Conference on Violence in the Health Sector is being hosted by Ireland this autumn, writes **Elizabeth Adams**

THE LARGEST worldwide conference dedicated to workplace aggression and violence within the health and social services sector is set to take place in Ireland this year, when the Fifth International Conference on Violence in the Health Sector comes to Dublin from October 26-28, 2016. This follows four successful international conferences on Violence in the Health Sector in Amsterdam (2008 and 2010), Vancouver (2012), and Miami, US (2014).

The theme of this year's conference is *'Broadening our view – responding together'*. The Dublin venue (the Crowne Plaza Hotel and Conference Centre, Santry) marks a homecoming for Irish nurse, Dr Kevin McKenna, lecturer with Dundalk Institute of Technology. Dr McKenna is a founding member and has co-chaired both the organisation and scientific committees of the International Conference on Violence in the Health Sector since its inception in 2008. In partnership with Bord Fáilte, the Dublin Convention Bureau, and Dundalk Institute of Technology, Dr McKenna has led the initiative to have Dublin selected as the host venue for the 2016 conference.

Work related aggression and violence within the health and social services sector is a major problem that diminishes the quality of working life for staff, compromises organisational effectiveness and ultimately impacts negatively on the provision and quality of care. These problems pervade both service settings and occupational groups. Dr McKenna completed his doctorate in this subject area with the RCSI, Dublin, and has led a number of national and international projects, including formulation of the Linking Service and Safety strategy for managing work-related aggression in Irish healthcare in which the INMO played a key role.

Together with Prof Ian Needham (chair) and Nico Oud (organiser), Dr McKenna has worked collaboratively with many national nursing associations under the umbrella of the International Council of Nurses for more than a decade in delivering this international conference. This conference is supported by over 40 national and international agencies including the International Council of Nurses, International Labour Organization, Public Services International, World Medical Association, International Hospital Federation, American Nurses Association, Sigma Theta Tau International and the International Alliance of Patient Organisations. The INMO is active in the local planning committee to support the hosting of the 2016 conference.

Considerable advancement in addressing the problem of aggression and violence in health and social care have been achieved from educational, research, practice, service and organisational perspectives nationally and internationally. In addition to raising awareness, the 2016 conference will provide a platform to share these international developments, with a particular emphasis on best practice research and initiatives to effectively respond to the problem. The specific aims of this year's conference are:

- To sensitise stakeholders to the issue of workplace violence in health/social care
- To offer multiple perspectives of violence – including biological, spiritual, experiential, legal, political and societal – so as to enhance our understanding of the topic
- To exchange experiences and strategies to effectively respond to the problem of workplace violence in order to encourage collaborative responses.

The conference provides a unique opportunity for nurses and midwives to network with a diverse community of colleagues engaged in this important area of work. Apart from the geographical diversity of delegates, there is also a multiplicity of perspectives including clinical/service, organisational, educational, research and regulatory. The conference sub-themes cover many concepts including:

- Economical aspects and implications of violence in healthcare
- Gender aspects and implications of violence in healthcare
- Legal and/or ethical aspects and implications for employers and employees
- Policies and strategies on workplace violence including local, national, and international and global guidelines, standards, reporting, prediction, risk assessment, prevention, management, after care and rehabilitation
- Scientific, methodological, operational aspects and instruments regarding workplace violence
- Social and psychological theoretical perspectives on workplace violence
- Staff training and education issues regarding workplace violence
- Violence towards patients and horizontal violence.

In addition to receiving a book of proceedings which includes abstracts and/or full papers by all presenters, all delegates attending will also receive a certificate of International Continuing Nursing Education Credits (ICNECs) from the ICN which is internationally accepted as continuing professional development.

Irish nurses and midwives are invited to submit an abstract for consideration as a conference workshop, an oral presentation or as a poster presentation. To submit an abstract or for further information on the conference see: **www.oudconsultancy.nl/dublin_5_ICWV/index.html**

Elizabeth Adams, INMO director of professional development, was actively involved with this conference during her tenure as consultant for nursing and health policy with the International Council of Nurses in Geneva

Q and A Bulletin Board

With INMO director of industrial relations Phil Ní Sheaghdha

Query from member

I am currently on a period of unpaid maternity leave. Will I lose all my annual leave entitlements during this period of time?

Reply

Thank you for query. While on unpaid maternity leave, you are regarded as being in employment and should retain all employment rights, such as annual leave.

During your 16 weeks of unpaid maternity leave, you can accrue annual leave and you should not lose any annual leave. You also accrue any public holidays that occur during this time. Annual leave that is accrued during unpaid maternity leave can be taken at a time that is agreed between the employee and the employer and any public holidays that accrue will be added to the end of the period of unpaid maternity leave.

While on parental leave, the same rules apply, you accrue your annual leave and any public holidays that may fall during this time.

While on either unpaid maternity leave or parental leave, you are entitled to continue to receive your increments and your incremental date should not change.

However, as this period of time is unpaid, you do not contribute to the HSE superannuation scheme, so this period is not reckonable for pension purposes.

Query from member

I work in the intellectual disability sector and have been asked to attend training on the 'Safeguarding Vulnerable Persons at Risk of Abuse' policy. Has this policy been agreed nationally? I am worried about the impact that this policy will have on my already overburdened day-to-day duties.

Reply

Thank you for your question. I can understand your concerns regarding the roll-out of this policy. In 2015, INMO members objected to this policy based on the lack of consultation with them and also the additional responsibilities it appears would be placed on INMO members regarding roles currently undertaken by other grades within the health services.

The Organisation has written to HSE management requesting that no implementation or training be requested of any INMO member until full consultation has taken place with the INMO and other unions at national level.

You should advise your manager of these facts if requested to partake in training or if other changes to your current role are suggested.

We will advise members when this consultation meeting is scheduled and update all members following the meeting. Should you have any further queries or questions, please contact your regional industrial relations officer who will be able to assist you further.

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

Quality & Safety

A column by Maureen Flynn

All in this together – experience based co-design

EXPERIENCE based co-design (EBCD) is an approach to improve healthcare services combining participatory and user experience (EB) and design tools and processes (CD) to bring about quality improvements. Staff, patients and carers use a co-design process to reflect on their experiences of a service, work together to identify improvement priorities, and to devise and implement changes. Jointly staff, service users and carers reflect and celebrate their achievements.[1] The EBCD approach however, incorporates experiences of service users/carers and staff via user-centric design methods to develop practical solutions that could positively impact on service users' experiences of healthcare.

Where did EBCD come from?

A decade ago an EBCD approach to improve patient experience was first piloted in a head and neck cancer service at Luton and Dunstable NHS hospital. To date there are over 80 reported EBCD projects in seven different countries.[2]

There were four overlapping strands of thought which contributed to the development of the EBCD approach:

- Participatory action research
- User-centred design – focus on the user's direct input in design
- Learning theory – learning in different ways
- Narrative-based approaches to change – telling the story.[1]

What is involved?

The EBCD cycle is divided into six stages *(see Figure)*:

- Setting up the project
- Gathering staff experiences through observational fieldwork and in-depth interviews
- Gathering patient and carer experiences through observation and 12-15 filmed narrative-based interviews
- Bringing staff, patients and carers together in a first co-design event to share, prompted by a short edited 'trigger' film of patient narratives, their experiences of a service and identify priorities for change
- Sustained co-design work in small groups formed around those priorities
- A celebration and review event.[3]

Why use EBCD in practice?

EBCD acknowledges emotions and experiences rather than attitudes and assumptions. These 'touch points' are catalysts for driving improvements. EBCD blends the aesthetics of what it feels like, with performance (functionality) and engineering (safety) to design improvements. The engagement of staff with service users/carers as partners with shared purpose improves communication and services, acknowledging we are all in this together to improve our healthcare.

Overall the process includes:

- Gathering experience information, observations, interviews
- Prioritise and agree key issues (touch points, critical points, good and bad, moments of truth, emotional hotspots)
- Patients/staff co-design solutions together.

International examples where EBCD has been used to improve experiences of giving and receiving care include:

- The productive operating theatre (TPOT, Ireland) – in progress
- Community mental health (Ireland)
- Emergency departments (Australia)
- Carers of chemotherapy (UK)
- Accelerated EBCD in lung cancer services and ICUs (UK)
- Mental health settings (international).

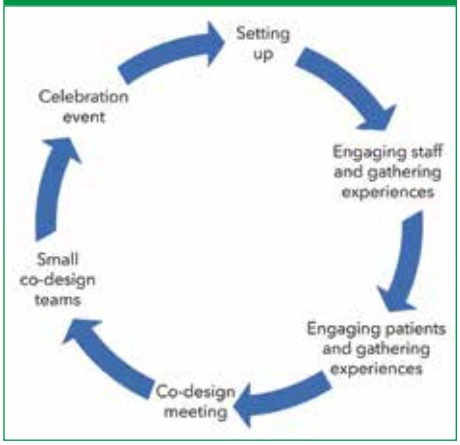
Get involved

At your next ward, unit or team meeting why not talk about how you engage with patients and families in designing care. If you would like to consider an EBCD project, supports are available through quality improvement teams locally and nationally. Project management principles strengthen the approach. Questions to consider:

- Is the EBCD project a standalone initiative or integrated with other initiatives?
- Will the project focus on experience, efficiency, safety or wider improvement issues?
- What is the focus of the project (area, department and/or speciality)?
- What is the strategy for leading it?
- To whom and how will the project be reported and who is accountable?
- What measurement strategy will be used to measure impact and sustainability of changes on experience and processes?
- Is there an evaluation planned?
- Ethical considerations must be observed in EBCD Quality Improvement (QI) projects and ethical approval should be sought for EBCD research activity.

Experience based co-design can link experience based practice to evidence based practices. When managed carefully EBCD brings groups together to work effectively towards common goals. It provides a mechanism to communicate and strengthen relationships/teams.

Experience based co-design six stage process



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

Acknowledgements
A particular thanks to Deirdre Munro and Lorraine Murphy for sharing their experience of EBCD and assistance in preparing this column. Special thanks also to Prof Glenn Robert, Kings College London for openly sharing publications and workshop material (2015/2016)

References on request. Resources available on http://www.kingsfund.org.uk/projects/ebcd
Contact: Deirdre Munro, QID HSE Email: deirdre.munro@hse.ie and Lorraine Murphy, QI Advisor Email: lorrainew.murphy@hse.ie

On the ground with the president

Strategy and initiative on nursing and midwifery values

CHIEF nursing officer, Dr Siobhan O'Halloran, joined by the Minister for Health, Leo Varadkar, launched her Office's Strategy for 2015-2017 along with an initiative on nursing and midwifery values, which I attended.

At the launch of the Strategy and initiative on nursing and midwifery values were (l-r): Liam Doran, INMO general secretary; Dr Philippa Ryan Withero, deputy chief nursing officer; Claire Mahon, INMO president; Leo Varadkar, Minister for Health; Dr Siobhan O'Halloran, chief nursing officer; Dr Anne-Marie Ryan, deputy chief nursing officer; and Susan Kent, deputy chief nursing officer

The Strategy is to ensure a broad understanding of the role of the CNO's Office across government and its role in developing health policy. It sets out the vision, mission and values for the Office. It also highlights the Office's strategic objectives until the end of 2017.

In addition, a communication and consultation initiative to affirm the values that underpin nursing and midwifery practice has been developed. The goal is to ensure that the values of care, compassion and competence are re-inforced in nursing and midwifery practice and culture across all settings. The initiative will involve extensive consultation with stakeholders and will develop a repository of good practice. This will help the nursing and midwifery professions contribute to a culture of safe patient care.

Interim report on nurse staffing/skill mix

I ALSO attended the recent launch of the *Interim Report on Staffing and Skill Mix for Nursing*, by the Minister for Health, Leo Varadkar and the chief nursing officer, Siobhan O'Halloran. This report was welcomed by the INMO. It was a positive day for nursing and a critical step in ensuring safe staffing levels on medical and surgical wards.

My key priority as president was to seek the establishment of safe minimum nurse and midwifery staffing levels. The Taskforce on Staffing and Skill Mix for Nursing was established in response to the INMO's 'Safe Staffing Campaign', launched in May 2014, due to the reduction in nurse staffing levels, on inpatient wards, arising from the ban on nurse recruitment.

I am delighted at the development of this framework for safe nurse staffing and skill mix in general and specialist medical and surgical care settings in adult hospitals in Ireland and the commitment to move, immediately, to pilot the interim recommendations. It offers the opportunity to move from staffing levels controlled by finances, to staffing levels governed by patient need and acuity as determined and applied by nursing staff.

ED dispute resolved

SINCE my last column, our ED members voted to accept the revised proposals in the ED dispute. The emphasis is now on implementation of the agreement in full, in the country's 26 EDs and the Organisation will continue to monitor this. The INMO will continue to seek additional beds, staff and services across the health service.

National Maternity Strategy 2016-2026

WE WARMLY welcomed the launch by the Minister for Health of the first National Maternity Strategy 2016-2026 – *Creating a Better Future Together.*

The Midwives Section, in particular, welcomes the recognition, within the strategy, of the need to give pregnant women appropriate and informed choices, supported by access to the correct level of care and support for their individual needs.

Branch meetings

I WAS out and about over the last few weeks meeting members on the ground at information, branch and section meetings. These gatherings are very informative and important events in our calendar.

Many branches put forward members for election to the Executive Council and I would like to thank those members for their interest in working on behalf of the Organisation.

As you can see there have been a number of positive developments within the nursing and midwifery professions over the last month. I am pleased to have been able to bring you some good news for change.

Get in touch

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

Claire

Breaking new ground

New president of the NMBI, Essene Cassidy, talks to **Tara Horan** about the challenges ahead in her term of office

ESSENE CASSIDY is no stranger to breaking new ground in her nursing career. She has moved seamlessly along an unworn path from children's nursing, through general nurse training and on to public health nursing, the latter as one of the first non-midwives to be permitted to enter that field as a postgraduate.

Now, since her election as president of the Nursing and Midwifery Board of Ireland (NMBI), Ms Cassidy is approaching her new role with a refreshing confidence and zeal. She was elected to the board of the newly-structured NMBI in October 2012, as the representative for public health nursing. This was the first board convened under the Nurses and Midwives Act 2011, which significantly reformed the regulation of nurses and midwives and meant a large body of work was on the cards to oversee the reforms.

"We began with a new board structure and a new Act. The CEO, Dr Maura Pidgeon, was also new just before we came in and she led us through this period of significant progress for nursing and midwifery," said Ms Cassidy.

Ms Cassidy is keen to promote all the essential work that the NMBI does, both in protecting the public and for the professions of nursing and midwifery.

"As the inaugural board, we did a lot of hard work in starting to address the issues of most relevance to the registrants and also to maintain public protection.

"I understood the distinct roles of public protection and promotion of the profession very quickly, and can wear different hats on different days. Although I am a nurse and a union member, I am able to represent whichever sphere I'm in at a given time."

Ms Cassidy is a registered children's, general and public health nurse with more than 25 years experience since she graduated from Temple St Children's Hospital, with which she still feels great affinity. She is currently an assistant director of public health nursing attached to the Early Years Inspectorate, Tusla, to which she was appointed in October 2014. Tusla is also breaking new ground since its inception in January 2014, when it became the dedicated State agency responsible for improving wellbeing and outcomes for children. This was the most comprehensive reform of child protection, early intervention and family support services ever undertaken in Ireland.

A member of the INMO throughout her career, Ms Cassidy became involved in the Waterford Branch and served as a workplace representative for Waterford Community Services in 2011, under the guidance of INMO IRO Liz Curran. She also became involved in the INMO PHN Section, which perhaps was the impetus for her running as the PHN representative on the new NMBI board.

Ms Cassidy said she hopes to bring her nursing experience gained across all of these roles and grades to her appointment. "I look forward to continuing, with my colleagues on the board, the reform and progress at the NMBI, and continuing the work that has taken place since the enactment of the 2011 Act."

She succeeds Paul Gallagher as president, who finished his three-year term of office in December 2015.

"I think it is important in this second term of the board that there is continuity between the old board and the new one, and I feel that I have the experience and the knowledge of what we've been through."

The 2011 Act enhances the protection of the public in its dealings with the professions of nursing and midwifery, while ensuring the integrity of the practice of the professions. The board comprises 23 members with a lay majority of 12. Of the remaining 11 members, eight are registered nurses and midwives elected by the professions.

"I acknowledge that the general perception of the NMBI is about the retention fee and fitness to practise issues. However, the board does so much other good work that hasn't been marketed to date.

"I want us to be transparent, to be relevant and visible to registrants. I want us to be seen as a good thing, not something to be afraid of. The key to this is for the NMBI to go out on roadshows so people can put a face to who we are and hear about the other work we do. We have to work more in partnership with our key stakeholders who are the staff organisations, the registrants and the Department of Health. We are all on the one journey, we are all here to do the same things, which is to protect the public and promote the professions."

The NMBI has just relaunched its website, **www.nmbi.ie**, which it hopes will keep registrants more up to date on developments in the future.

While on the first board, Ms Cassidy's work focused on two main areas – ethics and fitness to practise. As chair of the

NMBI ethics committee from 2012-15, she supported the revision and development of the updated Codes of Professional Conduct and Ethics for Nurses and Midwives and the Scope of Practice Framework for Nurses and Midwives, and the ongoing revision of the Medication Management Guidelines.

Ms Cassidy was recently invited by Chief Nursing Officer, Dr Siobhan O'Halloran, to represent the NMBI on her Office's three-year 'Strategy and Initiative on Nursing and Midwifery Values', which was launched last month.

"This is a fantastic honour for me to be working in partnership with the Chief Nurse in the Department of Health, and with Mary Wynne, nursing and midwifery services director in the HSE. It's a really good opportunity for the NMBI to move forward and proactively market what it does."

Fitness to practise

There are currently two separate fitness to practise processes running in parallel. One committee deals with older cases still being dealt with under the 1985 Act, with its recommendations just coming to the board at final approval stage.

All complaints received on or after October 2, 2012 fall under the 2011 Act and these are dealt with by the new Fitness to Practise Committee, on which Ms Cassidy sat as vice chair, with Noel Giblin as the chair.

In a new departure under the 2011 Act, fitness to practise inquiries are now generally held in public. However, ahead of this, the new Act provided for the creation of a Preliminary Proceedings Committee (PPC), separate from the Fitness to Practise Committee. This committee screens complaints received against registrants and only refers those with a *prima facia* case to the Fitness to Practise Committee for inquiry.

Ms Cassidy sees this as a great improvement on the 1985 Act structure.

"Under the 2011 Act we are trying to keep a forward momentum going. The complaint goes to the PPC first, which considers the complaint and the registrant's response, and decides whether there is a *prima facia* case."

To date under the 2011 Act, less than 20% of complaints go forward to the Fitness to Practise Committee as *prima facia* cases. The board members receive copies of all the documentation on what was considered and the registrant's response to the complaint. In the majority of cases the board will agree that there was no *prima facia* case. "The PPC is doing sterling work; it's our filter before full inquiry."

Ms Cassidy said the new Fitness to Practise Committee worked hard on setting up a structure for the 2011 Act. A panel of inquiry is convened for each complaint, made up of five people, with a lay majority.

While there was some controversy initially about the amount of publicity given about an upcoming inquiry, the current procedure is that a notice is put on the NMBI website and sent to the media, giving the date that an inquiry is to be held and no further details.

Retention fee

The biggest area of contention faced by the NMBI in the past year must have been the campaign against its attempt to raise the annual registration retention fee paid by all nurses and midwives.

"The retention fee issue was extremely divisive. We acknowledge that and what's done is done. However, the decision to increase it was reversed and it is now capped at €100 under the Lansdowne Road Agreement," said Ms Cassidy.

"The increase was sought on the basis of the information that the board was provided with in relation to the implementation of the 2011 Act. While the board is aware of the significant financial constraints that registrants are under, this has to be married with the fact that the NMBI is self-funding and our only source of funding is from our registrants. So when we want to work on developments and want to roll out on initiatives, we have to figure out how we are going to fund them.

"The financing of the NMBI is something that the board is actively working on. Being cognisant of the pressures on our registrants, we are also looking at flexible payment arrangements, to make it easier for them to maintain their registration."

Professional development

The NMBI plays a pivotal role in nursing and midwifery education in Ireland. Undergraduate and postgraduate programmes in nursing and midwifery in the country's 14 higher level institutions must comply with the standards and requirements set down by the NMBI. The NMBI also approves continuing professional development (CPD) courses, including those run by the INMO Professional Development Centre.

Part 11 of the 2011 Act provides, for the first time, a statutory basis for maintenance of continuing competence of registered nurses and midwives. When this part of the Act is commenced by the Minister for Health, the NMBI will have a one year period to develop, establish and operate one or more schemes to monitor the maintenance of professional competence by registered nurses and midwives.

The NMBI recognises and supports the importance of CPD to nurses and midwives throughout their professional careers. "As my own career shows, you don't stop learning as a nurse. You have to always think of the post you are in and what you can do to supplement your role. Often that means stepping outside of nursing and perhaps doing a multidisciplinary course to give you a different perspective. Diversity encourages healthy debate and gives us a wider view of what is required," said Ms Cassidy.

"We are going through a period of transition. We have significant organisational change to implement and achieve. As a board, we've learned a lot since our inception under the new Act. We are moving forward – it is an exciting time. Once we get through this period of transition, I want to see at the end of my tenure that we have delivered on the organisational change and we have an organisation that is future-proofed, fit for purpose and relevant to the registrants and our key stakeholders."

A native of Waterford City, Ms Cassidy moved to Dublin, with her husband and four children, last year, following her appointment to Tusla. Educated to Masters level at UCD in child health, Ms Cassidy also has a Higher Diploma in rehabilitation management from UCD, a HDip in public health nursing from UCC, and a Bachelor of nursing studies from TCD.

The NMBI's core functions

- Maintaining the Register of Nurses and Midwives
- Evaluating applications from Irish and overseas applicants who want to practise as nurses and midwives in Ireland
- Supporting nurses and midwives to provide care by developing standards and guidance that they can use in their day-to-day practice
- Setting requirements for nursing and midwifery educational programmes in higher level institutions
- Investigating complaints made by patients, their families, healthcare professionals, employers and including Fitness to Practise inquiries

New plans to ease trolley crisis

Progress in the ED crisis and the much welcomed Nurse Staffing/ Skill Mix report hit the headlines this month, **Ann Keating** reports

ED crisis

THE *Irish Independent* (February 6) ran a headline – **Nurses back plan aimed at easing trolleys crisis as 71pc vote in favour**. "The threat of hospital strike action by nurses has been lifted – but their union has warned that there can be no slide in agreed measures to reduce emergency department overcrowding. The return of industrial peace came after the Irish Nurses and Midwives Organisation accepted, by a margin of 71%to 29%, the revised proposals to trigger a series of measures aimed at easing the trolley crisis when overcrowding reaches a certain level. The proposals were agreed by the Workplace Relations Commission last month and involve a range of actions, including cancellation of operations, doctors doing more ward rounds to discharge patients and ultimately placing patients on trolleys in wards in order to make space in the emergency department." Liam Doran said: "There is also the ongoing problem of insufficient hospital beds and additional beds are essential if there is to be a significant dent in the trolley figures." He said: "Our members constantly stated, in all of the information meetings held recently, that this was never about pay and conditions. It was all about ensuring the unacceptable situation in emergency departments was prioritised by management."

Transfer of tasks

Nurses to get €20 weekly rise in 'win-win' deal was a headline in the *Irish Examiner* (February 11). "Nurses are set to receive a pay boost of an average of €20 per week following an agreement that will see them taking on four tasks usually carried out by doctors. The deal essentially sees the restoration of the 'unsocial hours' payment which nurses received for working in the evenings. The Irish Nurses and Midwives Organisation…took part in discussions as part of the Lansdowne Road Agreement, during October and November of last year, to agree the expansion of nursing and midwifery practice and restore premium pay of time plus one-sixth which was removed from nurses and midwives under the Haddington Road Agreement. The four tasks, previously carried out by doctors, are: Intravenous cannulation, emergency phlebotomy that is currently carried out by non-consultant hospital doctors, intravenous drug administration – first dose and nurse or midwife-led delegated discharge of patients…The deal is dependent on training being provided and agreed staffing levels being in place in order for nurses and midwives to take on these tasks in a safe manner. It was also agreed that these tasks cannot be the sole responsibility of any one single grade but that nursing/midwifery practice should expand to incorporate them…Phil Ni Sheaghdha said the deal would allow for an enhanced service to patients."

Nurse Staffing/Skill Mix

The *Evening Echo* (February 4) reported that **Nursing Group welcome report**. "The Irish Nurses and Midwives Organisation welcomed an *Interim Report on Nurse Staffing/Skill Mix* and a government commitment to move to pilot its recommendations. The Taskforce recommendations, and its approach to determining staffing levels, will, when rolled out nationally, avoid any repeat of the recent years when there was no floor, to nurse staffing levels, and reductions took place without any assessment of impact upon patients or upon the nursing staff and their ability to provide safe care. INMO general secretary, Liam Doran said: "This is a very positive day for nursing in Ireland. The Taskforce work, and its recommendations, offer the opportunity to move away from staffing levels determined, solely by finances, to staffing levels consistently being determined by patient need and acuity as determined and applied, by nursing staff. That is the way forward. It will, in future, prevent the dramatic reduction in nurse staffing levels which has taken place in recent years without any measure of the negative impact upon patients or staff as a result."

The story was also covered in the *Irish Examiner* (February 2) with the headline **New nursing plan for wards**. "A new model of nursing care where wards are staffed according to how sick patients are rather than ward size or cost will shortly be trialled in three hospitals under a €2 million pilot scheme. If it proves viable following testing throughout 2016, it will be rolled out nationally, ending the current 'one size fits all approach' to calculating ward staffing levels."

Maternity Strategy

The *Irish Examiner* (January 28) gave space to the launch of the Maternity Strategy – **Focus finally put on the mother – Overhaul of maternity services**. "It is not before its time that women are to be offered as natural a birth as possible, in a safe environment, under the new National Maternity Strategy…The plan promises to put women and families at the centre of all services and to treat them with dignity and compassion. The new strategy will involve the establishment of a new community midwifery service which is designed to facilitate better continuity of care and more choice in birth, with better information and communication throughout the different stages of pregnancy and birth. The announcement of the strategy yesterday has, understandably, been given a broad welcome by the medical profession, in particular the Irish Nurses and Midwives Organisation, a group that is never slow to criticise health services."

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

Commemorative Publication

March 2016

1916

Nurses and Midwives in the 1916 Easter Rising

Image credits:
O'Connell Bridge (Kelly's Corner, D.B.C. & Eden Quay) and Portico of General Post Office. Both pictures by TJ Westropp, May 17, 1916
By permission of the Royal Irish Academy © RIA

Pull Out

Image by TJ Westropp, General Post Office, flag staff at corner, May 17 [1916]. By permission of the Royal Irish Academy © RIA

Altraí agus Mná Cabhrach in Éirí amach na Cásca 1916

Mark Loughrey examines the role played by nurses and midwives in the events that took place in Dublin at Easter 1916

IN OCTOBER 1921, the Minister for Labour in the new Dáil Éireann, the republican, Countess Markievicz, wrote a letter to the Irish Nurses' Union, the precursor to the present day Irish Nurses and Midwives Organisation (INMO). Countess Markievicz was seemingly concerned at information she had received which suggested that the governors of the Meath Hospital, Dublin, were advertising for a nurse trained in England to fill the position of matron and asked if the Nurses' Union could shed any light on the matter.[1] Having made enquiries, the Union replied to Markievicz and indicated that the Meath governors sought an Irish nurse who had merely trained in England, where there was a larger range of training hospitals.[2] Hence, the Union had no objection to the advertisement and it seems that the Minister did not pursue the matter any further.

The sentiments expressed in Markievicz's letter point up the hostility to British rule that existed in Ireland at the time. That hostility increased with events that took place five years earlier in 1916, the year that witnessed the failed Easter uprising against British rule. The subsequent execution of the leaders of the Rising and the deportation and imprisonment of many of the rebels who took part, engendered outrage among the Irish public. The resultant heightening of nationalist sentiment led to the War of Independence, the rise of Sinn Féin and, ultimately, the establishment of the Irish Free State.

While the Rising's central protagonists have been the subject of much historical enquiry, many others who played a role in the events of Easter week 1916 have been overlooked. Among those overlooked are the many hospital staff, particularly the nurses and midwives, who tended to the wounded, partook in the conflict or lost their lives in it.

This article aims to shine a light on some of these women some 80 years after the INMO first commemorated the event by taking part in a remembrance procession through Dublin in 1935.[3]

Home Rule, under which Ireland would receive a modicum of independence, was insufficient to placate those who envisaged a more independent Ireland. In 1914, a dissident group known as the Irish Volunteers, became increasingly disillusioned with Ireland's status as part of the British Empire. A sub-group within the volunteers, the Irish Republican Brotherhood, was intent on holding an armed uprising against British rule and other nationalist groups, the Irish Citizens' Army and the women's auxiliary, Cumann na mBan, agreed to co-operate. On Easter Monday, April 24, 1916, these rebels[4] gathered in Dublin, proclaimed an Irish Republic and took control of a number of sites of strategic importance, among them the General Post Office (GPO), St Stephen's Green public park and the Four Courts.

From the outset, the rebels' plans went awry. Volunteers received mixed messages regarding the proposed date for the insurrection – some were stood down altogether – and a boat carrying German arms to aid the rebel assault was intercepted as it approached Tralee Bay, Co Kerry. As the conflict progressed, more and more soldiers arrived in Dublin and surrender by the rebels after six days of bloody conflict became inevitable.

Some 450 people were killed during the Easter Rising: 116 members of the military; 16 policemen; 64 rebels; and 254 civilians. A further 2,614 were wounded.[5]

The casualty toll placed an enormous strain on the city's hospitals and staff. Of the 700 people seen at the Charitable Infirmary, Jervis Street,[6] 38 were pronounced dead on arrival and 43 died in total.[7]

Located beside the rebel-occupied

Jacob's Biscuit Factory, the Adelaide Hospital[8] was also at the centre of events. There, five people were brought in dead and 70 were brought in wounded, four of whom later died.[9] Dublin's Royal Victoria Eye and Ear Hospital also found itself overstretched. In an effort to relieve the burden on surrounding institutions, that hospital's matron offered its 30 empty beds to the wounded. Some 50 injured soldiers soon arrived, some of whom had to be accommodated in neighbouring homes.[10]

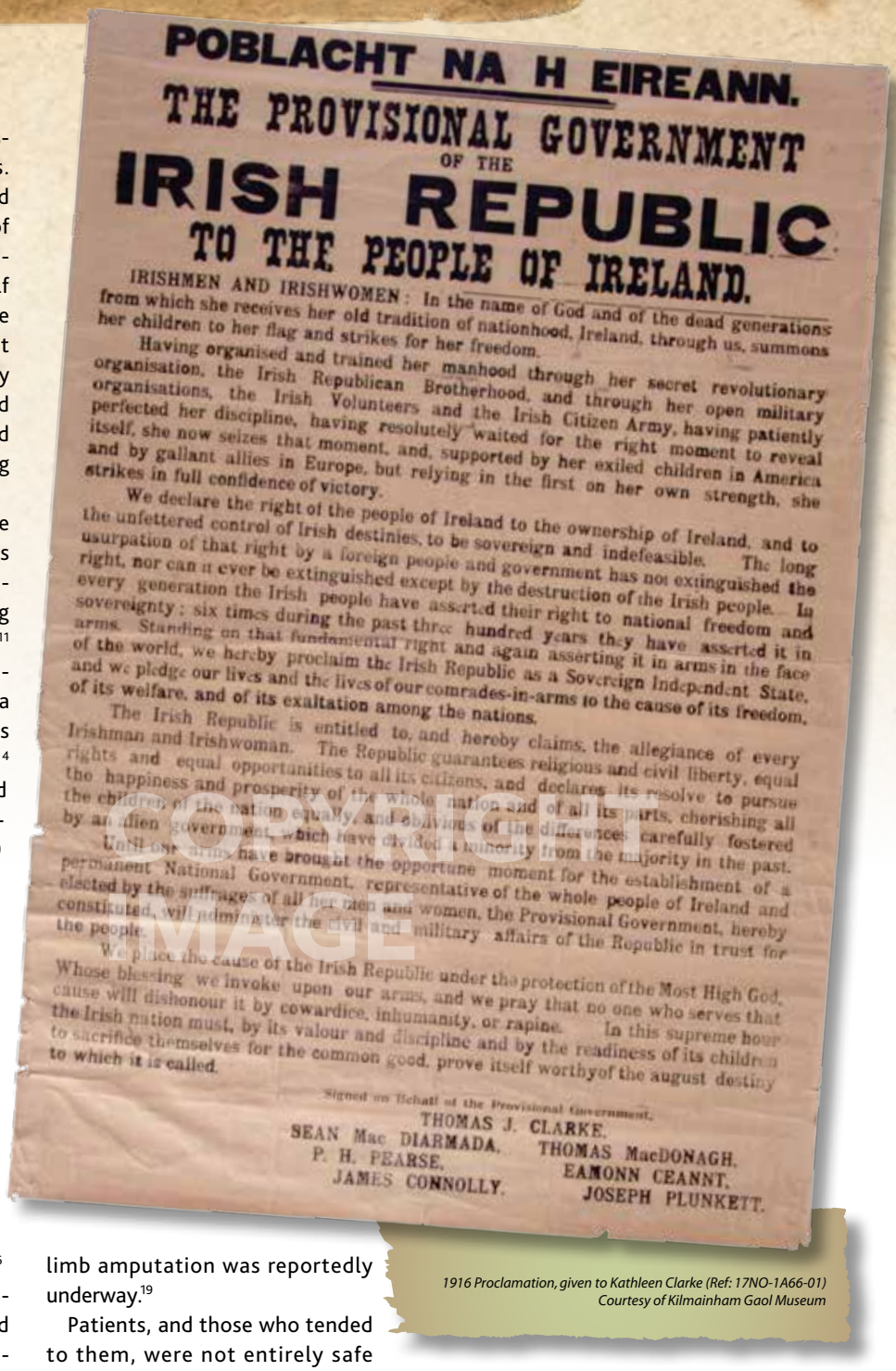
The casualty toll also resulted in the National Maternity Hospital, Holles Street, being converted into a temporary emergency department and treating some 40 cases with gunshot wounds,[11] 12 of whom died.[12] Dr Steevens' Hospital[13] attended to 100 injured and a further 130 cases of gunshot wounds were treated at Mercer's Hospital.[14] Being close to St Stephen's Green and the embattled Royal College of Surgeons, Mercer's was the scene of 20 deaths during the conflict.[15]

A nursing nun from Dublin's Mater Hospital gave a vivid account of the events of Easter week, recounting that in the absence of electricity the surgeon on duty worked day and night, his operating theatre illuminated only by candles sourced in the hospital's sacristy. The nun said the lack of electricity and gas rendered sterilisation of operating instruments impossible as water could not be boiled for the purpose, yet she recounted that no patients succumbed to post-operative infections.[16]

Many of the wounded were not physically able to make it to hospital and 'mercy-missions' became a defining feature of the Rising. A number of doctors from the Charitable Infirmary, Jervis Street, converted a grocer's van into an ambulance and administered first aid to the wounded on nearby Sackville Street (now O'Connell Street).[17]

Nurses in training to become Jubilee and Lady Dudley nurses, precursors to today's public health nurses, also provided first-aid on the street.[18] Yet the number of hospitals and mercy missions were insufficient to cope with the workload and a number of improvised hospitals were established, including in private houses.

A depot used to store medical supplies at Merrion Square was transformed into a temporary hospital in just three hours; work commenced at 2pm and by 5pm some 15 patients had been admitted and a limb amputation was reportedly underway.[19]



POBLACHT NA H EIREANN.

THE PROVISIONAL GOVERNMENT
OF THE
IRISH REPUBLIC
TO THE PEOPLE OF IRELAND.

IRISHMEN AND IRISHWOMEN: In the name of God and of the dead generations from which she receives her old tradition of nationhood, Ireland, through us, summons her children to her flag and strikes for her freedom.

Having organised and trained her manhood through her secret revolutionary organisation, the Irish Republican Brotherhood, and through her open military organisations, the Irish Volunteers and the Irish Citizen Army, having patiently perfected her discipline, having resolutely waited for the right moment to reveal itself, she now seizes that moment, and, supported by her exiled children in America and by gallant allies in Europe, but relying in the first on her own strength, she strikes in full confidence of victory.

We declare the right of the people of Ireland to the ownership of Ireland, and to the unfettered control of Irish destinies, to be sovereign and indefeasible. The long usurpation of that right by a foreign people and government has not extinguished the right, nor can it ever be extinguished except by the destruction of the Irish people. In every generation the Irish people have asserted their right to national freedom and sovereignty: six times during the past three hundred years they have asserted it in arms. Standing on that fundamental right and again asserting it in arms in the face of the world, we hereby proclaim the Irish Republic as a Sovereign Independent State, and we pledge our lives and the lives of our comrades-in-arms to the cause of its freedom, of its welfare, and of its exaltation among the nations.

The Irish Republic is entitled to, and hereby claims, the allegiance of every Irishman and Irishwoman. The Republic guarantees religious and civil liberty, equal rights and equal opportunities to all its citizens, and declares its resolve to pursue the happiness and prosperity of the whole nation and of all its parts, cherishing all the children of the nation equally, and oblivious of the differences carefully fostered by an alien government, which have divided a minority from the majority in the past.

Until our arms have brought the opportune moment for the establishment of a permanent National Government, representative of the whole people of Ireland and elected by the suffrage of all her men and women, the Provisional Government, hereby constituted, will administer the civil and military affairs of the Republic in trust for the people.

We place the cause of the Irish Republic under the protection of the Most High God, Whose blessing we invoke upon our arms, and we pray that no one who serves that cause will dishonour it by cowardice, inhumanity, or rapine. In this supreme hour the Irish nation must, by its valour and discipline and by the readiness of its children to sacrifice themselves for the common good, prove itself worthy of the august destiny to which it is called.

Signed on Behalf of the Provisional Government,

THOMAS J. CLARKE.
SEAN Mac DIARMADA. THOMAS MacDONAGH.
P. H. PEARSE. EAMONN CEANNT.
JAMES CONNOLLY. JOSEPH PLUNKETT.

1916 Proclamation, given to Kathleen Clarke (Ref: 17NO-1A66-01)
Courtesy of Kilmainham Gaol Museum

Patients, and those who tended to them, were not entirely safe inside the hospitals. More than 200 wounded were treated at the Royal City of Dublin Hospital, Baggot Street.[20] Here, stray bullets entered the operating theatre and the nurses' dining room.[21] The intense combat at the South Dublin Union, now the site of the modern day St James's Hospital, forced patients to take cover behind beds and mattresses, which they used as makeshift barricades.[22]

Across the city at the Rotunda Lying-in Hospital, the lady superintendent, Miss Ramsden, described the 'terrible rebellion' in which two bullets entered Ward 7 and necessitated the evacuation of patients to the rear of the institution.[23] Nonetheless, staff there persisted with their vital function of maternity care, albeit in darkness due to interruptions in the electricity supply.[24] Intent on avoiding the risk of injury from nearby gunfire, the National Maternity Hospital, Holles Street, displayed a Red Cross flag in order that it be spared the hostilities.[25]

For some staff who ventured beyond their hospital walls, danger was ever present and ambulance personnel recounted: *"Day by day [the ambulances] ran the gauntlet of bullet-swept streets, frequently struck by shots whilst on their journeys ... we cannot recall a single journey on which we did not get a bullet through somewhere".*[26]

Due to the closure of funeral homes, many of the dead were buried where they fell – including in gardens. Coffins were scarce and some of those who died were merely sewn into sheets prior to interment.[27]

Image by TJ Westropp, Kelly's Corner, DBC & Eden Quay, May 17 [1916]. By permission of the Royal Irish Academy © RIA

Northumberland Road and its environs, especially Mount Street Bridge, were the sites of intense fighting. Nurses from the nearby Sir Patrick Dun's Hospital[28] used bed quilts as stretchers with which to carry the injured from the street to the institution.[29] There, doctors and nurses exhibited 'complete disregard for their own safety' in tending to the wounded but, in a vivid reference to the brutality of the conflict, their uniforms reportedly soon resembled 'the aprons of slaughterhouse workers'.[30]

The sheer number of casualties resulted in bedlam at Sir Patrick Dun's, which had to accommodate patients in its nurses' home, on the floor, on sofas and even two to a bed.[31]

The Richmond

Buildings now owned by the INMO also featured in the conflict. In 2013 the INMO purchased the former Richmond Hospital, North Brunswick Street with a view to utilising the building as a state of the art Education and Events Centre. Today, the serenity that lies beyond the Richmond's gates belies the dramatic and poignant events that it witnessed during the Rising. St John's Convent, located beside the Richmond, was used as a temporary rebel outpost after volunteers received an 'enthusiastic reception' from the resident nuns who provided them with food and accommodation and prayed for them as they left to take part in the conflict.[32]

At one point, rebels considered occupying a balcony at the Richmond but were dissuaded from doing so by a doctor who requested that they respect the hospital's neutrality.[33]

The 300 or so casualties in the Richmond's catchment area overwhelmed the hospital and a number of the institution's patients were transferred to outlying facilities in the nearby North Dublin Union in order to free up space to accommodate the injured. Fifteen people were pronounced dead on arrival at the Richmond.[34] References to the scores of wounded and dead, while staggering, belie the actual suffering and circumstances that attended the loss of life. Tragically, a two-year-old boy was shot in the head as his mother wheeled him in his pram to the refuge of Father Mathew Hall – near the Richmond. A priest took the boy to the hospital but he died en route.[35]

The testimony of eye-witnesses is also illuminating. One man recounted: "*A number of dead were lying around: civilians, soldiers and volunteers. One of the civilian casualties was squatting against a wall with a white bundle; his head was slit open like a pomegranate. A volunteer was lying at the corner of Moore Lane, a dead Tommie beside him. I'll never forget that little volunteer. I looked at him. He was very dead. They had played a machine-gun on him. Pieces of wool, his undergarments, protruded through his uniform, making a scarecrow character of a man*".[36]

Siding with the rebels

The Richmond Hospital is an architecturally impressive building. Constructed in 1897, the story goes that it was designed as an extension to the Taj Mahal but, somehow, its plans found their way to Dublin.[37] The hospital's wards were large and airy with a window for each bed – a nod to Florence Nightingale who championed fresh air and light.[38] This design feature had two consequences. Firstly, the large windows left patients vulnerable and, so, they were nursed on the floor in order to avoid being wounded by stray bullets.[39] Secondly, the hospital's vantage permitted staff to signal to rebels the positions of approaching soldiers.[40] This suggests that the hospital staff sided with the volunteers. Indeed, when police came searching for one rebel, a surgeon lied that he had been discharged in order to help him evade capture.[41]

Suggestions that hospital staff tacitly assisted rebels are repeated time and again in accounts of the Rising. A nursing nun at the Mater Hospital recalled that a rebel was smuggled to that institution in a consignment of cabbage after he succumbed to bullet wounds at the GPO. Upon his arrival, he was placed under close observation by a detective, a measure which seemingly irritated the hospital staff, some of whom considered 'chloroforming' the investigator in order to let the volunteer make his escape.[42]

Ultimately, while the detective was in the pantry having dinner, a nurse procured the key leading from the hospital's mortuary to the street and quickly and surreptitiously led the rebel to freedom.

A short distance away the staff at the Charitable Infirmary, Jervis Street, went further still. The rebels who occupied the GPO bored a tunnel to Henry Street, through which they could make good their escape if they needed to. There are reports that the tunnel went further and terminated at the Charitable Infirmary – emerging in a hole at the hospital that was concealed by wardrobes and bed screens.[43]

It is suggested that staff at that institution colluded with the rebels by sending those who were badly injured to recuperate in a bed in the sick-nuns' ward. Here their faces were concealed in nuns' headdresses permitting them to evade capture by visiting detectives. One doctor, seemingly not in on the ruse, was perplexed by the sudden increase in the number of sick nuns at the hospital.[44]

Furthermore, nurses reputedly burned rebels' boots and uniforms on their arrival at the institution – effectively destroying the evidence. One volunteer reportedly awoke after an operation to remove bullets only to discover a baby in his arms, presumably in an effort to pass him off as a mother.[45]

It was said of the staff at the hospital: *"you would think there was a rebellion every day in the week to look at them"*.[46] Dublin voluntary hospitals reportedly frustrated investigating authorities by ignoring requests by British forces to report cases of gunshot wounds to them,[47] but the extent to which these hospitals sided with the rebels is a matter of conjecture.

Nurse Margaret Kehoe. Image courtesy of Ray Bateson

Elizabeth O'Farrell and her grave at Glasnevin Cemetery Image courtesy of Kilmainham and Glasnevin Cemetery Museum

Jeffery notes a tendency for some accounts of the 1916 Rising to have 'grown in the telling' and readers should make up their own minds if accounts of nurses' activities in hospitals such as the Charitable Infirmary are accurate or have been somewhat embellished over the years.[48]

What appears more certain is that nurses made great sacrifices to ensure the wounded were tended to. One nurse stationed at the military hospital at Dublin Castle, in a case of extreme presenteeism, developed appendicitis but refused to leave her post: "She probably saved several lives by her unselfishness, but it very nearly cost her own", said a colleague.[49]

General Maxwell, the Commander of the British Forces in Ireland, issued a statement following the rebellion in which 'in particular' he praised the "gallantry shown by those nurses who exposed themselves to a heavy fire in attending to and removing the wounded".[50]

Margaret Kehoe

One nurse whose sacrifice warrants especial mention is Margaret Kehoe.[51] Nurse Kehoe worked at the infirmary of the South Dublin Union. Being located on a sprawling 20-acre site, the Union was of strategic importance militarily because it was in close proximity to the British military headquarters. The assistant matron recalled events at the Union noting that the hospital's nurses' home was taken over by rebels with sleeping nurses awoken and forced to 'clear out'.[52] The Union became the site of intense gunfire and it was amid this that 43-year-old Nurse Kehoe lost her life.

There are many accounts of Nurse Kehoe's death. According to Caulfield, the nurse was thankful at a brief cessation in the conflict and remarked to a co-worker that she hoped there would be 'no bloodshed' at the institution.[53] With that, she heard gunshots – "the patients, the patients" she cried and ran downstairs against her colleague's advice.[54] When she reached the bottom of the stairs she was shot dead – after which her body was placed on a table by soldiers who asked her grieving colleague: "Are there any Sinn Feiners upstairs?"[55]

Although Caulfield foregoes explicitly attributing responsibility for the nurse's death to any one party, Molyneux and Kelly are less circumspect. Their account notes that Kehoe assumed that a momentary lull in hostilities signified a ceasefire, which permitted her to tend to the wounded. As she descended the staircase to do so she was shot by a "terrified British private" only to die "in agony" thereafter.[56]

Similarly, the injured rebel to whom Kehoe is often cited as being en route to attend, testified that soldiers at the Union were "taken by surprise" by shots he and another rebel had fired and "lost their heads" for a moment "because a nurse in full uniform opened the door and came down the stairs. They fired on her and killed her".[57]

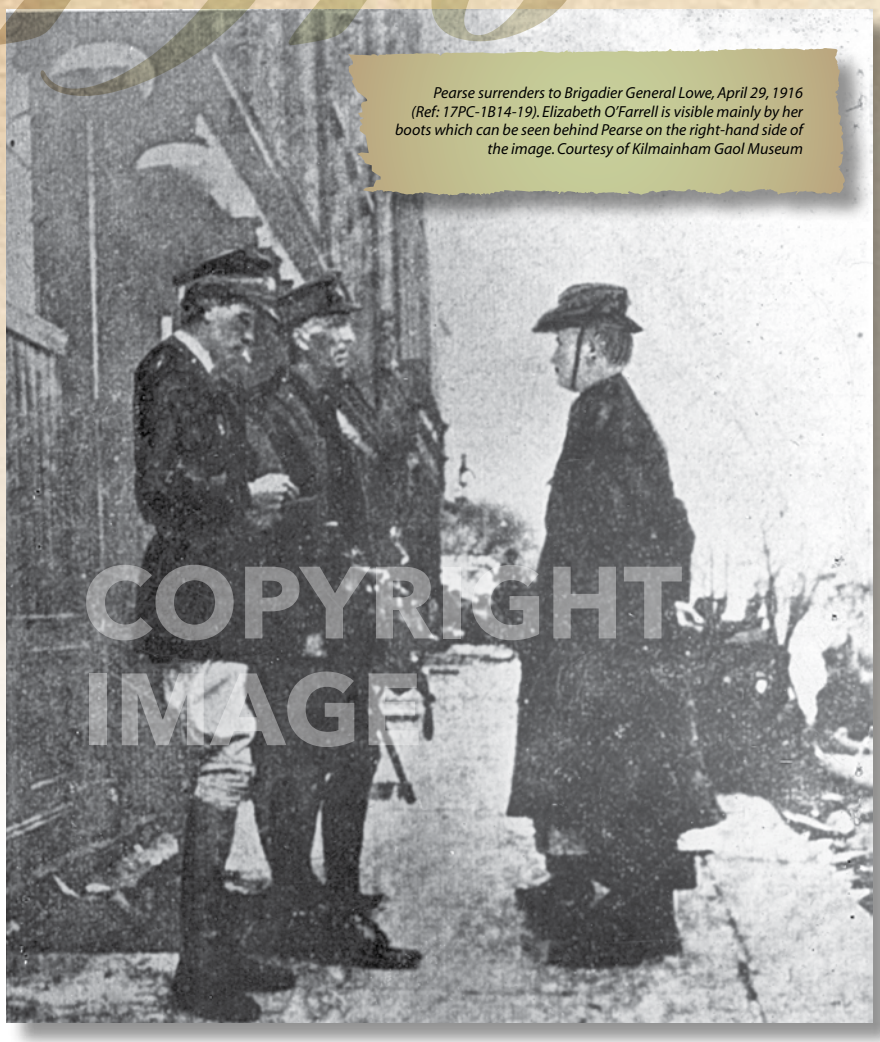
Following Kehoe's death, rebel leader Eamonn Ceannt reportedly remarked that the nurse had "died for Ireland just as surely as if she had worn the Volunteer uniform".[58]

In 1932, a piece in the republican newspaper *An Phoblacht* adopted a similar line:

"A Volunteer fell wounded outside [the] hospital door. Immediately a nurse rushed out to attend the fallen man. Just as she reached the door and ere she could reach the wounded man she herself fell wounded–struck down by British bullets… Keogh [sic] was in full uniform which could be plainly visible to the British… A true Irishwoman she certainly was".[59]

In 2015 it was suggested that Kehoe's shooting amounted to 'cold-blooded murder' and that the nurse had been 'airbrushed' from history for fear of it becoming known that a British soldier had shot a nurse in uniform.[60] True, historians of the Easter Rising assert that the British authorities were guilty of trying to 'cover-up' certain atrocities.[61] True too, that the British authorities were well aware of the galvanising effect that the shooting of a nurse could exert – after all British nurse Edith Cavell, just months earlier, had assumed martyr-status and caused a surge in anti-German sentiment (and enlistment to the British army) after she was executed by German authorities for aiding in the escape of Allied soldiers from Belgium during World War I. Yet, would the killing of a nurse by a rebel, even in error – a possibility that is mentioned by at least one historian[62] – not also have rankled and injured the Republican cause?

The Commander of the British Forces, by his own admission, described soldiers as edgy and ill at ease[63] – and the surprise attack made by volunteers on the soldiers who subsequently, it is asserted, shot



Pearse surrenders to Brigadier General Lowe, April 29, 1916 (Ref: 17PC-1B14-19). Elizabeth O'Farrell is visible mainly by her boots which can be seen behind Pearse on the right-hand side of the image. Courtesy of Kilmainham Gaol Museum

Kehoe suggest that her shooting was unintentional and accidental. This much was conceded by William T Cosgrave, himself a rebel at the South Dublin Union.[64]

While the truth about the circumstances of Nurse Kehoe's death remain open to conjecture, what appears more certain, as Bateson points out, is that she died fulfilling her nursing duties[65] and a plaque erected in her memory at St Kevin's Hospital (formerly the South Dublin Union and now St James's Hospital) in April 1965 referenced this:

"This plaque has been erected to the memory of Nurse Margaret J Kehoe, Leighlinbridge, Co Carlow, who died of bullet wounds received in this hospital while performing her Professional Duties in a heroic manner on Easter Monday, 1916".[66]

As the plaque was being unveiled Nurse Kehoe's death was cited as an example for nurses everywhere, with the hospital's matron remarking that the nurse had sacrificed her life for her patients' wellbeing.[67] The hospital's medical superintendent noted that the plaque would serve as a "source of constant pride and inspiration" to the hospital staff.[68] In spite of the eulogies the plaque subsequently disappeared and its current whereabouts are unknown.[69]

Elizabeth O'Farrell

Another central character in the 1916 Easter Rising was Elizabeth O'Farrell who, some years later, became a midwife. She was born in Dublin and following her schooling took a job at a printing house. She was a member of the Gaelic League and Inghinidhe na hÉireann and was trained in arms use by Countess Markievicz. O'Farrell was first exposed to nursing duties during her first aid training – a prerequisite when joining Cumann na mBan.[70]

O'Farrell was an ardent Republican and, while the Rising was being planned, spent her days spreading word of the impending insurrection in the provinces before returning to Dublin to partake. During the conflict, the 32-year-old ferried ammunition, food and messages between the various rebel outposts in the city and nursed the wounded.

From the second day of the insurrection she was stationed at the GPO, where she had made her way, with her friend Julia Grennan, in the rain. Years later, Grennan remarked: *"We were the only two who brought umbrellas to the Rising"*.[71]

As the GPO came under increasing fire, O'Farrell retreated to a house on Moore Street where she helped nurse the injured. There, the volunteers realised the futility of the rebellion and decided to surrender. O'Farrell accompanied rebel leader Pádraic Pearse to meet the British General where the official surrender took place. Here an iconic photograph (*see left*) was taken in which O'Farrell stood back from the camera largely behind Pearse. By her own admission she adopted this stance in order to frustrate what she saw as the "enemy press".[72] Hence, O'Farrell is largely visible only from the knees down in the photograph – with her shoes providing the primary clue that she was there at all.

The subsequent treatment of the image is noteworthy. Using what appears to be a rudimentary editing procedure, O'Farrell was removed from some versions of the photograph entirely, effectively airbrushing her from the historical record. In relation to this, one commentator remarked: "It was an editorial decision … Pearse was the important figure – Elizabeth wasn't".[73]

Pearse's letter of surrender noted: "*In order to prevent the further slaughter of Dublin citizens, and in the hope of saving the lives of our followers now surrounded and hopelessly outnumbered, the members of the Provisional Government present at Head-Quarters have agreed to an unconditional surrender*".[74]

O'Farrell was charged, white flag in hand, with delivering the surrender message to rebel garrisons throughout the city. She recalled: "I had to take my life in my hands several times".[75] In fact, while crossing the bridge at Grand Canal Street, a man walking just feet from O'Farrell was shot and she was obliged to alert locals who transported him to the nearby Sir Patrick Dun's Hospital.[76]

O'Farrell's co-operation in delivering the surrender message garnered her clemency and she was spared a lengthy spell in custody. She commenced her six-month-long training as a midwife at the National Maternity Hospital, Holles Street, in early 1921 where she achieved almost 70% in her final examinations. The hospital's matron described her as "a fair nurse, [with a] fair education".[77]

An examination of ballot papers in the INMO's archives suggests that O'Farrell ran for election to the Organisation's Midwives' Committee in 1925.[78] Furthermore, an examination of the delegates at the Organisation's 10th Annual Council Meeting in 1930 reveals a 'Miss O'Farrell' who attended to represent Dublin midwives.[79]

Image by T J Westropp, Hotel Metropole, Sackville St, May 17 [1916]. By permission of the Royal Irish Academy © RIA

Commemoration

While O'Farrell's role in the Easter Rising may be interpreted in many ways, in 1966, the year of the 50th anniversary of the Easter Rising, Ena Meehan, long time general secretary of the then called Irish Nurses Organisation (INO), found significance in O'Farrell's actions during the insurrection.

That year the INO collaborated in the establishment of the Elizabeth O'Farrell Foundation Committee of which Meehan was honorary secretary. The Foundation aimed to fund nursing and midwifery research and post-graduate education[80] and, in a letter to the *Irish Independent*, Meehan noted that O'Farrell's co-operation in spreading word of the surrender had helped to "prevent further bloodshed" and was of symbolic importance to the nursing profession which is "committed to the service of life".[81]

A number of memorials to O'Farrell exist. These include a bronze memorial, erected in 1966, at the National Maternity Hospital (*see right*). That hospital also awards a medal in O'Farrell's honour each year to midwives who excel academically. Dublin's City Quay, where O'Farrell was born, is the location of Elizabeth O'Farrell Park where a plaque in her memory reads: *"Her life was dedicated to the cause of Irish Freedom*".

O'Farrell died in 1957 and is buried in Glasnevin Cemetery, Dublin. Her gravestone reads: "*When duty called on the field of battle she went, under orders, the foe to meet bearing sadly, unfearingly, proudly, the flag of surrender but not defeat*".

The verse on O'Farrell's gravestone is a reference to the events that followed the Rising and alludes to the fact that, although the rebels' battle had been lost, a war of sorts was ongoing and about to intensify.

In the days that followed the insurrection a nurse wrote to the *British Journal of Nursing*: *"Nurses are mostly strong loyalists"* but: *"In Dublin the nursing profession is naturally in deep sorrow over the riots and terrible loss of life, and those of us who love Dublin look on the blackened ruins with grief – in time buildings can be erected, but the dead cannot be brought to life… every woman's heart is wrung to know that in our midst young men are* being shot, and other*s blotted out in penal servitude for life… it is so difficult for the English to understand the Irish, and to realise their real feelings and convictions"*.[82]

Tribute to Elizabeth O'Farrell at the National Maternity Hospital, Holles St, Dublin

The nurse's letter was prophetic. The execution and imprisonment of rebels shocked the public, heightened anti-British sentiment in Ireland and gave rise to the War of Independence and the subsequent granting of Free State status.

Amid the heady nationalist atmosphere Irish nurses shunned the College of

Nursing, the English nurse representative association which also traded in Ireland at the time.[83] Instead, in 1919 they were given the option of joining a new representative association for nurses and midwives which, in keeping with nationalist sentiment, featured a shamrock on its badge (*see left*). That association, known then as the Irish Nurses Union and now as the Irish Nurses and Midwives Organisation, grew to become the State's largest trade union for nurses and midwives. Its history, however, is a story for another day.

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ATHY/ BALTINGLASS BRANCH

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- Kildare/Wicklow community care services
- St Vincent's Hospital, Athy
- Baltinglass Community Nursing Unit
- Private nursing homes
- Practice nurses

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Latest news

Unlike some other INMO branches, the Athy/Baltinglass Branch generally has a very good attendance at meetings.

At the recent AGM, delegates and motions were put forward for the upcoming ADC which is being held in Killarney on Wednesday, May 4 to Friday, May 6.

The AGM heard members' concerns about future staffing levels. There was also concern due to the fact that our care of the elderly services are recruiting temporary nurses and therefore will not be able to compete with the acute sector which is offering permanent posts. This issue is being actively pursued by the INMO.

Industrial relations update

Derek Reilly is the IRO for the Athy/Baltinglass Branch.

St Vincent's Hospital, Athy

- The INMO has a proactive group of members who meet regularly to address areas of concern within the hospital. Of primary concern is maintaining safe staffing levels and ensuring that all vacant posts are replaced. Within the past year there have been negotiations in relation to developing future services and roster changes, ensuring those in acting positions are remunerated correctly. St Vincent's is a progressive centre with plans for further development in the future.

Baltinglass Community Nursing Unit

- The main area of concern in Baltinglass is poor staffing levels. CNM1 posts lost through the moratorium have yet to be replaced. This is high on the agenda for 2016. National talks are currently in process in relation to care of the elderly staffing.

Community:

- The issues within the community include redeployment and the large workload that PHNs and CRGNs have in the area. A number of members were involved in the recent agreement pertaining to the national PHN transfer panel.

CPD module

Jaundice in newborns

In the second clinical update in this continuing professional education series, **Rebecca Pearsall** and **Gerry Morrow** examine jaundice in the newborn child

THIS month's article focuses on the issue of jaundice in the newborn child.

Jaundice is a yellow colouration of the skin and sclerae (whites of the eyes) caused by the build-up of a chemical called bilirubin. Bilirubin is a bile pigment which is mainly produced from the breakdown of red blood cells.

Bilirubin levels are higher in newborn children. This is because newborn babies have a higher concentration of red blood corpuscles. These corpuscles also have a shorter lifespan and break down more quickly in very young children.

Terminology

For most babies, jaundice is completely harmless. This is called 'physiological jaundice'. Physiological jaundice can occur in both breastfed and formula fed babies.

Breastmilk jaundice is a type of physiological jaundice in breastfed babies, which can last for up to 12 weeks.

Pathological jaundice is caused by a range of illnesses in the newborn baby.

Jaundice is the most common condition of the newborn baby that requires medical attention.

Approximately 60% of babies born at term will develop jaundice in the first week of their lives. While approximately 80% of babies before term (gestation age under 38 weeks) will develop jaundice in the first week of their lives.

Causes of newborn jaundice

Physiological jaundice, the commonest cause of jaundice of the newborn, usually appears at two days of age, peaks between three to five days of age, and decreases by 10 days of age.

Breastmilk jaundice is a subtype of physiological jaundice apparent in breastfed babies – usually appears at two to four days of age, peaks at seven to 10 days of age, and can persist for up to 12 weeks.

In both these situations the newborn baby will be well, will gain weight normally, and have normal urine and stools.

Pathological jaundice is less common but important to recognise in order to treat potential underlying causes. There is a long list of these problems which can be grouped into the following categories:

- *Genetic* – includes rare conditions, Gilbert's syndrome and Crigler-Najjar syndrome
- *Anatomical* – includes malformations of the liver and biliary tree, where bile becomes obstructed in the liver
- *Metabolic* –rare problems which include hypothyroidism and galactosaemia
- *Infective* – includes sepsis
- *Blood group incompatibility* – occurs when the newborn baby has a different ABO or rhesus blood group from the mother. This causes red blood corpuscles to break down (haemolysis). There are also other more rare causes of haemolysis
- *Trauma* – in this situation large areas of bruising in the child (such as can be associated with birth trauma for example cephalhaematoma after ventouse delivery) can also cause jaundice.

Newborn babies with pathological jaundice will often develop the problem within the first 24 hours of their life, or after day six of the child's life. These babies also tend to be unwell (which can lead to poor feeding, irritability and unusual sleepiness), with more widespread and obvious jaundice, and problems with dark urine and pale stools.

Risk factors

Some newborns are at higher risk of developing jaundice. These factors include:

- Gestational age at birth under 38 weeks
- Breastfed babies
- A sibling with jaundice requiring treatment
- Male children
- Maternal age over 25
- Maternal diabetes mellitus
- European, Asian or Native American ethnicity.

Prognosis

For most babies, jaundice is not an indication of an underlying disease. Physiological jaundice is generally harmless and resolves by two weeks of age.

Breastmilk jaundice, in a baby who is otherwise well, is benign and self-limiting.

The prognosis for babies with jaundice due to an underlying condition depends on the cause. For example, surgical causes of jaundice (such as obstruction due to biliary atresia) are likely to resolve once the condition is treated.

Complications

Complications in newborn children with jaundice are rare. A prospective surveillance study found a UK incidence of bilirubin encephalopathy of 0.9 per 100,000 live births.[1] A study in Ireland in 2010 found that 2.5% of infants had phototherapy and that none had complications.[2]

However, the chemical subgroup of bilirubin, which is called 'unconjugated bilirubin', is able to penetrate the blood-brain barrier, the membrane between the brain and the blood. This chemical can be toxic to the tissue of the brain and spinal cord, causing a condition known as bilirubin encephalopathy.

The level at which bilirubin is likely to cause brain and spinal cord damage is variable and may be affected by a number of factors, which include the degree of prematurity, the rate of serum bilirubin increase, and co-existing illnesses in a newborn.

A number of terms are used to describe the neurological consequences of raised bilirubin in the blood stream (hyperbilirubinaemia), these are:

- *Acute bilirubin encephalopathy* – occurs when there is severe hyperbilirubinaemia. Children with this condition have problems that include lethargy, irritability, poor suck, abnormal muscle tone and posture (opisthotonus), high-pitched cry, apnoea and eventually seizures and coma
- *Chronic bilirubin encephalopathy* – a longer term problem which includes cerebral palsy, seizures, developmental delay, learning difficulties, vision and hearing problems, and dental dysplasia
- *Kernicterus* – describes the clinical features of either acute or chronic bilirubin

encephalopathy and the pathological findings of deep yellow staining in the brain.

Diagnosis

In order to make a diagnosis of jaundice in the newborn, you should make a clinical observation at every contact, particularly within the first 72 hours. If the baby has one or more risk factors for developing significant hyperbilirubinaemia, ensure they are re-examined during the first 48 hours. Record your findings in the clinical notes:

- Examine the baby in bright, preferably natural light, for example in daylight by a window
- Look at the skin of the whole body and blanch to assess for jaundice (for example gently pressing on the nose)
- Also examine the whites of the eyes (sclerae), gums and palate
- Check for any signs of illness or fever
- Assess weight gain
- Evidence of bruising.

Assess how widespread the jaundice has become. Jaundice spreads from the head downwards in the newborn. Widespread jaundice may indicate a more severe problem, but cannot be relied on in isolation to assess severity.

If there is doubt about the diagnosis, consider referral to a neonatologist or paediatrician for further assessment.

You should ask the baby's mother about:

- Obstetric history (including the mother's rhesus status and blood group if known) and the baby's gestational age at birth
- Age at onset and duration of jaundice
- Feeding history (type of feeding and whether there have been any problems with adequate intake)
- Number of wet or dirty nappies in a day (to assess the state of hydration)
- Also specifically ask about the presence of dark urine and/or pale stools
- Signs of illness (for example lethargy, fever, vomiting, significant weight loss, irritability)
- Family history of relevant conditions – for example significant haemolysis (including glucose-6-phosphate-dehydrogenase deficiency). Ask whether any siblings or close family members have required hospital treatment such as phototherapy or exchange blood transfusion for neonatal jaundice.

You should also offer parents and carers information on:

- How to check the baby for jaundice
- What to do if they suspect jaundice
- The importance of recognising jaundice in the first 24 hours
- Observing for signs of adequate hydration
- The importance of checking the baby's nappies for dark urine or pale stools.

Management

Arrange emergency admission (via 999 ambulance) if there is jaundice with features of bilirubin encephalopathy (for example atypical sleepiness, poor feeding or irritability).

Arrange urgent admission to a neonatal or paediatric unit (depending on local arrangements) within two hours if jaundice first appears at less than 24 hours of age.

Arrange urgent admission to a neonatal or paediatric unit (depending on local arrangements) as soon as possible and to be seen within six hours (using clinical judgement regarding more urgent referral or admission) if:

- Jaundice first appears at more than seven days of age
- The neonate is unwell (for example lethargy, fever, vomiting or irritability)
- Gestational age of less than 35 weeks
- Prolonged jaundice is suspected – that is a gestational age of less than 37 weeks with more than 21 days of jaundice; or a gestational age of 37 weeks or more with more than 14 days of jaundice
- Poor feeding and/or concerns about weight, particularly in breastfed infants
- Pale stools and dark urine.

For all other jaundiced neonates:

- If transcutaneous bilirubin measurements are available in primary care, record the level within six hours and manage according to local protocols
- If transcutaneous bilirubin measurements are unavailable in primary care, refer to a neonatal or paediatric unit for measurement of a serum bilirubin level within six hours. Do not rely on visual assessment of jaundice to guide management.

If admission is not necessary, reassure parents and carers that:

- Neonatal jaundice is common and is usually temporary and harmless
- Breastfeeding can usually continue.

Treatments

The choice of treatment in secondary care will depend on a number of factors, including the underlying cause of the jaundice. Treatment options include:

- *No treatment* – this may be appropriate for well newborn children with physiological or breastmilk jaundice and a bilirubin level below the treatment threshold
- Treatment of any underlying illness (such as infection), with as follows:
  - *Phototherapy*, absorption of light through the skin converts unconjugated bilirubin into products that are more easily excreted in the stool and urine
  - *Exchange transfusion*, indicated if the baby has signs of bilirubin encephalopathy and considered if the risk of kernicterus is high or jaundice is not responding to phototherapy
  - *Early surgical treatment,* required for conditions such as biliary atresia.

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

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CPD Quiz

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

1. Physiological jaundice in newborns is:

A) Usually temporary and harmless
B) More common than pathological jaundice
C) Less common in pre-term children
D) More common in mothers under the age of 25

2. Physiological jaundice in the newborn usually:

A) Starts when child is two days old
B) Is less common in breastfed children
C) Resolves when the child is 10 days old
D) Resolves when the child is 10 weeks old

3. Pathological jaundice in the newborn:

A) Is less common than physiological jaundice in the newborn
B) Can be caused by breastfeeding
C) Often starts within 24 hours of birth
D) Can be due to treatable causes

4. Complications of jaundice in the newborn include:

A) Irritability
B) Poor sucking
C) Stroke
D) Vomiting

5. Children with jaundice should be referred to a specialist if:

A) The jaundice has developed within the first 24 hours of life
B) The jaundice has persisted for longer than one week
C) The child is unwell
D) The child is less than 35 weeks of gestation

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.

Answers for the CPD multiple choice quiz on jaundice in newborns appear in the inverted box below.

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

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

Understanding the Code

In a series examining the new Code of Professional Conduct and Ethics, **Edward Mathews** discusses the fourth principle, Trust and Confidentiality

IN OUR exploration of the Code of Professional Conduct for registered nurses and midwives, this month, we focus on the fourth principle of the Code – Trust and Confidentiality.

Each principle in the Code underpins a set of ethical values and associated standards of conduct. The ethical values state the primary goals and obligations of nurses and midwives, and the standards of conduct and professional practice flow from these values. They also show the attitudes and behaviours that members of the public have the right to expect from nurses and midwives. It is important for all nurses and midwives to consider the totality of the contents of the Code, and to reflect on the principles, ethical values and standards in deciding how to practise nursing and midwifery.

Overall purpose

The overall purpose of this principle is trust, confidentiality and honesty. The first ethical value requires that nurses and midwives recognise that trust is a core professional principle at the centre of their relationship with patients and colleagues. In terms of the associated standards of conduct, the Code requires that nurses and midwives must try to develop relationships of trust with patients. In addition, they are required to show honesty, integrity and trustworthiness in all dealings with patients and colleagues.

In this regard we can see that the principle relating to trust and confidentiality extends beyond the relationship between a nurse and midwife and their patient, and also extends to the relationship that we have with colleagues in the workplace. The Code requires, as a standard, that each nurse and midwife gives honest, truthful, balanced information and advice to patients, based on best evidence or best available practice standards.

This takes us into the domain of sharing information with patients, which is a somewhat vexed area, in terms of what patients have a right to know, what they need to know, and what is in their best interest to know. This requires the exercise of professional judgement on the part of a nurse or midwife, who is operating as an independent practitioner, but also as part of a multidisciplinary team. If it is intended to withhold any information from a patient, this must not be taken light-heartedly, and nurses and midwives must recall their obligations pursuant to the Code, including the requirement for respect for dignity of the person, and also the best interests of the patient, which should be at the heart of everything a nurse or midwife does.

Impartiality

The standard also requires impartiality and integrity on the part of any nurse or midwife who is dealing with a patient. This may arise where personal beliefs conflict with a particular course of treatment which might be available, or indeed if a nurse or midwife was working for a commercial entity and was employed to extol the virtues of a particular product. Notwithstanding any of these characteristics of a working environment or personal life, a nurse or midwife is required to act in the best interest of the patient, and to give advice which is honest, truthful, balanced and based on the best available evidence.

Trusting relationships

The next value under this principle requires that confidentiality and honesty form the basis of a trusting relationship between the nurse or midwife and their patient, and in addition, reminds us that patients have a right to expect that their personal information remains private.

This will not be a surprising value for any nurse or midwife, but it is important to recall that arising from the privileged position that nurses/midwives hold, breaches of privacy carry with them a particular injury for a patient.

The standards of conduct associated with this value require that a nurse or midwife behaves in a manner that strengthens the public trust and confidence in the professions, and consequently any breach of privacy could be seen as not only injuring the patient, but also the professions. The Code also expects that nurses and midwives will uphold a patient's expectation that their personal information will remain private, but at the same time recognise that an inherent part of the provision of their care is the requirement to share information in an appropriate fashion. When making a decision to share information, the Code requires that each nurse or midwife exercises professional judgement, and acts responsibly in the disclosure and sharing of information.

While the Code does not make any explicit distinctions between the sharing of information among colleagues concerned with the care of a patient where this is necessary, and other more general sharing of information, the distinction is implicit in the provisions of the Code. One could not be seen to be in breach of the Code where the sharing of information is necessary, but one must be careful to exercise professional judgment in determining when it is necessary to share information. For example, a nurse/midwife may be involved in caring for a

patient who is undergoing a specific procedure and, in the course of preparing for the procedure, a patient may share with a nurse or midwife a very specific detail about their private life. In those circumstances, a nurse/midwife would have to exercise particular care not to share information which is not relevant to the patient's particular condition, and only communicate that which is relevant.

In addition, within the clinical team, nurses and midwives need to be careful only to disclose information to those who must of necessity receive that information. Examples have come to light where nurses and midwives have shared too widely within the clinical team or among their colleagues, information which patients would expect not to be shared unnecessarily, and which can put a registrant in breach of the Code.

In addition, nurses and midwives must exhibit extreme care in the use of social media, it can never be appropriate to share any information relating to a patient, or information that could potentially identify a patient or a particular clinical area in which a patient is being cared for, using social media or other similar communication media.

Difficult situations

The Code does recognise that difficult situations can arise for nurses and midwives, which are regarded as exceptional circumstances, which might require a nurse or midwife to share otherwise confidential information with people outside the clinical team. Circumstances might arise where one is required by law to release information to a court or other statutory body, or one may decide when exercising careful professional judgement, that it is necessary to share confidential information to protect the patient themselves, to protect the interests of society, or to protect the interests of other people. It is imperative that nurses/midwives exercise the most careful professional judgement in deciding to release information in these exceptional circumstances, though at the same time, they must be conscious of the interests of the patient, of society, and of other people. Where having exercised that careful judgement, the nurse or midwife comes to a decision that they must breach the confidence of the patient, they must only disclose the minimum amount of information necessary, and only to an appropriate person. This forms part of a core ethical value under the principle which requires the exercise of professional judgement and responsibility by each nurse and midwife in circumstances where such information must be shared.

Where a nurse or midwife has to make the difficult decision to share otherwise confidential information, outside the immediate care team, then the patient should be told that this is to occur, unless to do so would cause the patient serious harm. This is required to respect the dignity and autonomy of the individual, while at the same time allowing each nurse or midwife to exercise their professional judgement in the interest of others to whom they should have regard.

Careful professional judgement

Circumstances can also arise where a person may be regarded as lacking the ability to give consent, or have diminished capacity, and a nurse or midwife is often in a difficult situation in knowing whether, absent of the consent of the individual concerned, they can release information to those who are close to the patient. The Code requires that if a patient is considered to be incapable of giving or withholding consent to the disclosure of confidential information about them, that each nurse or midwife should consider whether disclosing the information to those close to the patient is what the patient would want or if it is in their best interest. This again requires the exercise of careful professional judgment.

Circumstances often arise where nurses and midwives are telephoned by those close to the patient and, in circumstances where the patient themselves cannot inform you as to whether they wish information disclosed to a particular person, then care must be taken in deciding whether to disclose that information. The Code does provide, as indicated, considerations such as the best interests of the patient, and what the patient might wish if they were able to give consent, but ultimately each nurse/midwife must make a judgement call. If a nurse makes a judgement call to release or withhold information, based on relevant consideration, it is important to record what has occurred, and also to set out one's rationale for making the decision in question. If a nurse or midwife were to make a good faith decision, based on relevant considerations, which later came to be questioned, then an accurate record of what they did, and why, would be important in showing that they exercised careful professional judgement in reaching their final decision.

Record management

Finally, and quite appropriately in times of developing IT infrastructures in hospitals, the Code explicitly recognises the role of nurses/midwives in safe guarding confidentiality which extends to all forms of record management, not only paper records but also the appropriate use of information technology and social media. As mentioned there is a requirement to maintain confidentiality in the context of using social media, that requires nurses/midwives to exercise vigilance and caution in ensuring that information contained in paper records and other IT systems is confidentially maintained. The relevance of this standard to maintaining patient clinical files as confidential will be immediately apparent, and each nurse and midwife will understand the necessity to ensure that no unauthorised access occurs to a patient's file, and that they themselves only access the file as necessary.

However, the requirement to maintain this level of confidentiality also extends for instance to summary sheets used at handover in many care environments, and nurses and midwives must exercise care to ensure that these are placed in an appropriate disposal facility, within the hospital, prior to leaving the clinical area. Additionally, nurses and midwives may be provided with usernames and passwords to IT databases, and it is important that these remain confidential to the nurse or midwife in question and that no unauthorised access to the system is permitted. Nurses and midwives should be vigilant not to access information via IT systems which is unnecessary for them to care for the patient in question, in particular nurses and midwives should be vigilant not to access the records or test results of others to whom they are not providing care, as this would be a breach of the patient's right to confidentiality.

Overall, it is important that nurses and midwives respect the trust and confidence invested in them by individual patients, and also to remain vigilant as to the trust and confidence invested in the professions generally, and this principle of the Code points us to a conclusion that such trust and confidence is best maintained by being honest with patients, showing integrity in one's relationships, building trustworthiness, respecting confidentiality and acting in the best interests of the patient and society as a whole.

Edward Mathews is INMO director of social policy and regulation

Global call to action on preventable stillbirths

Margaret Murphy, a member of the Scientific Advisory Committee of the International Stillbirth Alliance, shares her experience working on this call for global action with **Deirdre Munro**

DESPITE advances in maternity care, babies still die around the time of their birth. There are an estimated 2.6 million stillbirths annually across the globe, of which 98% occur in low-income and middle-income countries. A high number of these deaths are preventable, with half of all stillbirths (1.3 million) occurring during labour and birth.

Most result from preventable conditions such as maternal infections (most commonly syphilis and malaria), non-communicable diseases and obstetric complications. In high income countries stillbirth occurring during labour is a rare event with 90% of deaths occurring antenatally. Many stillbirths are preventable with high quality antenatal and intrapartum care.

Ending preventable stillbirths

In spite of the numbers of babies who die, stillbirth statistics remain hidden. There is global disagreement on a universal definition of what gestation constitutes stillbirth. Many countries do not record stillbirth rates and it does not feature strongly in global strategy documents, such as the United Nations sustainable development goals. To help address this silence, the *Lancet* launched its second series entitled 'Ending preventable stillbirths' on January 19, 2016. This series of four key papers brings together global experts in the area of stillbirth research. A synopsis of the contents of the four papers is presented below.

The stillbirth rate is a sensitive marker of quality and equity of healthcare. The *Lancet* series 2016 conducted economic cost benefit analysis and discovered such inputs result in a quadruple return on investment, by preventing maternal and newborn deaths and stillbirths, and improving child development.

Stillbirth creates a heavy burden of psychosocial and economic cost on families and nations. This burden of stillbirth affects women, families, caregivers, communities and societies. Parents experience various psychological symptoms that often persist long after the death of their baby, including anxiety, depression and protracted grief. Research suggests some of these symptoms could be lessened by respectful maternity services, including bereavement care.

An estimated 4.2 million women globally are living with depression associated with a previous stillbirth. In some cultures stigma and taboo can further exacerbate trauma for families, with many women socially ostracised. A fatalism exists that nothing can be done to prevent the occurrence of stillbirth and this can impede stillbirth prevention.

There are however chances of integrating stillbirths within women's and children's health programmes. The *Lancet* authors recommend that these opportunities be steadily grasped. Initiatives such as the 'Every Newborn Action Plan', within the Every Woman Every Child (EWEC) umbrella, with targets laid out for 2030, have included stillbirths. Data for tracking stillbirth rates have increased. Yet in many relevant policies mentions of stillbirth remain restricted. This results in the limitation of research and funding opportunities.

Series recommendations

The *Lancet* series has identified priority actions necessary to achieve a reduction in stillbirths, including:

- Intentional leadership, especially from policy makers, which is identified as the biggest challenge
- An increased voice, especially for women
- The implementation of integrated interventions with proportionate investment
- Indicators to measure effect of interventions and especially to monitor progress and quality of care
- Investigation into crucial knowledge gaps.

Summary

Through her involvement with the ISA Scientific Advisory Committee, Margaret will work to enhance international collaboration in the prevention of stillbirth and related adverse pregnancy outcomes, including psychosocial outcomes. This will be done through facilitating collaboration in conduct and dissemination of high quality collaborative research, in particular to collaborate with global partners in promoting action from the *Lancet's* stillbirth series.

Deirdre Munro is a member of the INMO Executive Council and is project co-ordinator QID, Corporate HSE

Deirdre Munro and Margaret Murphy are members of Global Village Midwives, which supports priority recommendations to end preventable stillbirths. Margaret Murphy is a lecturer in midwifery at University College Cork and a member of the Scientific Advisory Committee of the International Stillbirth Alliance. As a member of The Lancet stillbirths in high-income countries investigator group, Margaret contributed Irish stillbirth statistics to the Lancet series paper 4 by Flenady et al, 'Stillbirths: recall to action in high-income countries'. This is the first time that Irish stillbirth statistics have been included in such a global paper

Resources
– Global Village Midwives Twitter @Globalvillagemw
– www.thelancet.com/series/ending-preventable-stillbirths

Professionalism in practice

Students need to be familiar with the NMBI's professional guidelines to ensure good nursing and midwifery practice, writes **Dean Flanagan**

THE NURSING and Midwifery Board of Ireland (NMBI) sets the standards of professionalism that you're expected to meet as a nursing or midwifery student, and I would urge you to become familiar with the NMBI scope of practice, which will help you get to grips with your responsibilities as a professional and as a nurse or midwife.

The NMBI guidelines are the foundation of good nursing and midwifery practice and are a key tool in the health and wellbeing of the public. Failing to adhere to the scope of practice may lead to a registered nurse or midwife being removed from the register, so it's vital to gain a good understanding of what's expected from you *(see Table 1)*.

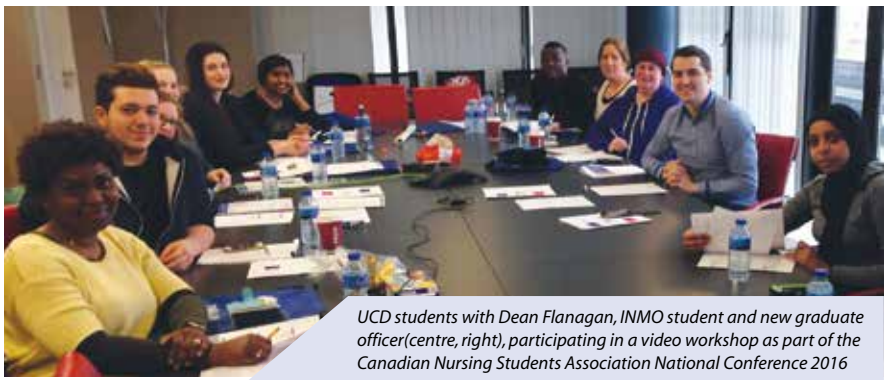
You're still learning, so it's perfectly acceptable to ask questions. Preceptors are there to support students. Get regular feedback from preceptors to build on your strengths and address your weaknesses.

Video conference workshop

As part of the Canadian Nursing Students' Association National Conference 2016, students in UCD participated in a video conference workshop recently. The theme of the workshop was *'Visioning a global future: what are the most pressing difficulties facing nursing and global health currently?'* The findings from this workshop, which was held on January 29, will be presented at the International Congress of Nurses Student Assembly 2016. The workshop was a great opportunity for Irish students to share their views on the issues facing nursing as well as giving them the opportunity to interact with Canadian nursing students.

Preceptor of the Year award

Due to the growing popularity of the INMO 'Preceptor of the Year' award, this is now an annual event. The award will be given to an INMO member who has inspired and motivated a nursing or midwifery student to reach their full potential. Student nurses and midwives can nominate their preceptor before April 8, 2016 at **www.inmo.ie/Preceptor** The preceptor of the year will be invited, with a guest, to receive their award at the annual awards dinner at the ADC on May 5. They will also receive a €1,000 cash prize sponsored by Cornmarket. The student member who nominates the winning preceptor will also be invited, with a guest, to the awards dinner and will also receive a prize.



UCD students with Dean Flanagan, INMO student and new graduate officer(centre, right), participating in a video workshop as part of the Canadian Nursing Students Association National Conference 2016

Table 1: Extracts from NMBI scope of practice guidelines

Make the care of people your first concern, treating them as individuals and respecting their dignity	*Make care your first concern* – Do not accept gifts that you think could be interpreted as an attempt to gain preferential treatment *Respect dignity* – When referring to the patient case studies in your coursework, or anything that may identify an individual, be sure to change the names or make them anonymous, eg. patient A
Work with others to protect and promote the health and wellbeing of those in your care, their families and carers and the wider community	*Work with others* – Try to co-operate with members of your team and respect their individual contributions to your education – Let your preceptor/clinical placement co-ordinator know if you believe you or someone else is putting someone at risk of harm
Provide a high standard of practice and care at all times	*High standard of care* – Ask for help when you need it and recognise when you're out of your depth; it's not going to look bad if you admit that you need more guidance
Be open and honest, act with integrity and uphold the reputation of your profession	*Be open and honest* – Do not plagiarise coursework or clinical assessments *Uphold the reputation of your profession* – Be aware that how you act outside of your placement, in your spare time, also impacts on your perceived ability to practise – It may be useful to view NMBI's social media guidelines

Dean Flanagan is INMO student and new graduate officer

Social media – An open letter to members

Dear Member,

AS AN organisation the INMO constantly strives to promote and protect the welfare of members, in all matters related to their employment, pay and working conditions, while also promoting the objectives of justice, equity and equality.

To further these aims, it is necessary that constant contact is maintained with our membership through meetings in local workplaces, our branch/section structure, and also our annual delegate conference. It is through these structures that the true democracy of the INMO is reflected and this in turn shapes and influences all our work and activity. In addition, we communicate with members through email, text messaging, posted circulars, *WIN – World of Irish Nursing & Midwifery* journal and through social media to further facilitate focused professional debate on matters of mutual interest.

Maintaining this contact is extremely important and we always welcome the views of members in relation to all matters relevant to the work of the Organisation. It is only through members talking with us that we can continue to work to protect, defend and advance the pay and working conditions of nurses and midwives, and assist with ongoing professional development.

It is therefore essential that we hear the views of members, both when they are satisfied, and when they are not, with our work. We fully encourage and respect the rights of our members to freely express their opinions and the facts upon which they are based, relating to the work of the Organisation.

However, it is also the policy of the Organisation that all nurses and midwives, and the staff of the Organisation, must be treated with respect at all times, in all communications. While recognising, and fundamentally respecting, both the right and duty of members to tell us their opinions, it is not acceptable that any member, or staff of the Organisation, would be subject to abuse, in any form, including online via social media. Constructive, open debate is always worthwhile. However, personal abuse serves no good and is only destructive while also being unprofessional.

It must also be remembered that, as an Organisation made up of registered professionals, all are bound by the NMBI Code of Professional Conduct and Ethics for Registered Nurses and Midwives. This code requires that all registrants should be aware of their professional responsibilities when using social media, which is further supported by the NMBI guidance to nurses and midwives on social media and networking.

In this context social media offers a powerful medium to communicate the message of our Organisation, and to receive the full views of our members, and we welcome members communicating with us through social media. However, social media and other communication fora, must not be used in a manner which is abusive to members, or to the employees of the Organisation.

The INMO will continue to do everything, within its collective power, to promote and protect the welfare of members in all matters relating to their employment, pay and working conditions. We will continue to communicate with, and listen to our members, using whatever media our members choose.

In doing so we commit to be respectful of the rights of each individual we communicate with, in accordance with the ethos of our Organisation, and the requirements of the Code of Professional Conduct and Ethics for Registered Nurses and Midwives. In return we ask and expect that all members will do likewise, showing respect to fellow members and employees of the INMO, when expressing their views about the work of the Organisation.

Yours sincerely,

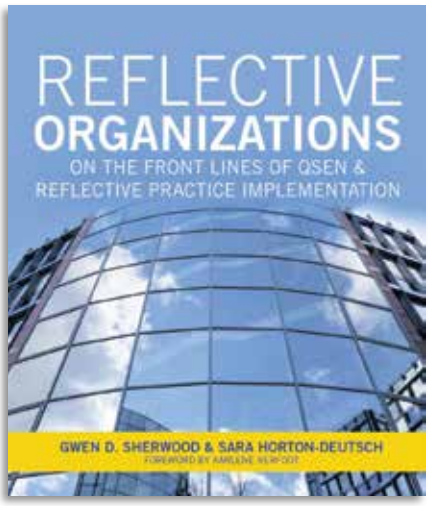
Claire Mahon, *President*
Geraldine Talty, *First Vice President*
Martina Harkin-Kelly, *Second Vice President*

Take time to reflect

THE authors of *Reflective Organizations* have a distinguished record in nursing education, quality and safety in health education, transforming organisations and compassionate and creative approaches to education and learning. There are a number of contributing authors which reduces a purely academic focus to one that presents real examples of change and development in a variety of practice and teaching settings.

Framed by the authors' rationale for transforming healthcare professionals to respond rapidly and reflectively to increasing demands, they present a number of interesting arguments, supported by numerous examples of proposals to support future-orientated healthcare. Starting with transforming education in both content and teaching style, a clear line of reasoning is presented for the consideration of new approaches that can equip healthcare professionals to be more reflective learners and educators.

A number of fresh techniques intended to stimulate learning through creative teaching strategies are presented with clear examples of how they were incorporated into practice. The importance of



both reflective leaders and learning environments is well argued, including risk taking and facing challenges. The book builds on themes such as the development of collaborative teams with useful examples, with the emphasis on quality and safety and the positive outcomes that can be achieved for service users and healthcare professionals alike.

What makes this book readable is the way it speaks to education providers and professionals in practice and avoids creating a theory/practice gap by presenting examples of how proposed strategies and approaches can be implemented. The thread throughout is reflection and its benefit to learning and development. Summary sections at the end of each chapter are very useful as are the thought provoking questions scattered throughout.

The book focuses primarily on the US health and education systems and, although providing excellent examples of ideas and strategies, the translation may be a slight challenge to our systems.

In summary, this was a much easier and more enjoyable read than the cover and size might denote, being well presented and laid out. It has relevance for any individual or groups considering ways to enhance care outcomes, learning opportunities, teaching content and styles, and personal and professional development, with an overall theme of reflection and collaboration at its core.

– Lorna Peelo-Kilroe, Strategic Project Officer at HSE Office of Nursing & Midwifery Services Director

Reflective Organizations: On the front lines of QSEN & reflective practice implementation by Gwen D Sherwood and Sara Horton-Deutsch; published by Sigma Theta Tau International: Indianapolis, USA

Crossword Competition

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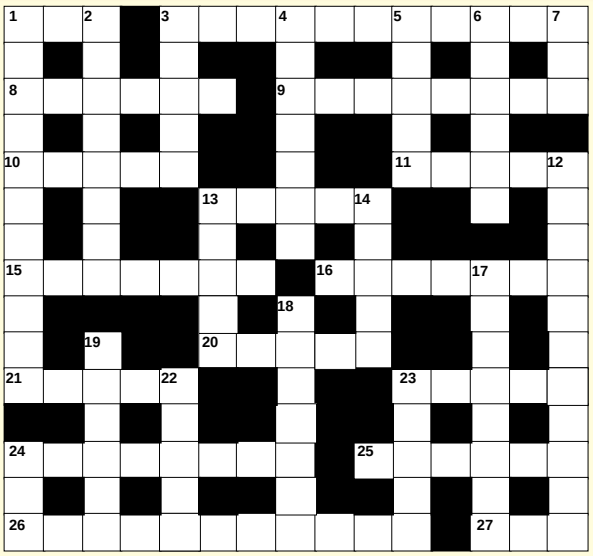


Across

1. Donkey or fool (3)
3. That's some volatile rut – it's off the spectrum! (11)
8. Sign of the zodiac, the bull (6)
9. Unwelcome type of reaction, perhaps shown with ill grace (8)
10 & 23d. Pile bronze up to achieve Scandinavian recognition (5,5)
11. Showing signs of age or worry (5)
13. Peruses (5)
15 & 16. How I assessed henna to identify leprosy (7,7)
20. Depart (5)
21. Subvention (5)
23. Spaghetti, for example (5)
24. Cross associated with Nazis (8)
25. Scandinavian marauder (6)
26. Hymn about the whitebeam I'd chopped (5,4,2)
27. The first woman in the Bible. (3)

Down

1. Some nights, Sonia can be amazing! (11)
2. Obstinate (8)
3. Customary (5)
4. But it's not the highways that pay it, it's the motorists! (4,3)
5. Perfect (5)
6. Ancient tale or myth (6)
7. Spasmodic movement (3)
12. Unravel England's tie from this (11)
13. Learn about what concerns the kidneys (5)
14. Glow, radiate (5)
17. Ingredient also called pimento (8)
18. Dashing, brave (7)
19. Spiced sausage (6)
22. Name of a book, film etc (5)
23. See 10 across
24. Ocean. (3)

Solutions to February crossword:

Across:
1. Scrivener's palsy 6. Item 10. Colon 11. Double bed 12. Amassed 15. Corgi 17. Etna 18. Hide 19. Rebel 21. Crossed 24. Cave 25. Poor 26. Inner 28. Talking 33. Treasurer 34. Let in 35. Reel 36. Englishman

Down
1. Sick 2. Role model 3. Venus 4. Nudge 5. Rout 7. Tuber 8. Midfielder 9. Placard 13. Suir 14. Dessert 16. Shoplifter 20. Brain stem 21. Cypress 22. Earl 27. Niece 29. Aural 30. Kells 31. Wren 32. Anon

The winner of the February crossword is: Mary O'Malley Headford Galway

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

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

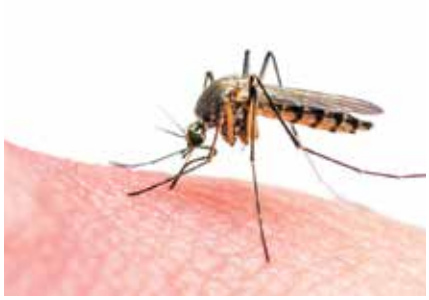
Zika virus: nurses are first point of care

Education and community resilience key in prevention and intervention of virus

AS THE largest group of health professionals in the world, nurses play a vital role in educating patients on risk and prevention of the Zika virus, as well as providing care to those affected by the virus.

The International Council of Nurses (ICN) has issued a recommendation that nurses in infected countries advise patients to protect themselves against mosquito bites through the use of insect repellents, bed nets, window and door screens, and by covering exposed areas of skin. In addition, any containers, such as flower pots or buckets, that many contain water where mosquitoes can breed, should be emptied and removed.

In non-affected countries, the ICN advises nurses and midwives to ask whether their pregnant patients have recently travelled to infected countries and to advise them against travel to those areas.



"With nurses providing the majority of primary healthcare in most countries, it is important they are aware of the risks of the virus, the ways to prevent its spread, and when testing and treatment are needed," said Dr Frances Hughes, CEO of the ICN.

"To reduce fear and anxiety, it is important for communities to have access to up-to-date and accurate information, and nurses are the key vehicle of delivery of this information. Nurses are also well placed to educate and offer psychosocial support to reassure the public and build community resilience, as well as ensure early detection and intervention," said Dr Hughes.

In May 2015, the first infections of Zika virus were confirmed in Brazil and since then the virus has spread to over 13 countries in the Americas and in Cape Verde, Africa, with cases now confirmed in the US and Europe.

While the virus is transmitted to people primarily through the bite of an infected *Aedes* species, it can also be spread through blood transfusion and sexual contact. Unfortunately, there are many cases in Brazil and other countries in South America, in which a pregnant mother has passed the virus on to her unborn child.

Al Jazeera reported that the Brazilian Minister of Health has announced that there are more than 4,000 suspected and 400 confirmed cases of microcephaly among newborn babies with many strongly suspected of being caused by the Zika virus.

Mental health research network

A RESEARCH network that aims to enhance the mental health and wellbeing of people throughout their lifetime has been launched by Kathleen Lynch, Minister of State at the Department of Health.

ENGAGE (Interdisciplinary Clinical Mental Health Research Network) generates and disseminates high-quality collaborative research about mental health and is based on principles of inclusivity, valuing diversity and partnership across communities and services.

Speaking at the network launch, Dr Aine Horgan, chair of ENGAGE, said: "The network will provide a mechanism for the accelerated transfer of research evidence into practice and a forum to influence national research policy. The initiative is all about collaboration and inclusivity and we look forward to working with service users, community bodies and the general public in addressing how research can be generated, discussed and applied to address the key challenges in society related to mental health and wellbeing."

New education standards to support nursing and midwifery care

THE Nursing and Midwifery Board of Ireland (NMBI) has launched new standards and requirements to support the education of nurses and midwives in Ireland to help them provide the safest, most effective care possible to patients.

The two documents, *Midwife Registration Programme Standards and Requirements* and *Nurse Registration Programmes Standards and Requirements*, outline the undergraduate programmes that students must complete in order to become a nurse or midwife in Ireland.

"The aim of these revised standards and requirements is to support the continuous enhancement of professional undergraduate education programmes in Ireland, thereby ensuring that new registrants are equipped to meet the challenges to provide responsive, high-quality, compassionate and safe patient care," NMBI president Essene Cassidy said.

The new standards, which have been developed following a comprehensive review of undergraduate nursing and midwifery education in Ireland, are in keeping with the NMBI's responsibilities to protect the public in its dealings with nurses and midwives, and to protect the integrity of nursing and midwifery practice through high standards of professional education, training, practice and professional conduct.

They also incorporate the legislative requirements of the Nurses and Midwives Act 2011, the EU Directive 2013/55/EU concerning the recognition of professional qualifications, as well as building on the recommendations contained in the *Report of the Review of Undergraduate Nursing and Midwifery Degree Programmes* and other reports into the provision of healthcare in Ireland.

HPV DNA testing in cervical cancer could improve efficacy of screening process

THE Health Information and Quality Authority (HIQA) is to conduct research to determine the optimal primary screening test for the prevention of cervical cancer in Ireland.

At the request of the National Screening Service, HIQA will undertake a health technology assessment to independently evaluate the clinical, financial, ethical and organisational implications of establishing human papillomavirus (HPV) testing as the primary screening test for preventing cervical cancer. At present, liquid-based cytology is used as the primary screening tool by the National Cervical Screening Programme (CervicalCheck).

If low grade abnormalities are detected, the same sample is tested for HPV DNA to determine if the woman should be referred for colposcopy or back to routine screening. Changing the order of these tests, that is, using HPV DNA testing as the primary test followed by liquid-based cytology, has the potential to improve the detection of cancerous and pre-cancerous cell changes and to increase the efficiency of the screening process.

HIQA director of health technology assessment, Dr Máirín Ryan said: "By examining international evidence on the clinical and cost-effectiveness of HPV testing and by modelling these benefits, along with the budget impact of switching to HPV DNA testing for the Irish healthcare system, we will be in a position to provide independent advice on the optimal screening strategy for preventing cervical cancer in Ireland."

HPV is a common virus usually spread by skin-to-skin contact during sexual contact. Most people will have HPV at some point in their lives and in most cases it causes no symptoms and is cleared by the body's immune system. However, persistent infection with a number of HPV virus types can lead to cervical cancer.

The final results of the health technology assessment are expected at the end of the year and will be submitted to the National Screening Service for consideration.

Diabetes toolkit launched for nurses

Elaine Newell, community diabetes nurse specialist, is presented with the Diabetes Toolkit for Practice Nurses by Abina O'Flynn and Gary Hannify from MSD

A NEW diabetes toolkit resource to support nurses working with patients with diabetes is to be presented to every practice nurse in Galway.

This toolkit will support practice nurses by providing the vital resources needed to monitor high-risk diabetes patients, support their treatment and help them to effectively manage the condition. It contains educational material about diabetes symptoms, treatment and management of the condition, as well as support tools that patients can use themselves. The toolkit was developed by community diabetes nurse specialist, Elaine Newell, in partnership with MSD, Saolta University Health Care Group and Galway University Hospitals.

Is your home covered?

Marc Evans offers some tips on how to ensure you have adequate cover for your home

FOR most people their home is their most valuable asset. Therefore it is important to ensure you have the right home insurance cover. When you are looking for home insurance you should always discuss the level of cover and the benefits of the policy. The following tips will help you to ask the right questions and get the best value when shopping around for home insurance.

How much should I insure my home for?

When it comes to insuring your home it's important to know what the word 'home' refers to. The home includes domestic outbuildings, garages, greenhouses, sanitary fixtures, swimming pools, tennis courts, patios, terraces, driveways, footpaths, walls, gates, hedges, fences, aerials, satellite dishes and their fittings and masts, including landlord's fixtures and fittings, all on the same site. This may seem complicated but you need to think of more than just the house itself.

It is also important to remember it is not the selling value you should insure your home for. It is the value it would cost to rebuild it should the need arise. To get an up-to-date valuation on the rebuilding costs of your property, there is an easy to use calculator to guide you on the Chartered Surveyors of Ireland website at **www.scsi.ie**

How much should I insure contents for?

When it comes to insuring the contents of your home, valuations can vary, as everyone is different. Contents are defined as all property including business equipment, valuables, clothing, personal effects and money in your home or its domestic outbuildings, garages or greenhouses owned by any member of your household or for which they are responsible. An easy way to look at it is all items which you would take from your home if you were to move house.

What are the essential benefits?

With so many different levels of cover under home insurance it is important to make sure you have a checklist of benefits that you should look for on any home insurance policy *(see Table)*.

Checklist of benefits

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

Check for extra services

Some insurance policies offer extra services. For example, Cornmarket home insurance policies include Home Rescue,* which provides an emergency repair service to secure your home and prevent further loss or damage occurring following an emergency, as a result of the following:

- Damage to piping, leaks from sanitary fixtures/fittings and fixed water installations within your home
- Failure of the electrical supply within your home as a result of a fault or damage to the internal electrical installations
- Your home being made insecure or if entry is impeded, due to loss/theft of keys or damage to locks, as a result of theft or any other accidental cause, or in the event that a child may have locked themselves in a room
- Storm damage or any other accidental damage to the roof that renders your home insecure
- Breakage of glazing to external windows or doors that renders your home unsecured.

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

What if I need to make a claim?

If you need to make a claim you can do so by calling the claims number found in your insurance underwriter policy booklet.

How can I get the best price?

When deciding on home insurance you should ensure:

- The amount your buildings are insured for is correct and not over or under insured
- Your contents are insured for the right amount
- That valuable items such as engagement rings are covered
- That you ask about the excess amount, it's important to know if you do claim how much you have to pay
- That you tell the insurance company if you have been claims free for more than three years as this may reduce your premium.

Marc Evans, Director, Cornmarket Group Financial Services Ltd

March

Saturday 5
INMO International Nurses Section Conference and Culturefest. INMO HQ, Dublin. Registration at 8.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Monday 7
Emergency Department Section meeting. All interested members welcome to attend this meeting. INMO HQ. 12pm-2pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

April

Monday 4
National Children's Nurses Section meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 9
PHN Section meeting. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 9
CRGN Section meeting. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 9
Clinical Nurse/Midwife Managers Section meeting. INMO HQ. From 10am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Tuesday 12
Telephone Triage Section meeting. Heritage Hotel, Portlaoise. Preparing for HIQA inspections. From 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

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

Friday 15 and Saturday 16
ODN Section Conference. Clarion Hotel, Liffey Valley, Dublin. Please log on to **www.inmoprofessional.ie** to book your place or contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 16
School Nurses Section meeting. Portlaoise Heritage Hotel. From 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Thursday 21
Retired Nurses and Midwives Section meeting. INMO HQ. From 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 23
GP Practice Section meeting. INMO HQ. From 11am. Fitness to practise session. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

May

Wednesday 11
OHN Annual conference. Maryborough Hotel, Douglas, Cork. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Notice

- Annette Halton is calling on all former staff of Mercer's Hospital to form a committee so as to make a reunion a success.

  Contact Ms Halton Doyle at Tel: 087 8137402 or email: annettehalton@eircom.net or Margaret Hynes nee Lowery, Tel: 087 2055742, email: mmahynes@hotmail.com

EORNA 2017

- The eight Congress of the European Operating Room Nurses Association (EORNA) will be held in Rhodes Island, Greece from May 4-7, 2017.

  Submissions for abstracts is now open online. The theme for the Congress is 'The Colossus of Perioperative Nursing'

  Abstracts that address the latest clinical practice, education and innovation, research/evidence based practice, leadership and management, informatics, healthy workplaces, risk management and service development issues or any other latest trends and developments relevant to perioperative nursing are welcome for education session proposal or for poster presentation.

  Useful information on abstract submission, registration, as well as accommodation options is now available on **www.eornacongress.eu**

INMO Membership Fees 2015

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

Events and conferences

- Irish Nurses and Midwives Golf society annual outing. Mullingar Golf Club. €50. Coffee/tea on arrival, golf and dinner. Booking from March 28 on BRS at mullingargolfclub.com. Booking will only be confirmed on receipt of payment within five days, to Kay Browne, treasurer at Mullingar Golf Club, Belvedere Mullingar. For queries, contact Kay Browne at Tel: 086 826932
- The eighth Child and Family Nursing Conference will be held on Tuesday, April 12, 2016 in Cork University Hospital. Email: Bebhinn.osullivan@hse.ie for more information
- The eighth Sonas APC International Dementia Conference will be held in the Citywest Hotel, Dublin on March 16 and 17, 2016. Contact events@sonasapc.ie

Condolences

- The INMO Limerick Branch extends their deepest sympathies to Ailish Bredin, senior staff nurse at Brothers of Charity Brawnmore, on the recent death of her mother Margaret Roche. RIP
- Sincere condolences to Eileen Selby, from all her INMO colleagues, on the recent death of her sister Rita Flynn. May she rest in peace
- The ODN Section offer their deepest sympathies to their former colleague Mona Guickian-Fisher on the recent loss of her husband, Phil Fisher. RIP
- The INMO Retired Nurses Section would like to extend their condolences to Louise Mahon, whose son Jamie who lived in Melbourne, Australia with his wife and sons, passed away on January 17, 2016. May he rest in peace