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WIN

Journal of the Irish Nurses and Midwives Organisation

World of Irish Nursing & Midwifery

Latest INMO CPD education programme
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Immunotherapy innovation in cancer care
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Spotlight on midwifery

Preparations underway for midwifery festival

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INMO Professional Events 2023

ONLINE AND IN-PERSON EVENTS

All conferences and webinars are Category 1 approved by NMBI

SCAN ME!

MARCH 7

National Care of the Older Person Section Conference

Midlands Park Hotel, Portlaoise, Co Laoise

MARCH 30

RNID Section

The Richmond Education and Event Centre, Dublin

SEPTEMBER 26

Telephone Triage Nurses Section

Midlands Park Hotel, Portlaoise, Co Laoise

NOVEMBER 16

All Ireland Midwifery Conference

For further details go to
www.inmoprofessional.ie/conference
or contact jean.carroll@inmo.ie

NEWS & VIEWS

FEATURES

CLINICAL

LIVING

JOBS & TRAINING

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FREE TO ATTEND

for all practising and student healthcare professionals

ALL-IRELAND 2023 MATERNITY & MIDWIFERY FESTIVAL

MATERNITY & MIDWIFERY FORUM

The Helix, Dublin

Tuesday 18 April 2023

IN-PERSON, LIVE AND ON DEMAND

@MidwiferyForum #AllIrelandMMF2023

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THE PRACTISING MIDWIFE

MATFLIX
VIDEO STREAMING FROM MATERNITY EXPERTS

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Underfunding coming home to roost

THE global pandemic continues to profoundly affect our country. The geopolitical instability caused by Russia's senseless invasion of Ukraine has deepened a cost-of-living crisis. This is happening against a backdrop of record income tax and corporation tax receipts by the Irish government. Strategic interventions must be made by the government to ensure that meaningful improvements are made to all facets of the delivery of public services, particularly the health service.

Oireachtas presentation

We presented evidence to the Joint Oireachtas Committee on Health last month to demonstrate the effects of this chaotic model of healthcare delivery, repeating the statistics of increasing physical assaults and verbal abuse endured by nurses and midwives. We set out the measures needed to curb and address this – you can read coverage of our presentation to TDs and senators on *page 10*.

The pandemic exposed years of underfunding, understaffing and underresourcing in our health service. As time goes on, new challenges and problems that require critical investment and reform continue to be revealed. The cracks can no longer be patched over however, and the return of overcrowding in the country's hospitals, staff shortages and unmet needs can no longer be tolerated.

A significant proportion of nurses and midwives who are working in poor clinical environments are burned out and exhausted without adequate on-site protection or support. This must be urgently addressed.

Our recent consultation with members in workplaces echoed this feeling loudly. There is a sense that those who are working in, and those who are depending on, our health services are being ignored. Even the most tragic of events does not serve as a wake-up call.

Multicultural Ireland

We very much have a multicultural workforce in Ireland and the Irish health service is extremely reliant on non-EU recruitment for nurses, midwives, doctors and many other workers within the system. The INMO has sought additional support measures to improve integration for these workers both at work and in society.

The chaotic pace and overcrowded workplaces are difficult for all new entrants and, while excellent clinical facilitation is in place in several areas, it is not sufficiently supported or funded as a necessary part of integration and orientation for newly qualified or newly recruited nurses and midwives. Facilitating such support was a very clear request coming from members during the recent consultation meetings.

On February 18, the Organisation was proud to take part in the solidarity march against the worrying pockets of anti-immigration sentiment which has reared its head in Ireland lately. Our services have not been immune from this and we must all be part of ensuring that any such sentiment expressed to our colleagues by relatives, patients or protesters is simply not tolerated.

African, Filipino and Indian nurses – our friends and colleagues – walked with us and felt strongly supported by nursing and midwifery professions in this public display of zero tolerance towards racism.

Ireland is changing and the need to ensure we maintain our long and proud history of tolerance and welcome those who are fleeing war, persecution or famine must continue. As a nation, we have a history of emigration ourselves and we have relied on the refuge of other nations in our not-too-distant past.

It was very clear from the 50,000 strong turnout on February 18 that we as a society stand against racism and anti-migrant sentiment. See *page 8* for more details on the INMO's involvement in the march.

Phil Ní Sheaghdha
General Secretary, INMO

INMO 2023 SURVEY

Your 2023 survey is now open

MAKE YOUR VOICE HEARD

SCAN THE QR CODE AND TELL US ABOUT YOUR WORKING LIFE

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Registered Nurse Intellectual Disability Section Conference

Thursday, 30 March 2023

Theme:
Re-energising for the future in ID Nursing

Venue: The Richmond Education and Event Centre, Dublin
Fee: €60 INMO members

INMO Members Only In-Person Event

THIS EVENT IS LIMITED TO THE FIRST 80 BOOKINGS

Contact jean.carroll@inmo.ie for further information on this event
To book email **education@inmo.ie** or call **01 6640618/41**

SCAN ME!

A positive focus with the president

Karen McGowan, INMO president

Power of meeting in person

IT WAS fantastic to meet with so many members during our recent consultation meetings. The past few years really impinged on our ability to meet face to face, but the readiness to re-engage was clear. We have clear sight of the issues members raised and how to work towards them. Safe staffing is on everyone's agenda as it is a major problem with regard to retaining qualified staff. There is strength in our union that comes from the participation of the members. Thank you to everyone who engaged with us, particularly those who we met on wards and in emergency departments. It was great to have so many contributions while on site.

Valued role of the intellectual disability nurse

THIS month I wanted to focus on the valued role of the registered nurse in intellectual disability (RNID) within the acute care setting so I caught up with Carmel Daly who is a CNM2 for the Intellectual Disability Liaison Service, Louth Hospital Group. Ms Daly is based in Our Lady of Lourdes Hospital (OLOL), Drogheda. This new service was established in 2021 involving a partnership between OLOL, Louth/Meath Intellectual Disability Services, St John of God North East services and the Nursing and Midwifery Planning and Development Unit (NMPDU).

Carmel Daly, CNM2, OLOL ID liaison service

Ms Daly has postgraduate training in psychiatric nursing and a diploma in business studies in nursing management, contemporary palliative care practice, health assessment and sensory processing disorder. She has worked in ID services in Australia and Northern Ireland and across the various age groups and settings for people with ID. She explained that her role was established and funded by NMPDU initially for two years and, due to its success, a commitment has been received to fund the post as a permanent position. Her role is multidimensional, involving direct patient contact to identify adjustments necessary to support the patient/carers on their journey from point of contact – be that the emergency department or elsewhere – right through to discharge.

People with intellectual disabilities are living longer and children with complex intellectual disabilities are surviving into adulthood. Research indicates people with ID are prone to poorer health outcomes when compared with the general population. They have multimorbidities and use healthcare services more, therefore the ID liaison service is central to ensuring that their care is optimised. Ms Daly is passionate about raising the profile of people with ID and the role of ID nursing, and sees career progression of the RNID as care progression for people with ID.

"Barriers to accessing healthcare for people with ID include difficulty in communication with healthcare practitioners. My role involves raising awareness and supporting staff to develop their competencies in providing care to patients with ID. I do this by delivering training to staff across departments and within ID services, and to family and carers, on the importance of providing relevant information and supporting the person to communicate their needs, to ensure proper continuity of care, thus achieving better outcomes. The health passport is an integral part of this. Staff at OLOL receive ongoing training on the health passport and I view it as the patient's safety communication tool. Staff in acute settings identify patient-specific, reasonable adjustments and complete nursing care plans, from the information on the passport. I am driven by a desire to ensure that the healthcare needs of people with ID, regardless of their diagnosis or prognosis, are assessed and met," Ms Daly said.

Executive Council update

THE Executive Council met this month and discussed and reviewed the consultation meetings that have been taking place nationwide over the past few weeks. I want to thank our members across the country for organising and participating in these meetings. It is clear that members are feeling the burnout from the past few years and there are multiple local issues impinging on their ability to do their jobs appropriately. It really was fantastic to meet with members in person. We draw support and strength from each other and there is such solidarity among the membership.

Another recent event of note was when INMO general secretary Phil Ní Sheaghdha and I attended the unveiling of the Stardust Victims Eternal Memorial in Artane in Dublin on February 11. We will always remember the 48 victims that never came home.

Annual delegate conference plans are going well and we look forward to meeting up in Killarney in early May. My sincere thanks to the INMO Killarney Branch for all the work it is doing to ensure we have a great conference. I also want to thank the Standing Orders Committee as it is coming into a busy time reviewing the motions for debate at conference.

The Care of the Older Persons Section will host its annual conference in Mullingar on March 7 and the RNID Section will be hosting its annual conference in the Richmond Education and Event Centre in Dublin on March 30. The calibre of speakers for these events is impressive and I encourage members working in these specialised areas to attend. The networking opportunities at these events are a great way to get to know others working in your field.

Get in touch

You can contact me at INMO HQ at Tel: 01 6640 600 or by email to: president@inmo.ie

INMO backs call for an Ireland-for-All

ON Saturday, February 18 INMO members and staff joined the Ireland-for-All march in Dublin city centre to celebrate diversity and demand respect for people of all backgrounds.

In the region of 50,000 people from communities, clubs, services, trade unions, political parties, Traveller and migrant rights groups and other progressive groups came together to show solidarity and stand up against racism.

Standing in solidarity: *"INMO members and staff marched in demand of an Ireland-for-All*

The group marched from the Garden of Remembrance to the Customs House in Dublin where veteran civil rights activist Bernadette McAliskey addressed the crowd stressing that Ireland has capacity to welcome refugees, who are not the source of Ireland's problems. She said people in Ireland needed to ask themselves "Whose side are you on?", urging attendees to adhere to the side of "humanity, decency and human rights".

Singer Christy Moore told the crowd at the rally that he was there to express his revulsion about attacks on refugees and sang *"Viva lá Quinta Brigada"* – a song in tribute to Irish people who joined the fight against fascism during the Spanish Civil War.

INMO general secretary Phil Ní Sheaghdha said: "People in communities across Ireland face unaffordable bills, skyrocketing rents and long waiting lists for public services. Government policy has caused the health, housing and cost of living crises. These issues were not caused by the presence of ethnic minorities and refugees.

"We joined this march because our public health service depends heavily on the valuable contributions of our migrant workforce. The deliberate scapegoating of minorities by the far right is a vicious tactic used to play on people's fears and spread division within our diverse communities."

Executive Council sanctions ballots for industrial action on location-by-location basis

FOLLOWING a month-long period of consultation with the HSE and the Department of Health with little progress, the INMO Executive Council has sanctioned a campaign of industrial action in pursuance of safe staffing.

INMO general secretary Phil Ní Sheaghdha said: "It has been made very clear to us at each meeting we attended in recent weeks that there is a severe staffing crisis in our hospitals. Nurses in each hospital have stated that unsafe staffing is the norm. This is unacceptable with regard to patient safety and nurses' safety at work.

"Ballots for industrial action have been sanctioned on a location-by-location basis, as it is clear that the staffing levels in certain locations are enduring a huge shortfall.

"We know that many hospitals cannot keep up with the pace at which nurses and midwives are leaving to work in safer environments.

"The INMO Executive Council is now seeking that the Department of Health and the HSE produce a fully-funded workforce plan for next winter, before the INMO annual delegate conference is held in May. If this plan is not completed, a national ballot will be considered at the ADC."

INMO president Karen McGowan said: "Safe staffing should not be a pipe dream for nurses and midwives. Patients should be made aware of the severity of the staffing deficits our members are trying to work through.

"Hospital management in each location cannot keep trying to fill from an empty cup. The expectation that we can run our health service at a less-than-safe staffing capacity must be challenged."

Pressure on hospital staff must be addressed

OVER 11,289 admitted patients went without a hospital bed in January 2023, according to the INMO Trolley Watch figures. The top five most overcrowded hospitals for January were:

- University Hospital Limerick – 1,180 patients
- Cork University Hospital – 1,145 patients
- University Hospital Galway – 728 patients
- Letterkenny University Hospital – 650 patients
- St Vincent's University Hospital – 594 patients.

INMO general secretary Phil Ní Sheaghdha said: "A lack of adequate planning has put unnecessary stress on nurses and the patients they were trying to provide care for. The number of patients on trolleys in wards outside our emergency departments is unacceptably high. This practice should not be allowed to continue as a measure to try take pressure off EDs. We cannot continue to accept the wait-until-things-get-unbearably-bad approach before an attempt is made to lessen the pressure on our public hospital system."

Overcrowding causing aggression in Irish hospitals, Oireachtas told

ADDRESSING the Joint Oireachtas Committee on Health last month, the INMO called for zero tolerance of violence and aggression in the workplace, stressing that the physical and mental health of nurses and midwives in the workplace must be prioritised. The INMO also stressed that employers' obligations under health and safety legislation must be strictly adhered to.

An INMO delegation attended the Joint Oireachtas Committee on Health on February 8, 2023, which focused on the welfare and safety of workers and patients in the public health service, alongside representatives from Fórsa, SIPTU and the IMO.

In its statement to the committee, the INMO also called for the implementation of an occupational injury scheme recognising long Covid as an occupational injury. In particular, the INMO called for the implementation of safe staffing measures and stronger intervention from the Health and Safety Authority (HSA), with more inspections and the establishment of a division to focus specifically on the health services.

"The HSE must tackle this issue head on. The INMO is again repeating our call for a full review and audit of security systems and protocols in Irish hospitals. An audit has not been completed since 2016 and it is time to rectify this situation", said INMO general secretary Phil Ní Sheaghdha.

The INMO delegation also included director of industrial relations Albert Murphy and INMO member Sylvia Chambers, who is a CNM2 in a Dublin paediatric hospital.

For a significant portion of the session, the committee's focus was on nurses and midwives' experiences of assaults and the effects of overcrowding on violence and aggression in hospitals.

Giving the INMO's opening statement, Ms Ní Sheaghdha focused on the incidence of assaults, stating that according to HSE records "unfortunately there have been 5,593 reported assaults against nursing and midwifery staff in the period between January 2021 and October 2022", continuing that this figure did not include nurses and midwives in non-HSE workplaces.

Ms Ní Sheaghdha added: "Public hospitals are operating at approximately 110%/111% occupancy when we know the safety level is 82%." She said delays in implementing programmes to increase access to care outside of acute public hospitals was having an impact on hospital capacity and overcrowding.

Ms Ní Sheaghdha also spoke of the lack of action from the HSA in ensuring the safety of hospitals as workplaces, and the discrepancy in this regard between healthcare settings and other workplaces and industries.

Ms Chambers, who works on the frontline in a Dublin paediatric emergency department, told the Oireachtas committee of her first-hand experience of both physical and verbal assault in her workplace. She cited the effects of overcrowding and long waits on the incidence of verbal and physical assaults in the hospitals, noting that nurses in EDs were obliged to prioritise resus and urgent trauma cases, leaving children and their parents waiting "up to 10 and 12 hours", which in turn leads to parents becoming aggressive.

Joint Oireachtas Committee on Health: *INMO general secretary Phil Ní Sheaghdha (below, left) and INMO member, Sylvia Chambers, a paediatric CNM2 in a Dublin ED, addressed the committee on the effects of hospital overcrowding on the safety and wellbeing of both staff and patients*

Ms Chambers also said that parents being unable to obtain a GP appointment for their child was causing increased attendances to EDs and this was impacting the workload and capacity in Irish hospitals.

Stressing that assaults have a significant effect on nurses' wellbeing with a long-term impact on retention in EDs, and that in her own department she had seen a high number of resignations in recent months, Ms Chambers said "I take so much pride in my work but I don't feel safe going to work". She continued: "I have asked in exit interviews why people are leaving and it is because they're stressed, they are afraid in work, and they can't provide appropriate care."

Ms Chambers also said that, although incident reports were used in the case of assaults, it was difficult for staff to take proper action following an incident of physical or verbal aggression. "I could be verbally abused four or five times in a night," Ms Chambers said, "I won't put in an incident report form. I'm too busy."

The committee also discussed the prevalence of long Covid among nurses and midwives and the continued impact of this illness on many healthcare workers. It noted that the initial supports put in place to support people who had acquired Covid-19 at work were no longer in place despite the fact that many healthcare workers continue to experience symptoms that affected their ability to work.

The representatives of the various unions addressing the Oireachtas committee were in concordance that heightened security of hospitals was needed, along with measures to reduce overcrowding and waiting times, with an urgent need to address staffing issues.

Committee members agreed that the incidence of assaults across the health service was completely unacceptable and that a zero tolerance approach was needed. The committee thanked attendees and healthcare workers for their detailed accounts of their experiences.

– Beibhinn Dunne

INMO director of industrial relations **Albert Murphy** updates members

Discussions ongoing on several national issues

THE INMO commenced the year participating in discussions and negotiations on several ongoing national issues in both the National Joint Council and the Workplace Relations Commission. There follows a synopsis of the latest developments.

Payroll and pension arrears

THE INMO and other unions involved in the National Joint Council (NJC) forum with the HSE have been dealing with the arrears of payments due under Building Momentum for both current employees and pensioners.

While commitments have been received on payment dates, the unions have expressed strong concerns in correspondence to employers in relation to unacceptable delays.

This matter was raised at the Health Service Oversight Body and subsequently has been referred to the Public Service Advisory Group (PSAG). A meeting of PSAG took place on the February 8 and the INMO has been advised that the complaint made by the union, that these delays constitute a breach of Building Momentum, has been upheld. We will be engaging with employers to ensure compliance in a reasonable time in relation to future pay awards.

ED agreement under review

A review of the implementation of the entire INMO/HSE Emergency Department Agreement is due to conclude by the end of March. This review was agreed at the INMO/HSE ED Forum at a meeting in the Workplace Relations Commission in January.

Mediator Sean McHugh was agreed as the independent chairperson for this review and the report comes under the auspices of the WRC.

It was also agreed at the meeting that, subject to verification of the 2022 admissions data, 83 additional nurse posts will be sanctioned for EDs.

On behalf of the INMO, the meeting was attended by director of industrial relations Albert Murphy, assistant directors of IR Mary Rose Carroll and Maeve Brehony, IRO Bernadette Stenson and Executive Council member and ED nurse Sarah Meagher.

Pandemic Recognition Payment appeals process

The appeals body set up to deal with the Pandemic Recognition Payment has now concluded its business, having received and dealt with a total of 3,500 appeals.

Most of the appeals received were allowed by the appeals body and the HSE is in the course of notifying the appellants and employers of the outcomes.

The INMO is still awaiting engagement with the Department of Health in relation to the issue of groups who have been excluded from the pandemic payment.

Section 39 pay restoration

The long-running claim by the ICTU for pay restoration in the voluntary and community sector (Section 39 organisations), in which the INMO has played a significant role, is to be heard in the Workplace Relations Commission.

The HSE has confirmed that it will attend the WRC in relation to this process, and a hearing is expected to take place shortly.

Out-of hours payments to managers in RNID

A conciliation conference took place last month in relation to out-of-hours payments to RNID managers. Employers had previously offered 75% of the theatre on-call rates to RNID managers, and unions rejected this proposition on the basis that they do not accept the work of an RNID is of less value than work performed by other on-call nurses, and it would establish an unhelpful precedent. A further conciliation conference was arranged for late February.

ED – winter surge extension

The HSE agreed to extend the enhanced overtime arrangements – designed to help ease hospital overcrowding – into February, to cover the holiday weekend of February 4-6. The INMO was seeking that the enhanced overtime arrangements would apply throughout February and would be eligible to all staff during the full week.

National Investigation Unit

Agreement has been reached with the HSE in relation to the appointment of an assessor for the appointment of full-time investigators to the National Investigation Unit. Agreement has also been reached to appoint a former Labour Court chair to act as adjudicator in the event of disputes arising between unions and management in relation to aspects of the investigative processes that are currently referrable to third parties under collective agreements. The INMO is still awaiting confirmation that the terms of reference for the National Investigation Unit will be amended to provide for additional members of the investigation teams and once this is provided then all matters in relation to the establishment of the unit will be resolved.

CUH outsourcing

The National Joint Council staff chair wrote to Mary Day, HSE national director of acute operations, on December 23 to object to arrangements whereby external management consultants were taking an active role in running hospital operations at Cork University Hospital (CUH) in the absence of the CEO. The NJC requested that the arrangement be stood down and the matter has subsequently been referred to the Public Service Agreement Group (PSAG) and was found to be a breach of Building Momentum.

INMO Health & Safety Group

THE INMO Health and Safety Group met on February 10 and discussed the HSE's draft document on Healthy Workplaces and the planned Worker's Memorial Day event on April 28, with details to be finalised by the ICTU Occupational Safety and Health Committee. The group also reviewed a report from Karen Eccles, national health and safety released rep, following which it was agreed that a leaflet on the role of the safety rep and lead worker representative will be provided.

In addition, the safety rep course will be held on April 19-20, at which 22 new safety reps will be trained.

on recent national issues

HIQA finds widespread unsafe staffing

THE HSE and the Department of Health must heed warnings on insufficient nurse and midwife staffing emanating from the HIQA inspection reports issued as we went to press, the INMO has warned. They were published on a day when 605 admitted patients were without a bed in Irish hospitals.

INMO general secretary Phil Ní Sheaghdha said: "We once again commend HIQA for its role in inspecting the current state of our hospitals. The INMO is firmly of the view that more unannounced inspections must take place.

"HIQA's reports into University Hospital Kerry and Tallaght University Hospital paint a bleak picture of the realities of unsafe nurse staffing. In the case of both hospitals, unsafe nursing staff levels meant that medical assessment units had to close or operate at a reduced capacity. The situation in University Hospital Kerry is of a particular concern to us and we have sought urgent meetings with hospital management on how safe staffing can be achieved.

"HIQA's report into Cork University Maternity Hospital highlights the crisis in midwifery staffing that exists in many maternity units right across the country. It is not acceptable to our members that they are not in a position to provide one-to-one support for women in labour.

"Of the 10 HIQA reports carried out in hospitals in the past 11 months, not one hospital has been found fully compliant when it comes to staffing. This is totally unacceptable but not a surprise to our union. The INMO has been long sounding the alarm on the very real human impact that unsafe staffing has on both nurses and the patients they are trying to provide care for.

"The HSE and the Department of Health have been provided with substantial independent information from HIQA when it comes to the level of non and partial compliance on the ability of hospitals to organise and manage their workforce to achieve safe and reliable healthcare. These are not reports that should just sit on a shelf or in an inbox. They must be the catalyst for change when it comes to making safe staffing a reality."

HSE's enhanced relocation package aimed at attracting more staff to Ireland

FOLLOWING representations by the INMO, the payment of the accommodation allowance under the HSE's International Recruitment Relocation Package is now payable for a longer period.

The duration of the allowance has increased from 28 days to three months, subject to the maximum amount payable, as and from January 1, 2023.

This is part of an initiative launched by the HSE last July to recruit nurses and midwives from overseas to Ireland. The efforts to address staff shortages throughout the health service, which have been consistently highlighted by the INMO for several years, from the national pool of qualified nurses and midwives has not been sufficient.

Thus, the HSE is now offering this enhanced relocation package to attract health professionals from abroad to Ireland.

In this regard the HSE has approved a relocation package for international recruitment of all disciplines.

The package includes allowances payable to all candidates to meet initial costs of relocating such as accommodation and flight allowances. Additional costs such as registration fees, visa fees, aptitude test fees etc are payable on behalf of the candidate. The exact cost is dependent on where the candidate is relocating from, the discipline, specialty of the post and any relevant framework conditions applicable.

An allowance is payable towards vouched accommodation and flight expenses up to a combined total amount of €4,160 for candidates relocating from the EU/UK and €4,710 for candidates relocating from outside the EU.

Increase in places on PHN sponsorship programme

SEVERAL issues pertaining to public health nursing are ongoing.

Sponsorship Programme for 2023/2024

The INMO understands that placement places for the student PHN sponsorship programme for 2023/2024 will be increased to 160 places. Applications for this year's intake have now closed and applications are currently being assessed by the HSE and the three higher education institutions involved.

Dignity at Work and Claim for Re-activation of an Integration Office in NERS

The INMO has written to the HSE National Employee Relations Service (NERS) seeking that in the context of the revised Dignity at Work Policy that there would be mandatory training for management and reps, and education for all employees in relation to the role of dignity at work.

Management has confirmed that they are prepared to engage proactively on this matter.

The INMO has also sought the reintroduction of an Integration Office within the NERS which was originally established in 2002, to support international nurses with workplace and community integration.

Prioritisation document

PHN management and community operations have issued a prioritisation document in relation to service pressures. It is intended that this document will be reviewed in three months.

The INMO has asked for feedback from PHNs on this document.

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

Care of the Older Person Section Conference

IN-PERSON EVENT

Tuesday, 7 March 2023

Venue: Midland Park Hotel, Portlaoise
Time: 9.30am - 4.00pm
Fee: €70 INMO members; €110 non members

Kindly sponsored by
Cara Allcare Pharmacy

PROGRAMME OF THE DAY

9.00: Registration and trade exhibition

9.30: Welcome address

9.45: Updates in gerontology, a national perspective
Speaker: Deirdre Lang, Director of Nursing, National Lead in Older Person Services

10.15: An overview of Delirium
Speaker: Aoife Dillon, Advanced Nurse Practitioner, St James Hospital

10.45: Coffee break and trade exhibition

11.15: The management and recording of psychotropic medication
Speaker: Deirdre O'Mahony, Home Care Pharmacist and Lorna Conlon, Home Care Pharmacist with Cara AllCare Pharmacy Group

11.45: The legal aspects of documentation
Speaker: Eithne NiDhomhnaill, Nurse Consultant

12.15: Alzheimer's Clinical Trial & ReMind supplement to support eye and brain health
Speaker: Professor John Nolan, Director of Research Nutrition Research Centre of Ireland

12.45: Lunch and trade exhibition

2.00: Living with Lewy Body Dementia
Speaker: Kevin Quaid, Author & Co-founder of Lewy Body Ireland

2.30: Falls Awareness and Management in Residential Care Settings for Older Adults
Speaker: Daragh Rodger, Advanced Nurse Practitioner, Dublin North

3.00: Fitness to practice
Speaker: Joe Hoolan, Regulatory Services Officer, INMO

3.30: Assisted Decision Making
Speaker: Ciara Davin, Barrister at Law

4.00: Evaluation, draws and close

SCAN ME!

Contact jean.carroll@inmo.ie for further information on this event
Booking is essential: email **education@inmo.ie** or call **01 6640618/41**

Positive progress made on clinical concerns within UHL paediatric unit

POSITIVE initiatives were proposed at a meeting last month with nurse management in relation to INMO members' wide range of clinical concerns in the paediatric unit at University Hospital Limerick (UHL).

The proposed initiatives include:

- A full review of all activity within the day ward
- The appointment of a CNM2 in charge
- A process to have a paediatric HDU ANP for the deteriorating child position progressed
- An increase of clinical skills facilitators in the paediatric unit from one to two positions
- A new standard operating procedure (SOP) for admission of CAMHS patients to the unit is almost ready for implementation.

The INMO welcomed the positive initiatives and advised management that the INMO's priority was to secure the 24/7 CNM2. Senior paediatric nurses outlined the importance of a CNM2 being in charge, including the need for clinical governance of the unit 24/7 by an appropriate nurse manager grade, which would also help with the retention of nurses through promotional opportunities.

While there were significant levels of nurse management for clinical governance available on weekdays from 8am-4pm (ie. director of nursing, assistant director of nursing, CNM3 and CNM2s), outside of these times currently a staff nurse/CNM1 was in charge, which the INMO said was inappropriate in this specialist children's service in an acute adult hospital.

– Mary Fogarty, INMO assistant director of IR

Member summarily dismissed during probation period wins case in WRC

THE INMO represented a member at the Workplace Relations Commission (WRC) who was summarily dismissed during her probationary period while working as a practice nurse for a private company.

The member received an invitation, at short notice, to attend a meeting with her manager to discuss her performance. As this was normal practice the member attended in good faith.

At this short meeting the member was advised she was not meeting the company's expectations and was handed a letter confirming her contract of employment was terminated with immediate effect.

The INMO wrote to the company appealing the decision advising our member was given no prior warning that the meeting was serious, that her job was in jeopardy nor was she afforded the opportunity to request representation at this meeting. The appeal was denied and the case was then referred to the WRC.

At the WRC the INMO provided evidence that the process prior to termination was flawed, that no fair procedure or any form of disciplinary process was applied.

The adjudication officer noted there was no evidence of management formally documenting any concerns in relation to the worker's performance prior to the decision to terminate her contract.

The adjudicator stated, although an employer has the prerogative to assess performance during the probationary period, it should always be a two-way process with ongoing formal communications to ensure the employee knows where they stand.

The adjudication officer found in favour of our member and recommended monetary compensation.

– Karen Clarke, INMO IRE

Long-running system error caused errors in payment for unsocial hours

STAFF in older persons services in one site in CHO3 who had errors in their unsocial hours pay have had the matter resolved further to INMO engagement with HR.

A coding rule on the SAP payroll system had overridden the unsocial hours pay rule, to pay nurses time and 1/6th from 6pm until end of shift. This error had continued since early 2021 but has been rectified on the system going forward and each nurse will be met by local nurse management to rectify records and process arrears.

This highlights the need for INMO members to always check payslips and be vigilant regarding payment of all premia hours, incremental credit and allowances. Any possible errors should be reported through your line manager and to HR. Should assistance be needed, contact your local INMO representative.

– Karen Liston, INMO IRE

Sick leave recording error

IT HAS come to the attention of the INMO that the Avista Services Limerick may be recording sick leave entitlements in hours. Under the Public Sector Sick Leave Scheme, sick leave entitlements are not recorded in hours, they are recorded in days. If recorded in hours there may be a loss of paid leave to members. The INMO has raised this matter with the Avista Service requesting an immediate confirmation that all sick leave is recorded correctly. If any member has a query on this matter, contact the INMO office in Limerick at inmolimerick@inmo.ie

– Marian Spelman, INMO IRE

For ongoing updates on industrial relations issues see **www.inmo.ie**

INMO Professional

INMO
Irish Nurses and Midwives Organisation
Working Together

NEW

INMO Section
Advanced Nurse/Midwife Practitioner
Clinical Nurse/Midwife Specialist

A meeting will be taking place in The Richmond Education & Event Centre on Monday 20 March at 11am.
All interested members are welcome to attend.

This forum will facilitate colleagues from across the country to link with each other for specialised networking, information sharing and above all else support for each other in these roles.

If you wish to be affiliated to this section, please contact membership@inmo.ie including your membership number

INMO
Irish Nurses and Midwives Organisation
Working Together

SAFETY REPRESENTATIVE TRAINING
FOR NURSES/MIDWIVES

ONLINE COURSE

Dates:
Wednesday, 19 April 2023
and
Thursday, 20 April 2023

The INMO are delighted to announce further training for **health and safety representatives** in the workplace.

The aim of this training is to provide members with the knowledge, skills, and confidence to represent members on their health and safety in the workplace.

Current arrangements and legislation means INMO members are entitled to receive time off to attend safety representative training.

If you have recently been appointed as a health and safety rep this is the course for you.

For further details please contact Cora on **cora.duffy@inmo.ie**

Call on HSE to commit to safety at NowDoc service

THE INMO has called on the HSE to address safety concerns about the NowDoc out-of-hours service in Donegal/Leitrim and to ensure it is properly funded.

The INMO is acting on behalf of nurses working in the service, further to recent commentary on delays in triage at the service.

INMO IRO Neal Donoghue said: "Prior to and throughout the Covid-19 pandemic, nurses working in NowDoc sounded the alarm in relation to the serious lack of investment in the out-of-hours GP services for their communities.

"Significantly, at a time when all healthcare services are under immense pressure and the HSE is directing the public to use out-of-hours GP services rather than attend emergency departments, no commensurate increase in triage services has been provided.

"In the Northwest, the HSE has fundamentally failed to put in place the necessary structures and supports required to manage NowDoc. Nurses are reporting that this weakness is contributing to the risks to the public in terms of delays in patients being seen by GPs.

"Nurses in the service have a vast range of knowledge and expertise in telephone triage and endeavour to provide the highest standards of service to their communities. However, the HSE continues to employ nurses on temporary contracts in insufficient numbers which is simply unsustainable given the demand for their skills and expertise elsewhere and needs of the service."

INMO secures special leave with pay for member with long Covid

THE INMO assisted a member working in South Infirmary Victoria University Hospital with a grievance procedure regarding the inappropriate application of sick leave, despite her ongoing medical certification and diagnosis of long Covid.

The member first contracted Covid-19 in the course of her work in January 2021 and was out of work on special leave with pay (SLWP) from the date of her infection. She resumed work in May 2021.

In November 2021 the member had to cease working due to ongoing symptoms which her GP and consultants have attributed to long Covid. Management placed the member on sick leave.

The INMO contended that she should have been placed on SLWP as her circumstances meets the criteria for the continuation of SLWP beyond 28 days, as per HR Circular 073/2020 Application of Special Leave with Pay for Covid-19 to employees who have contracted Covid-19. Following representation from the INMO up to stage three of the hospital's grievance procedure, the employer reinstated the member's sick leave and repaid her SLWP in full, with premium pay.

– Gráinne Walsh, INMO IRE

Retrospection of enhanced practice contract achieved for member

THE INMO represented a member under the grievance procedure in her claim for retrospective pay and pension adjustment for the enhanced nurse/midwife practice contract from 2020 to 2019.

The member was on leave at the time management circulated information regarding the application process for the enhanced practice contract to all staff and was not provided with the information. She was therefore unaware she could apply for the contract which would increase her annual pay.

The member contacted management seeking retrospective application of the enhanced practice contract from 2020 to 2019 which management refused.

The member then sought advice and assistance from the INMO with this issue. A grievance was lodged stating the member was denied the opportunity to apply in a timely manner as management had not made her aware of the application process, and she was at a financial loss as a result.

The grievance was upheld at stage three of the process and our member, who had since retired, had her pay and pension amended to reflect the change in salary from 2019.

– Karen Clarke, INMO IRE

World news

Nurses and midwives in action around the world

Australia

- Leaked letter reveals 'unprecedented vacancies' in Queensland Health's maternity units
- Australian Nursing and Midwifery Federation lament decision to close Victorian midwifery service

Canada

- Newfoundland nurses feeling broken, forced to walk away from jobs they love
- Success of healthcare changes hinge on recruitment and retention
- Nova Scotia Health expands nursing training programmes amid staffing crisis

Italy

- Healthcare still chaos in emergency rooms, union complains

Portugal

- Union of nurses announces strike in the centre region

Spain

- SATSE union announces strike days while denouncing nurses and physiotherapists being "left out" of negotiations

UK

- Petition calling for fair pay for nursing staff signed by 100,000 people
- Nurses fighting for fair pay head to Downing Street
- Pay discussions between RCN and Scottish government 'progressing'

US

- Picket at New York medical centre over staff shortages
- Michigan nurses report more patients dying due to understaffing, poll finds
- Samaritan nurses picket outside hospital, demanding more staff and better contracts

INMO deputy general secretary **Edward Mathews** rounds up global nursing and midwifery news

ICN intervenes on key healthcare issues at WHO forum

THE International Council of Nurses (ICN), within which the INMO is the Irish national nursing association, represented the voices of nurses on key healthcare issues in its interventions at the WHO Executive Board meetings in Geneva, Switzerland, which ran from January 30 to February 7.

The Council's interventions at the 152nd session of the WHO Executive Board ensured the nursing voice was heard on several key healthcare issues, including:

- Universal health coverage
- The prevention and control of non-communicable diseases in mental health
- Infection prevention and control
- Strengthening WHO's preparedness for and response to health emergencies (with the World Health Professions Alliance)
- The Global Health for Peace initiative.

The ICN also intervened in a discussion about how so-called non-state actors, such as the ICN, can be more involved in the governance of WHO.

Speaking after the event, ICN chief executive officer Howard Catton said there was special recognition of the role of nurses and healthcare workers by WHO director general Tedros Adhanom Ghebreyesus.

Mr Catton reflected on how the director general often talks about health workers being the backbones of our health systems, and of course, he's right. Additionally he noted that the Director General and delegates had stressed even more the protections needed for health workers. Worryingly, attacks on health workers and facilities have gone up over the last year, a situation which must also be recognised in Ireland and as discussed in our submissions to the Oireachtas Health Committee in recent weeks.

Mr Catton also discussed how there can be no doubt about the enormity of the challenges we are facing, from war and conflict to climate change, and that we need our political leaders to come to a consensus more than ever before.

He noted signs of differences during the course of the event, but also a huge note of optimism was the WHO's Global Health for Peace initiative, recognising the inextricable link between health and peace, and nurses as both health workers and peacemakers.

The ICN also had the opportunity to meet with WHO's new chief nursing officer, Dr Amelia Tuipulotu.

The ICN will continue its advocacy on behalf of nurses at the upcoming World Health Assembly.

ICM launches 'Twin to Win' pilot project

THE International Confederation of Midwives (ICM), within which the INMO is the Irish national midwifery association, recently launched its 'Twin to Win' pilot project.

Just before the New Year, midwives from around the world descended on Casablanca, Morocco to participate in kick-off meetings for the first-ever 'Twin to Win' pilot project.

Over the next two years, six midwives' associations will form three pairs, within which they will support each other to design and execute collaborative and individual projects with the ultimate goal of strengthening midwifery in their respective countries.

Twinning is a cross-cultural, reciprocal process where two groups of people work together to achieve joint goals. The method has been recognised as an effective way to improve the quality of midwifery care in health systems by means of building the leadership capacity of midwives from both professional associations involved in the partnership.

The Twin to Win project was developed in response to ICM midwives' associations asking for more association-strengthening activities. Unlike other twinning projects, Twin to Win matches associations from similar social and economic contexts to establish non-hierarchical, mutually beneficial relationships between the sets of twins.

The ICM will take a backseat role in the project by facilitating workshops and regular progress check-ins, enabling the twins to work independently and in consideration of their existing workloads.

Associations from the following countries are participating in the pilot project:

- Burundi and Uganda (English-speaking)
- Senegal and Mali (French-speaking)
- Guatemala and Costa Rica (Spanish-speaking)

During their time in Morocco, the twins established project commitments, worked on their project plans, shared stories about midwifery in their countries and developed personal relationships with each other – an essential feature of the feminist communication model that twinning promotes.

The workshops were led by ICM midwife advisor, Liselotte Kweekel and expert consultant on twinning Franka Cadée – both midwives have extensive twinning experience having participated in many twinning activities throughout their midwifery careers.

The ICM said it was very proud to have launched this pilot project which stands as an example of its efforts to prioritise association-strengthening and cross-cultural collaboration.

Each set of twins is now working on their project concepts which will be shared in due course.

Migrant Nurses Ireland:
Pictured at the first national conference of Migrant Nurses Ireland which was held in the Richmond Education and Events Centre recently. During the conference, INMO general secretary Phil Ní Sheaghdha was presented with an MNI shield by Vinod George, advanced nurse practitioner, Galway University Hospital (below, left) and INMO deputy general secretary Edward Mathews was presented with an MNI shield by Preethy Manoj, CNM2, Connolly Hospital

MNI hosts first national conference

MIGRANT Nurses Ireland held its first national conference on January 21 at the INMO's Richmond Education and Event Centre, Dublin.

Migrant Nurses Ireland, whose members are all members of the International Nurses/Midwives Section of the INMO, work closely with the INMO in promoting INMO membership among migrant nurses and midwives, and in ensuring that the collective and individual issues affecting migrant nurses can be effectively addressed.

Speakers included Indian Ambassador to Ireland Akhilesh Mishra and INMO general secretary Phil Ní Sheaghdha.

The conference also heard from many migrant nurses, midwives and other professionals regarding their experiences in the Irish health system, and in relation to the importance of effective integration approaches.

The conference also hosted a colourful tapestry of multi ethnic art, music and dance performances.

Cancer nurses: uniting voices and taking action

TO MARK World Cancer Day 2023, Dr Patsy Yates of Queensland University of Technology, Australia addressed the International Council of Nurses (ICN) outlining some of the of the realities of cancer and cancer care.

Dr Yates told the ICN, that despite extraordinary advances in cancer treatments and that many cancers can be cured if identified early, more than 10 million people across the world will die each year from cancer.

When coupled with the fact that around 30-50% of cancer cases can be prevented, it is clear that more action is required.

Dr Yates said that there is overwhelming data that cancer outcomes are worse for those in low- and middle-income countries and in communities that experience socioeconomic disadvantage. This is because many of the causes of cancer are related to social determinants of health. Late cancer diagnoses are also more common in disadvantaged communities.

Modern cancer treatments are expensive, making access to treatments which can cure the disease or improve a person's quality of life, difficult for those living in countries with limited resources or where universal health coverage is not available.

Dr Yates surmised that the burden of cancer should not just be a concern for those who work in cancer settings. Nurses working in all settings, especially primary and family care settings, have a key role to play in educating the community about how to reduce the risk of cancer and the importance of cancer screening.

Highlighting the crucial roles nurses play in cancer care, Dr Yates said: "For most of my nursing career I have worked in cancer settings where I have witnessed on a daily basis the critical role that nurses play in reducing the burden of cancer on individuals and families. We know that early detection of cancer and of side effects of cancer treatments is important to achieve better outcomes. Nurses are well placed to facilitate more rapid access to the right services and to provide continuity and coordination between the person affected by cancer and the many other care providers. No other care provider has the same level of contact, the holistic perspective, and the understanding of how systems work than a nursing professional does."

Held on February 4 each year, World Cancer Day aims to raise awareness of the critical need for action to reduce the worldwide burden of cancer. Led by the Union for International Cancer Control (UICC), the theme this year was *'Close the care gap: Everyone deserves access to cancer care'*. Dr Yates encouraged nurses to reflect on what they can do to close the care gap and reduce the inequities in our care systems.

The UICC has a range of campaign materials and toolkits that can help you to take action which can be accessed on their website **www.uicc.org**

Introducing Executive Council members

Tracey Ó Fiaich

Senior staff nurse, ICU, Mullingar Regional Hospital

TRACEY Ó Fiaich started her nurse training in 1991 in University Hospital Galway. A few years after qualifying she moved to London to work in intensive care, an area of nursing that she is passionate about. On return to Ireland she briefly worked in Beaumont Hospital before getting married, moving to Mullingar and taking up her role in Mullingar Regional Hospital. She completed a masters in health promotion in 2016.

On her return to Ireland Ms Ó Fiaich re-joined the INMO. In 2019 she was chairperson of her local strike committee and this inspired her to put herself forward for the Executive Council. She has also recently been elected chairperson of the Mullingar Branch.

"I always encourage students, new graduates and nurses from other countries to join the INMO. We are so much stronger as a collective. When we speak with one voice we amplify our issues and concerns and have a better chance of succeeding. The union also provides essential insurance and reassurance for the nursing and midwifery professions."

For Ms Ó Fiaich, actively listening to members is essential in her role as Executive Council member. Nationally and locally, she would like to see greater recognition and respect for the work of nurses and midwives. "The implementation of the HSE's dignity at work policy at a local level is a priority. We are actioning motions brought to ADC last year and safe staffing levels are our top priority at the moment. With meetings going on nationwide to discuss potential industrial action it has never been clearer that this is a matter of urgency and necessity for our membership. Legislation around safe staffing levels would make our workplaces safer for both staff and patients. The time has come to let our voices be heard and get the full respect we deserve."

Ron Russell

CNM2, endoscopy/decontamination, Midland Regional Hospital, Portlaoise

RON Russell is a senior staff nurse in endoscopy in Midland Regional Hospital, Portlaoise. He is also the clinical lead in decontamination for the hospital. Originally from Australia, he qualified in 2001 and has held positions across several specialties, even working in the Australian outback. He has completed a clinical leadership programme and a postgraduate diploma in peri-operative nursing. He was also a branch officer of the New South Wales Nurses and Midwives Association.

Early in his career he met his wife, an Irish psychiatric nurse working in Australia, and they decided to move to Ireland in 2014. On arrival, he joined the INMO and became a member of both the Operating Department Nurses Section and the Laois Branch.

Mr Russell advises all nurses and midwives to join a union saying, "At a bare minimum, it offers you security and representation. It offers you legal assistance and insurance and all the benefits that go along with that. I think it's important for morale to acknowledge when we make gains and celebrate our wins. As a union we have made substantial gains since the 2019 strike, but there is much more still to do."

Mr Russell is acutely aware of the urgency with which staffing deficits need to be addressed, stating, "Young nurses and midwives will always travel but we need to create a health service that makes them want to come back. Staffing levels in hospitals and health facilities nationwide are unsafe and this needs to be tackled immediately. We need workplaces where all nurses and midwives feel safe and feel valued and are able to deliver the care that they were initially signed up. I think nurses should be respected and valued a lot more than they are."

Sean Shaughnessy

Senior staff nurse, University Hospital Galway

SEAN Shaughnessy is senior staff nurse and interRAI assessor at University Hospital Galway, carrying out homecare assessments for patients. At age 20 he moved to the UK to begin his training. He started his career in Romford in Essex working in intensive care and high dependency units.

Galway is home, so when an opportunity arose he took up a job in UHG initially working in intensive care until three years ago when he moved to his new role. In 2011 he became active with the INMO Galway Branch of which he is chairperson. "I think it's important to have the union to steer us in the right direction. Within nursing and midwifery, we all face the same problems, but we don't always talk to each other. We're well versed in clinical knowledge but we seldom venture into the field of rights and entitlements. It's important to celebrate the gains made through the union. Since 2019 we have seen all grades move to the enhanced pay scale but staffing levels are still appallingly unsafe."

On staffing levels and patient safety, Mr Shaughnessy said: "It's becoming incredibly hard to be elderly in our health service. For minor support to major support the only route often seems to be through acute hospitals and this is often not where they are best placed. Trolley numbers are abnormally high and we need to stop accepting them as normal. Nurses see the patient 24 hours a day, but the decision makers may only see patients for 15 minutes per day. I would like to see this change. Nurses have to stop being asked to pick up the shortages throughout the system. When you improve the position of the healthcare workers, you improve conditions for patients."

Shining the spotlight on midwifery practice

Midwives are encouraged to attend the All-Ireland Maternity and Midwifery Festival, which takes place in The Helix, Dublin next month

IT IS apt that the forthcoming All-Ireland Maternity and Midwifery Festival is set to take place in The Helix theatre and event centre in Dublin next month – where the spotlight will firmly be focused on advances in midwifery practice and research. To be held on Tuesday, April 18, the festival will present the latest developments across midwifery and maternity care, and provide participants with an opportunity to network with colleagues, visit the diverse exhibitions and demonstrations, attend talks, and experience free wellbeing taster therapies.

This annual event has previously proven a great opportunity to share best practice and insights from maternity practitioners from across the island, and this year's line-up promises to be no different, with a wide range of presentations.

INMO Executive Council member Lynda Moore said: "It's more important than ever that advances in clinical practice and research continue to be spotlighted and applauded and that midwives make their voices heard. Midwives are the cornerstone for exemplary maternity care and therefore need to be clinically, professionally and politically visible in order to be truly recognised. Events like this provide an opportunity for us to learn from each other and increase our visibility within the health service."

As well as Ms Moore, speakers at the festival will include: Sue Macdonald, programme curator, Maternity and Midwifery Festivals; Sheila McClelland, chief executive, Nursing and Midwifery Board of Ireland; Dr Hazel Keedle, academic program advisor and senior lecturer, Western Sydney University, Australia; Ursula Nagle, PhD candidate, Trinity College Dublin and ANP in specialist perinatal mental health, Rotunda Hospital; and Angela Dunne, director of midwifery, National Women and Infants Health Programme, HSE.

"Sharing experiences and building networks at events like these is vital to build the wonderful profession of midwifery in Ireland and ensure the delivery of quality midwifery-led care and woman-and-baby centred services in hospitals and in communities. I would encourage all midwives to take the opportunity to attend the important learning events on offer at the festival," Ms Moore added.

The event gives midwives the chance to recharge their batteries and learn from the fantastic dedication and commitment of their midwifery and maternity peers across the island of Ireland. The programme for the day will offer networking opportunities and exhibitions, as well as demonstrations to view.

Afternoon seminars will include sessions on midwifery workplace culture, postnatal nutrition, postpartum haemorrhage management, complex pregnancies, safety and proficiency standards, and much more. Speakers will include: Mary Brosnan, director of midwifery and nursing, National Maternity Hospital and associate adjunct professor, UCD School of Nursing Midwifery and Health Sciences; Avril Flynn, midwife, childbirth educator and hypnobirth practitioner; Verena Wallace MBE, senior midwifery advisor, Nursing and Midwifery Council; Ciara O'Dwyer, midwife, University Hospital Waterford; Sue Hendy and Dr Cathy Adams, directors of Resilience in Health; Imelda Fitzgerald, clinical placement co-ordinator at Cork University Maternity Hospital; and Dr Déirdre Daly, director, Trinity Centre for Maternity Care Research (TCMCR) and associate professor in Midwifery, Trinity College Dublin.

Dr Jean Carragher, midwifery lecturer, School of Health and Science, Dundalk Institute of Technology will deliver a seminar on new developments in midwifery education and research and

INMO Executive Council midwives (anti clockwise from left) Audrey Horan, Lynda Moore, Annette Keating and Paula Barry

Deborah Pinkerton-Holmes, ANP in Addictions, Northern and Social Care Trust will present on inclusive services and social challenges. Roisin Lennon, ANP, Sligo University Hospital will deliver a session on improving women's choices and Dawn Adams, PhD researcher, Ulster University will speak on the technological changes affecting diabetes care in pregnancy.

The event will also feature presentation of the All-Ireland Maternity and Midwifery Forum Trailblazers Award, recognising leaders in maternity care nominated by their colleagues. The deadline to nominate a colleague for a midwifery award is fast approaching and must be submitted by March 6.

We highly recommend INMO midwife members attend this free event which promises to be lively and informative. This is a hybrid event so if you can't make it to Dublin, you'll be able to watch the livestream of the event. Recordings of the of the full festival programme will be available afterwards to review presentations and catch up on those you missed. Book your place now on **Eventbrite.co.uk**

See page 4 for more details

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RESEARCH AND INNOVATION AWARD 2023

A bursary of €1000 will be awarded for a recently completed research project promoting and improving quality of patient-care and / or staff working conditions in an innovative way.

Entrants must be fully paid up members of the INMO and in membership for a minimum period of one year from January 2022.

Entrants can apply online at www.inmo.ie
The closing date for applications is Monday, 3 April 2023.

For more information visit:
www.inmo.ie and www.inmoprofessional.ie

SCAN ME!

Irish Nurses and Midwives Organisation
Working Together

Nurse and Midwife Representative Training 2023

The aim of this training course is to provide members in the workplace with the knowledge, skills and confidence to represent and support members in the workplace. The representative also acts as a liaison between the INMO members, INMO officials and INMO head office.

The course takes place over two days and there are agreements within the public health service for paid released time off to attend INMO rep training courses.

The INMO also provides an Advanced Representative Training Course. This training is at advanced level, the requirement for attending the advanced representative training is to have completed the basic representative training and have been an active INMO representative in the workplace for at least one year.

If you are interested in attending a representative training course in 2023, please make contact with your INMO official and they will issue you with an "Expression of Interest Form" to complete and return.

2023 DATES*		
01 & 02	**MARCH**	DUBLIN
27 & 28	**MARCH**	GALWAY
24 & 25	**MAY**	WATERFORD
13 & 14	**JUNE**	DUBLIN
20 & 21	**JUNE**	MIDLANDS/CAVAN
27 & 28	**JUNE**	LIMERICK
20 & 21	**SEPTEMBER**	DUBLIN
27 & 28	**SEPTEMBER**	SLIGO
03 & 04	**OCTOBER**	CORK
12 & 13	**OCTOBER**	DUBLIN

Please note that the Dates and Locations are subject to change

Contact your INMO Official

Dublin: 01 6640600, Cork: 021 4703000, Galway: 091 581818 and Limerick: 061 308999

Q and A Bulletin Board

With INMO director of industrial relations Albert Murphy

Critical illness protocol

Q. I am working in the public health service and was out sick under the critical illness protocol (CIP) scheme for six months. Since my return to work I have been out sick with a non-critical illness and was advised that I have no paid sick leave remaining because I had previously been absent under the CIP. Is this correct?

Under the revised provisions for the CIP you can now continue to access the limits of the protocol within 12 months of your return to work, even when you are not critically ill, provided that:

- You previously had been absent because of a critical illness/injury
- You are now absent from a non-critical illness/injury within the 12 months of your return to work.

The original 'protective year' provided that an employee could avail of the limits of the CIP within 12 months of the first date of absence so this revised protective year will enhance the support to those who return to work following a serious illness/injury who may then suffer from a routine illness/injury in the following year.

Pregnancy-related sick leave

Q. I have a query in relation to pregnancy-related sick leave. I am currently out on sick leave as a result of my pregnancy. I have been out for a number of weeks so far and have been hospitalised for two consecutive days. What is my entitlement to sick leave?

Because you were hospitalised for two days or more you would be covered under the critical illness protocol. This allows sick leave to be paid at six months full pay and six months half pay. The employer will take into account any previous sick leave. When submitting medical certificates to the employer, the consultant or GP must write on the certificate that the sick leave is pregnancy-related.

Public holidays and part-time work

Q. I am currently working part-time 20 hours per week. My employer advised because I worked part-time I am not entitled to any of the public holidays. Sure this is not correct?

All permanent and temporary employees who work full-time receive public holiday benefits. If you work on a casual or part-time basis, you must have worked at least 40 hours during the five-week period before the public holiday. Your employer will decide what your entitlement for the public holiday day is. In lieu of a public holiday you can get one of the following: a paid day off on the public holiday; a paid day off within a month; an extra day's annual leave; or an extra day's pay.

Parental leave and premium shift access

Q. I am currently availing of parental leave and have a document that confirms with my employer that I am availing of parental leave on a roster of one day per week. My employer has now advised that I have a reduced entitlement to access shifts that would earn premium payment. My employer claims that I am now a part-time worker. Can you please clarify if this is the case?

No, this is not the situation and your employer is not correct. Parental leave is granted on the understanding that all of your terms and conditions of employment are protected. With this in mind, you are not considered to be a part-time worker, rather you are simply availing of a temporary reduction while on parental leave and so you have to be regarded as not being absent. This means that you retain all your employment rights other than the right to remuneration and superannuation benefits. Should you have any further difficulties in this area, please get in touch with your INMO industrial relations official who will be able to act on your behalf.

Annual leave cancellation

Q. I had annual leave booked and authorised by my employer, however a week before I was due to take this leave my employer advised that they were cancelling my leave. Can they do this?

Under Section 20 of the Organisation of Working Time Act, the employer must give one month's notice of their intention to cancel annual leave. The employer, having consulted the employee or the trade union (if any) of which they are a member, not later than one month before the day on which the annual leave or, as the case may be the portion thereof, is due to commence. Any such cancellation of leave however is most unusual and should not occur.

Know your rights and entitlements

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

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

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

Learning from our mistakes

By reflecting on why incidents have occurred we can learn to avoid repeating errors and improve patient safety, writes **Orla Kenny**

I CAN still remember, as clear as day, the bright but anxious face of the junior staff nurse as she strode across the surgical unit towards me. "I've just given Bed 3's medication to Bed 2". Split seconds past as I absorbed this disclosure, processing the potential ramifications before proceeding into action. As clinical nurse manager (CNM) of a busy surgical unit, the responsibility for the provision of nursing care lay with me and I took this role very seriously.

Although highly undesirable, not to mention contrary to the 10 rights of medicines administration,[1] I am sure there are many occasions when the medication of a patient in Bed 3 on any given ward would have negligible effects on a patient in Bed 2, however, this was not one of them. In this case the patient in Bed 3 had a particularly complex resistant hypertension and was taking three antihypertensive tablets. Suffice to say that the patient in Bed 2 did not suffer with hypertension.

My initial reaction was 'let's be as open and honest as possible and let's act quickly'. I led the staff nurse back to the patient in Bed 2, trailing a Dinamap behind me and informed him of what had happened. I apologised for this error and explained that we would endeavour to do our best to rectify the situation while prioritising his safety. This of course was open disclosure[2] in practice, but I didn't think of it as that at the time, it simply felt like the right approach and the way we did business in the unit.

I recall attaching the BP cuff while speaking and setting the Dinamap to automatically monitor his blood pressure as it inevitably started to drop. The patient became angry and I couldn't blame him. He had questioned the nurse as she handed him these tablets, not recognising them as his usual ones but trusting in the system and took them when she assured him they were his.

The next necessary action was escalation, I contacted the patient's registrar and the assistant director of nursing. Coincidentally, the unit pharmacist arrived for that morning's medication reconciliation but I soon redirected him to review the prescriptions of the patients in Bed 2 and Bed 3 for any other potential interactions.

I recall the irritation expressed by the registrar at this error, while I appreciated that this affected the patient's wellbeing and length of hospital stay – and therefore the scheduled patient list – I do remember thinking that their reaction wasn't helping anyone involved.

The medication error was categorised as a category 2 moderate incident[3] as it required an extended hospital stay for monitoring as well as treatment with intravenous fluids. The patient required transfer to a monitored bed despite having been considered suitable for discharge prior to the incident. I phoned the patient's wife to inform her of what had happened and what the implications were. I subsequently met with both the patient and his wife when she arrived on the unit. There was a range of emotions to manage at this meeting from anxiety to anger. When the patient received the necessary treatment and was stabilised and the staff nurse involved was assigned a medication management module to complete, I put the incident aside and continued with the rest of my work.

Reflective practice

At that time I would have rolled my eyes at the idea of using reflective practice or After Action Review[4] to process what had happened. However, with the advantage of hindsight, I appreciate how reflective practice could have benefited the nursing team, not to mention the patients in our care.

If I was back as CNM on the surgical unit tomorrow and the same situation arose what would I do differently? The initial responses and actions taken were appropriate but more could have been done to disseminate the learning from this incident with the view to mitigate against future similar situations.

An alternative to closing out this incident following escalation, risk management and targeted professional development could have been an anonymised case study presented both locally and organisation wide at journal clubs, departmental meetings, through the medication safety newsletter and via clinical safety alerts.

At local level, facilitating a meaningful workshop to encourage the unit staff to discuss what went wrong, in keeping with a 'just culture',[5] and discussing why the incident occurred in the first instance. Potential reasons could have included disproportionate workload, multiple distractions, similar patient names and proximity of patient beds. The staff could have then brainstormed potential solutions to prevent such an incident from happening again.

These solutions could have been developed into quality improvement initiatives led by the frontline staff and supported by nursing management. Using a staff empowerment approach supports those working at the frontline of the healthcare system to use solutions that they see fit[6] and to be accountable for those solutions rather than implementing a top-down only approach to patient safety initiatives.

Working with our patients and adopting a patient-centred approach to care supports the patient to actively input into their own care.[7] If a patient questions the medication administered to them, then the nurse should actively engage with this questioning rather than passively insisting that the tablets are correct and subsequently having to deal with a patient safety incident. Sharing the lessons from incidents and working with our patients raises awareness, supports staff and promotes patient safety.[8]

Orla Kenny is a nurse, PHN candidate and patient engagement manager at the RCSI Hospital Group

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A column by Maureen Flynn

Quality & Safety

Patient Safety Together: learning, sharing and improving

IN THIS month's column we introduce Patient Safety Together: learning, sharing and improving. This freely available on-line resource provides a reliable and easily accessible approach to sharing patient safety learning within Irish healthcare.

Using up-to-date quality and patient safety (QPS) information including incident management data and national and international evidence Patient Safety Together enables nurses, midwives and all users to:

Learn from patients/service users/staff

- Patient safety stories: give a voice to both patients/service users and staff who have been involved in, or impacted by patient safety issues and want to share learning. They will be available in video and narrative format and will share learning from areas of excellence, positive experiences in our healthcare system and from when things go wrong
- The patient safety community: will create a national peer supported online community for QPS staff.

Access further QPS learning

- Signposting: to QPS academic papers, resources, conferences etc
- Bi-monthly HSE Patient Safety Digest developed by the HSE Health Library Ireland Services – in collaboration with the National QPS Directorate team cataloguing journal articles and reports relating to patient safety.

Learn from incidents, research and data

- HSE National Patient Safety Alerts (NPSAs): are high priority communications in relation to patient safety issues, which require HSE services and HSE funded agencies to take specific action(s) within an identified timeframe, in order to reduce the risk of occurrence or recurrence of patient safety incidents that have the potential to cause serious harm or death.[1]

- Patient safety supplements: will inform HSE and HSE funded agencies of timely and relevant QPS information for learning purposes. Content will be identified from several patient safety intelligence sources including the analysis of incident reporting, reports from front line services, or new national or international research and evidence.

By actively identifying and sharing learning Patient Safety Together will be a valuable learning source to help reassure everyone using and working in our health services that we aim to continually improve our patient care, support our staff and help prevent patient safety incidents occurring or recurring.

Development

Patients and multidisciplinary staff from over 16 areas across our health services were involved in co-developing Patient Safety Together including:

- The Forum for Irish Post Graduate Medical Training Bodies
- Health Information and Quality Authority
- Mental Health Commission
- National Patient Safety Office, Department of Health
- Patient Representatives
- Patients for Patient Safety Ireland
- State Claims Agency

HSE

- National Patient/Service User Forum
- CCO Clinical Forum
- Digital team
- National Ambulance Service
- National Health and Social Care Professions Office
- National Quality and Patient Safety Directorate
- National Screening Service
- Office of Nursing and Midwifery Services Director
- QPS Acute Operations
- QPS Community Operations.

Get involved

At your next ward team or department meeting you might like to share information on Patient Safety Together and explore how this can help in your area of practice. You can find patient safety together at: **www.hse.ie/pst**

You can also enquire who is the person nominated to receive HSE NPSAs in your organisation. If you are interested in developing a patient safety story or if you are a QPS staff member interested in joining the patient safety community please email patientsafetytogether@hse.ie

Maureen Flynn is the director of nursing ONMSD, QPS Connect lead, HSE National Quality and Patient Safety Directorate

Acknowledgements:
Thank you to my colleagues Catherine Hogan and Noemi Palacios for collaboration and assistance in writing this column. Dr Orla Healy, national clinical director and Lorraine Schwanberg, assistant national director NQPSD are very grateful for everyone's important contribution and appreciate the collaborative way the team worked together determinedly, over the past three years, to build this important new resource

1. A new multidisciplinary HSE NPSA committee chaired by Dr Darren McLoughlin with members representing those who use and work in our health services oversee the development and communication of the NPSAs in conjunction with relevant stakeholders

Irish Nurses and Midwives Organisation

Preceptor of the Year 2023

Sponsored by Cornmarket

The award recognises an INMO member who has inspired and motivated the student to reach their full potential.

Submit using **official nomination form** on **www.inmo.ie**

The winner will receive their award at **INMO ADC in Killarney** along with the student member who nominated them.

NOMINATIONS

The deadline for nominations is **Thursday, 30 March 2023**

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Irish Nurses and Midwives Organisation
Working Together

For more information visit
www.inmo.ie/preceptor_of_the_Year

SCAN ME!

New Grads who received their NMBI Pin in 2022 start on point 1 of the nursing salary scale, which is €32,542.

Once you have completed a further 16 weeks of work post your internship, this can include your pre-reg experience. You then skip point 2 of the salary scale and more to point 3, which is worth €35,405.

However, if you received your NMBI Pin in 2021, you should now be moving to point 4 of the salary scale on your next increment date. This means that you are now eligible to apply for the Enhanced Practice Contract. This would allow you to move onto point 1 of the enhanced nurse salary scale, worth €39,291.

Depending on your work location you may also be entitled to the medical and surgical ward allowance, worth €2,466 per annum.

Many of you will be moved to the new pay scale automatically and will already be receiving the allocation allowance, but it is important to check with your HR/Payroll department.

TOP TIP

Check your payslip, as this should state what point of the scale you are on and when your next increment is due.

If you have any further questions get in touch with INMO Student/New Grad Officer Róisín at **roisin.oconnell@inmo.ie.**

If you're not a new graduate but have questions about your pay, call our **information office on 01 6640600.**

Sharing our experiences

Róisín O'Connell reports on the recent visit of Norwegian students and new graduates

A DELEGATION of Norwegian student and new graduate nurses visited the INMO last month. The programme of events offered many opportunities for delegates to share their experiences with one another and reflect on the differences and common experiences they face as nurses and midwives.

The programme included presentations from the president of the European Federation of Nurses Associations (EFN) Elizabeth Adams and talks from Edward Matthews, INMO deputy general secretary and Steve Pitman, INMO head of education. We debated topics surrounding the state of the nursing and midwifery professions and education in Ireland, and discussed what a union does for its members.

The event saw student and new graduate nurses and midwives come together from Norway and Ireland and discuss what nursing is like in their respective countries. Many of the students were surprised by both the similarities and differences between the professions in the two countries.

One of the Irish students in attendance, Christopher O'Dwyer, spoke about the opportunities the visit afforded INMO student and new graduate members.

"It was great to meet with our Norwegian colleagues and to discuss the similarities and differences between our health systems. However, one commonality that shone through was the commitment to patient care. The content delivered on the day by my INMO colleagues gave our visitors a unique insight to the daily routine of nursing in Ireland but also the importance of the INMO's work," he told *WIN*

Events like this demonstrate the changes that can be made to our health and education system to benefit nursing and midwifery students. They also empower our student nurses and midwives to realise the effect they can have as students on health policy, while also encouraging them to participate in other INMO events.

Pictured at the Richmond Education and Event Centre were (l-r): Róisín O'Connell, INMO student and new graduate officer; Elizabeth Adams, president of the EFN; and Benedicte Molnes, president of European Nursing Student Association (ENSA)

Get involved as a rep

Now more than ever, it is essential that each class has a student rep who is connected with me. If your group does not have an INMO student rep, please discuss this among yourselves and nominate one rep for each year, discipline and placement area, if you are spread across multiple sites.

It is worth noting that INMO student reps are distinct from student union reps as the INMO is the professional body representing nurses and midwives dealing with matters relating to the workplace.

Being a rep does not mean taking on a body of work and solving your class's problems by yourself. A rep is someone who lets me know about any collective issues in their group so that I can either address these concerns or bring them to the attention of senior management. This means that your voice is represented at national negotiations.

If you are interested in learning more, about becoming a rep please do not hesitate to contact me.

Preceptor of the Year Award 2023

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

This award recognises the essential work of our nurse and midwife preceptors, which is a fundamental component of nursing and midwifery education.

Nominate your preceptor before March 30 online or by email via the form available at: **www.inmo.ie/Preceptor_of_the_Year**

If you wish to nominate your preceptor, please don't hesitate to fill in the form as it is important we recognise the amazing nurses and midwives working within our health service.

Róisín O'Connell is the INMO's student and new graduate officer. If you have a question for her, please email roisin.oconnell@inmo.ie

INMO Professional DEVELOPMENT CENTRE

THE ROYAL COLLEGE OF MIDWIVES

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Annual Delegate Conference 2023

Poster Competition

NURSING & MIDWIFERY INNOVATIONS IN PRACTICE

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Be in with a chance of winning up to €500

The INMO recognises the significant contribution that nurses and midwives make to enhancing and developing the quality of care delivered to patients and service users.

To showcase the innovations in practice, nurses and midwives are invited to submit a poster for presentation at the Annual Delegates Conference (ADC) the first week in May in Killarney, Co Kerry.

SCAN ME!

SUBMISSION DEADLINE - Friday, 7th April 2023

Notification of successful submissions - Friday, 14th April 2023

For more information contact education@inmo.ie

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THE ROYAL COLLEGE OF MIDWIVES

Bereavement care – getting it right

When you have one chance to get it right when working with bereaved parents, it is important to be well prepared

DEVELOPING an awareness, knowledge and understanding of the importance of providing parent-led, sensitive and empathic care for parents whose baby has died before, during or shortly after birth is vital.

This e-learning course aims to support midwives in learning these skills and will focus specifically on losses from late miscarriage to 28 days of life. It is not intended to replace face-to-face training which facilitates the development of skills in this important area of care.

This module will take approximately three and a half hours to complete.

Why it matters

When a baby dies before, at or around the time of birth, or in the first few weeks of life, there is a small corridor of opportunity for parents to gather memories to last a lifetime. Time spent with their baby can be precious, but what people choose to do in that time will be very individual and may vary greatly.

They too have only 'one chance to get it right', but in the shock and finality of what has happened, parents can't know what they don't know. They need time and support to make decisions that are right for them.

Role of the midwife

Informing parents of what is possible and offering choices and help in creating memories is an important part of the role of the midwife and will ensure the provision of care that is individualised and parent led. With choice, however, comes the burden of responsibility and parents may need support to make decisions that are right for them, and to know that they may also change their minds within a clear timeframe.

It is important that both parents are treated equally in terms of giving information and recognising their need for support. Acknowledging how difficult this must be for them and doing what you can to meet a partner's immediate needs can go a long way in letting them know that you realise both parents have experienced this loss.

Parents can be concerned by their own or their partner's reaction and will be reassured to hear it is normal to have many different reactions.

Parents' long-term wellbeing is influenced by the attitudes and behaviour of the staff who care for them. After the traumatic events surrounding their baby's death, it is a natural part of the grieving process to replay the memories again and again.

Memories of insensitive care add to parents' grief. Memories of thoughtful, empathic, compassionate care provide long term comfort and emotional healing.

Learning outcomes

Having completed this module, you will:

- Identify the unique impact of grief in relation to pregnancy loss and the death of a baby for parents and their families
- Identify, develop and use techniques to deliver bad news and communicate sensitively and effectively with bereaved parents
- Develop an understanding of the importance of empathetic care
- Learn how to support parents' decision-making during times of stress

- Understand the importance of parent-led care
- Recognise the impact of pregnancy loss and the death of a baby on health professionals
- Recognise the importance of ongoing support for bereaved parents and the potential impact of their loss on all subsequent pregnancies.

RCM i-learn access for INMO midwife members

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

Section focus

INMO Professional

Jean Carroll, Section Development Officer

RNID Section conference to feature talks on autism, trauma and PTSD

THE Registered Nurse in Intellectual Disability (RNID) Section will host its annual conference on Thursday, March 30 at the Richmond Education and Event Centre.

The topics that will be discussed on the day include: assisted decision-making; autism; trauma and post traumatic stress disorder; and a review of research into workplace bullying and implications for the nursing profession. There will also be a presentation on women's health and a talk about how we can achieve greater, more meaningful involvement of people with intellectual disabilities in research.

Also featured will be short sessions on innovations in nursing roles, which include hospitalisation, morbidity and mortality due to respiratory tract infections in adults with an ID and preventing and managing chronic illnesses in people with IDs. These sessions will be delivered by advanced nurse practitioners, clinical nurse specialists, senior lecturers and nurse managers.

See *page 6* for instructions on how to book your place.

Launch of new advanced practice group

THE INMO is launching a national networking group for advanced nurse/midwife practitioners and clinical nurse/midwife specialists. The aim of this forum will be to facilitate collaboration with colleagues across the country.

Opportunities for information sharing, specialised networking and support will all be available. The first meeting of this group will take place on Monday, March 20 at 11am in the Richmond Education and Event Centre. The meeting will be followed by an informal lunch. This is a hybrid event so members who can't attend in person have the option of joining online.

Contact INMO section development officer jean.carroll@inmo.ie for further details.

A thank you to members

THANK you to all INMO members who turned out for their section AGMs in January and February.

AGMs are important meetings and opportunities for members to have their voices heard.

We greatly appreciate the efforts that you made in attending.

A sincere thank you also to all outgoing national section officers for the time you have given to running your section and ensuring that the work you carry out remains relevant.

We also welcome new officers to a number of sections and look forward to working closely with you in continuing to deliver on your missions and visions.

Breastfeeding: The best start

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

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The Irish Nurses and Midwives Organisation supports breastfeeding

For more information log onto **www.breastfeeding.ie**

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Continuing professional development for nurses and midwives

INMO EDUCATION PROGRAMMES

In the pull-out this month…

Healthcare Provider CPR and AED *(in person)*

Mar 8

This course has two parts: online and practical. The online section will be sent to participants before the course date and must be completed prior to attendance.
This course will equip participants with the necessary theory and skills for the provision of CPR and AED use in emergency situations, in line with the latest American Heart Association guidelines. The care of the adult, child and infant will be included.
The certificate awarded has a lifespan of two years.
Times: 11am-12.30pm or 1pm-2.30pm.
Fee: €135 INMO members; €175 non-members

Diabetes CBT and General Wellbeing

Mar 9

This online course is for nurses and midwives who have an interest in the management of a patient with diabetes. The literature would suggest that diabetes, chronic disease management and the self-care that is associated with it brings high incidence rates of depression, anxiety, and negative thoughts. The use of different strategies, Cognitive Behavioural Therapy (CBT) and clinical trials look at the area of wellbeing and theories and models to help clients and healthcare providers try and formulate plans to look at these issues.

PEG Feeding – caring for adults and paediatrics who have a PEG tube in the hospital/community setting

Mar 10

This short online introductory programme is aimed at all nurses working within the hospital and community setting caring for adults and paediatrics who have a percutaneous endoscopic gastrostomy (PEG) tube. It will address the clinical indications and requirements for PEG feeding in the home and hospital setting. It will provide guidance on medication administration and nutrition with a focus on hospital policies and government guidance. It will also discuss the complications of PEG feeding that can occur and how these can be clinically managed.

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"You insure your car, you insure your house; Why not insure your profession?"

Nurses and Midwives; Together we are Stronger

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- Advocating for safe quality care delivered by registered nurses and midwives
- Representing nurses and midwives individually and collectively in the workplace
- The leading voice for nurses and midwives in Irish health care
- Campaigning for restoration of Nurse and Midwife pay and hours
- Providing expert representation in workplace relations
- Full support in NMBI fitness to practice public hearings with expert professional and legal representation
- Professional development offering career development and professional education
- Professional library service
- Employment information service – law – conditions of employment – your rights and entitlements
- Access to income continuance protection plan (supplementary to the sick leave scheme)
- Discount shopping with INMO group scheme with major savings
- Free legal aid for occupational or bodily injury claims
- Legal and counselling helplines

Union membership costs €5.75 per week

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Education Programmes

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Email: education@inmo.ie

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Time: 10am-1pm

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Mar 8 **Healthcare Provider CPR and AED** *(in person)*

This course will equip participants with the necessary theory and skills for the provision of adult/child and infant CPR and AED use in emergency situations, in line with the latest guidelines recommended by the AHA. The online theory section will be sent on to participants prior to course date and must be completed before attending the practical session. The certificate awarded on completion of the course has a life span of two years. Times: 11am-12.30pm or 1pm-2.30pm. Fee: €135 INMO members; €175 non-members.

Mar 8 **Introduction to Treating and Preventing Pressure Ulcers**

This course will advise participants on pressure ulcer prevention. Topics covered on the day include; causes of pressure ulcers, risk assessment, and prevention of pressure ulcers. On completion of this course, participants will be able to: discuss the causes of pressure ulcers; identify the factors that place a person at risk of developing pressure ulcers; have an understanding of the key principles of preventing ulcers and be able to take action to prevent pressure ulcers in the clinical environment; have an understanding of pressure ulcer classifications and grading; have an understanding of the key principles of the SSKIN Bundle and how to implement it in the clinical environment.

Mar 9 **Diabetes CBT and General Wellbeing**

This online course is for nurses and midwives who have an interest in the management of a patient with diabetes. The literature would suggest that diabetes, chronic disease management and the self-care that is associated with it brings high incidence rates of depression, anxiety, and negative thoughts. The use of different strategies, cognitive behavioural therapy (CBT) and clinical trials look at the area of wellbeing and theories and models to help clients and healthcare providers try and formulate plans to look at these issues.

Mar 10 **PEG Feeding – Caring for Adults and Paediatrics who have a PEG Tube in the Hospital/Community Setting**

This introductory programme is aimed at all nurses working within the hospital and community setting caring for adults and paediatrics who have a percutaneous endoscopic gastrostomy (PEG) tube. It will address the clinical indications and requirements for PEG feeding in the home and hospital setting. It will provide guidance on medication administration and nutrition with a focus on hospital policies and government guidance. It will also discuss the complications of PEG feeding that can occur and how these can be clinically managed.

Mar 10 **Competency-based Interview Skills for Nurses and Midwives**

This programme will assist participants for a competency-based interview that enables candidates to show how they would demonstrate certain behaviours and skills in the workplace by answering questions about how they have reacted to and dealt with and previous workplace situations. It will explore preparation, presentation and performance during the interview and briefly focus on CV preparation.

Mar 15 **Become More Assertive**

This programme is designed to help nurses and midwives develop their skills to be more assertive to help them make decisions with conviction; to deal with difficult situations and people and to influence others positively. Learning outcomes: learn how to distinguish between assertive, passive and aggressive behaviours, how to assertively handle difficult situations, how to change your thinking and ultimately your behaviours and how to respond assertively to behaviours in others and learn how to influence others positively.

Mar 16 **Risk management and incident reporting**

This new online programme outlines the core principles of best practice in managing risk, underpinned by philosophy and care needs. At the end of the session participants will be enabled to: understand key terms and definitions related to risk management in healthcare; outline the stages of the risk management process based on the international standard and framework for risk management; outline the five steps of risk assessment; understand the purpose and maintenance of a risk register and complete accurate records of incidents for incident reporting. Ultimately, this programme promotes best practice with risk management and patient safety.

Cancellation policy: For cancellations five days before the course due date, a full credit to transfer on to a course at a future date will be offered. For non-attendance, there is no refund or transfer. If a course is cancelled due to insufficient numbers, a full online refund will be issued.

Mar 20 **Introduction to Effective Library Search Skills**

This course is aimed at nurses and midwives who would like to develop valuable lifelong information seeking skills to get the most up-to date information. This course will assist participants who are undertaking academic programmes.

Mar 22 **Medication Management Best Practice 2020 Guidance for Nurses and Midwives**

This programme supports nurses and midwives in providing safe, evidence-based practice in the area of medication management. It will cover key topics such as: the key principles of medication management, the medication management cycle, management of controlled drugs and medication safety. Participants will have the opportunity to update their knowledge in line with the most up-to-date NMBI Guidance for Registered Nurses and Midwives Administration (2020) and HIQA requirements for medication management.

Mar 22 **The Importance of Documentation for Nurses and Midwives – Getting it Right**

This short programme will assist nurses and midwives in understanding their duty of care and responsibility in the area of best practice in documentation, keeping good records and their ethical and legal responsibility of getting it right. Introduction to legal and professional requirements: NMBI Code and Guidance for Recording Clinical Practice, relevant HIQA regulations and standards, adhering to consent and data protection legislation in record keeping, purpose of healthcare records and documentation, including questions and answers.

Mar 28 **Peripheral Intravenous Cannulation**

This programme provides guidance to participants in the skill of peripheral intravenous cannulation. Instruction will be provided on the sites used for peripheral intravenous cannulation, identifying criteria for evaluating a vein and the principles of an aseptic technique. The aim is for participants to be able to carry out the procedure in a competent and safe manner. While this course will provide the necessary knowledge and skills to undertake peripheral intravenous cannulation, it will be necessary for each nurse and midwife attending to ensure that they abide by their local policy on peripheral intravenous cannulation in their place of work.

Mar 28 **Telephone Assessment and Advice Skills for Nurses and Midwives**

This short online programme is for nurses and midwives involved in providing telephone assessment and advice, in A&E, general practice and other community settings. Such calls assess patients' needs and may provide advice for self care, prompt the caller to seek immediate medical attention or refer the patient to another healthcare professional or agency. This programme will provide strategies and guidance on how best to communicate with each caller and handle in a professional and tactful manner.

Mar 29 **Tracheostomy Care Study Day**

This programme introduces a holistic and inter-disciplinary approach to the management of the adult patient with a tracheostomy. Participants will be given the necessary knowledge, skills and confidence to assess, manage and evaluate the nursing care of a patient with tracheostomy.

Mar 29 **Wound Management For Nurses and Midwives**

This course will advise participants on wound care management. Topics will include; wound healing, wound bed preparation and treatment options, and dressing selections. Participants will be able to: understand the anatomy and physiology of wound management; understand and identify the factors influencing wound healing; understand and identify the differences between acute and chronic wounds; understand and implement a holistic assessment of individuals with wounds; understand the current modalities of different types of dressing and their application.

Mar 30 **Infection Control Risk Register: Regulation 27: Guide to Thematic/Focused Inspections in your Facility**

This course is for staff who are interested in infection prevention and control standards. It will identify key areas relevant to the new focused HIQA infection control guidelines/inspections (October 2021). This programme will provide information and outline the actions required by registered providers to ensure that procedures, consistent with the National Standards for infection prevention and control in community services, published by HIQA, are implemented by staff.

Apr 13 **Phlebotomy**

This programme provides participants with the skill and theory to perform phlebotomy in a competent and safe manner. It will cover topics such as sites used for phlebotomy, criteria for evaluating a vein, principles of an aseptic technique as well as complications that may arise during and after the procedure. Guidance will be given on how to reassure the individual in relation to the procedure and on gaining consent.

Apr 14 **Adult Asthma – Getting the Basics Right**

This short online programme is aimed at nurses and midwives working in clinical practice who require basic knowledge and skills to care for people with asthma on a day-today basis. The programme will assist participants in gaining an understanding of the clinical evidence underpinning the diagnosis and ongoing care and management of the person with asthma utilising current best practice.

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5 Day Programme
MAY - 23, 24, 25
JUNE - 27, 28
2023

Training, Delivery & Evaluation

May/June 2023

This five-day course "Training Delivery and Evaluation" 6N3326 award will equip the nurse/midwife with the knowledge, skills and confidence to plan, deliver and assess learning and evaluate training provision. This course would suit every nurse/midwife working with student nurses in a clinical learning environment and also in centres of nurse education.

A wide range of training methods, including role-play, small group work, case studies, action learning, online training and forums will be used to enhance the learning process. The course aims to foster and share the rich and diverse knowledge and skills of participants whilst providing them with the expertise and confidence to impart their knowledge effectively.

This training will lead to QQI level 6 component certificate in Training, Delivery and Evaluation (formally Train the Trainer FETAC 6) and it carries 15 ECTs (European Credit Transfer and Accumulation System). Throughout the programme, trainer support is also available for each nurse/midwife attending the course.

Time: 9.30am - 5.00pm

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

HOW TO BOOK

A non-refundable deposit of €200* must be made to reserve a place.

EARLY BIRD FEE

€550 INMO members

Available until Friday, 28 April 2023.
After this date the fee is €625 for INMO members.

Fee for non members is €875

*Payment in full must be made prior to **Friday, 12 May 2023.**

34 NMBI CEUs

Module 6N3326 - QQI Level 6
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Apr 19 **Leg Ulcer Assessment and Management**

This course will advise participants on leg ulcer management. Topics will include: pathophysiology, assessment and management of leg ulcers. Participants will gain an understanding of the theory of different causes of leg ulcerations, a deeper understanding of the pathophysiology of leg ulceration, different non-invasive assessments and the importance of compression for venous leg ulcerations.

Apr 20 **Chronic Obstructive Pulmonary Disease – Getting the Basics Right**

This short online programme is aimed at nurses working in clinical practice who require basic knowledge and skills to care for people with COPD on a day-today basis. The programme will assist participants in gaining an understanding of the clinical evidence underpinning the diagnosis and ongoing care and management of the person with COPD utilising current best practice.

Apr 21 **Paediatric Asthma – Understanding the Basics**

This online programme is aimed at nurses and midwives who are working in clinical practice who require basic knowledge and skills to care for children and their families with asthma on a day-to-day basis. The programme will assist participants in gaining an understanding of the clinical evidence underpinning the diagnosis and ongoing care and management of the child with asthma utilising current best practice.

Apr 25 **Healthcare Provider CPR and AED**

This course has two parts: online and practical. The online section will be sent to participants before the course date and must be completed prior to attendance. This course will equip participants with the necessary theory and skills for the provision of CPR and AED use in emergency situations, in line with the latest American Heart Association guidelines. The care of the adult, child and infant will be included.

Apr 26 **Falls Reduction, Assessment and Review**

The purpose of this programme is to promote a consistent approach to falls reduction for older people through assessment, individualised care planning and post-falls review. It promotes excellence among nurses who provide care to the patients at risk of falls, informed by current evidence. The main aim is to assist nurses to identify those patients or residents who are at risk of falls and to reduce that risk by providing knowledge on falls reduction techniques, ultimately improving patient safety and minimising injuries in the older population.

Apr 27 **Understanding and Developing Care Plans for Nurses and Midwives**

This course provides nurses and midwives with the most up-to-date information regarding policy and standards. It will enhance their understanding of nursing care plans, reflecting on the past, present and future use of care planning and its importance in the workplace. It will focus on the need for comprehensive assessment, including risk assessment and care planning. Participants will be provided with practical tips on how to prepare for and carry out a comprehensive assessment, enabling them to develop a person-centred care plan.

INMO Professional

INMO Irish Nurses and Midwives Organisation Working Together

Understanding and Developing Care Plans

for Nurses and Midwives

Thursday, 27 April 2023

LIVE ONLINE EVENT

Time: 10am - 1pm

Fee: €30 INMO members; €65 non members

This short programme provides nurses and midwives with the most up-to-date information regarding policy and standards. It will enhance their understanding of nursing care plans, reflecting on the past, present and future use of care planning and its importance in the workplace. It will focus on the need for comprehensive assessment, including risk assessment and care planning. Participants will be provided with practical tips on how to prepare for and carry out a comprehensive assessment, enabling them to develop a person-centred care plan.

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INMO
Irish Nurses and Midwives Organisation
Working Together

LIVE ONLINE EVENT

Fee: €30 INMO members;
€65 Non members

Telephone Assessment & Advice Skills

for Nurses and Midwives

Tuesday, 28 March 2023

Time: 10am - 1pm

This short online programme is for nurses and midwives providing telephone assessment and advice, in A&E, minor injury clinics, general practice, chronic disease management and other community settings. Such calls assess patients' needs and provide advice for self-care, prompt the caller to seek immediate medical attention or refer the patient to another healthcare professional or agency. This programme will provide strategies and guidance on how best to communicate with each caller and handle calls in a professional and tactful manner. Participants will also work on case scenarios.

Participants will learn:

- How to adopt good communication skills that involve mindful listening and speech that is compassionate and understanding yet clear to signpost patient in the right direction
- Guidance on how to carry out health consultations and assessments over the phone
- Identifying red flags through effective questioning skills
- Giving self-care & call-back advice
- How to accurately assess patients and use recommended disposition to save lives
- Accurate record-keeping for continuity of care and future reference
- Identify and discuss risks involved with Telephone Triage

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Searching the literature databases

Following last month's article on information literacy, this month Niamh Adams focuses on tips for searching for literature using the CINAHL database

THE Cumulative Index to Nursing and Allied Health Literature (CINAHL) was first launched online in 1984 to provide a database that included articles from reputable academic journals and other sources concerning nursing and allied health. Since then, the database has gone through several iterations to become one of the most important resources for academics and professionals alike. Today it indexes 3,736 journals, of which 3,233 are peer-reviewed.[1] There are several versions of the database, including CINAHL Complete and Ultimate. These refer to the full-text availability to which the library subscribes; the core database remains the same.

Why use CINAHL?

Studies of the database have found to be a good source of primary research for performing systematic reviews.[2] A study of the integrity of databases in terms of the indexing of predatory journals found that CINAHL contained no citations from such journals when compared with other databases.[3] This is significant when considering the importance of using credible sources of research for college or work.

In practical terms, CINAHL can be used for several purposes. In our experience, we would consider CINAHL a great place to start a search for an academic assignment or to develop or update a work policy. The key to getting the most out of this database is to clearly understand what you are looking for. A search can be as thorough as required. It is important to get into the habit of thinking about this before starting your search. That way you can apply appropriate limits to the search. For example, do you only require primary research or do you only want recent review articles? Is there a time limit on what you are searching?

Getting the most out of CINAHL

Use the advanced search screen

Although there is a simple search screen available, to see your search strategy and avail of other facilities such as mapping subject headings, it is important always to use the advanced search option.

Get to know CINAHL subject headings

Even if you are conducting a simple search, getting to know the subject headings that CINAHL uses is useful in completing an accurate and precise search.

Check out the range of limits available

Refining your search by using the different limits available in the database is a great way to narrow a search, and CINAHL provides several useful options. Some of the more useful limits include peer-review, age group, research articles, metasynthesis, journal subgroup and language.

Saving search results and strategies

By creating a personal account within the database, it is possible to save search strategies to work on later and to save citations.

If you would like to find out more about using CINAHL and how to get the most out of your searches, please get in touch and book an appointment with the library staff. Alternatively, the library runs an online course that introduces searching techniques using the CINAHL database. See the details below for upcoming courses.

Library news

We are currently rolling out Open Athens as a method for our members to access the online library. Although only in the early stages of implementation, if you are interested in registering for Open Athens access, please visit **https://inmo.ie/Library** or contact niamh.adams@inmo.ie

Literature Searching Service

Let us assist you with your searching. The library offers a literature searching service which is available to members for a small fee and can be useful if you are having difficulty finding relevant articles or if you do not have enough time to complete your search yourself.

Other library services

For further information on this or any of the library services, please call: 01 6640614/25 or email: library@inmo.ie If you wish to visit the library, please make an appointment in advance so we can ensure that there will be a staff member available to assist you. The library opening hours are Monday to Thursday: 8.30am-5.00pm, Friday: 8.30am-4.30pm.

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Chronic disease nursing
The dermatology experience

Sheila Ryan gives an overview of specialist dermatology nursing in the Irish setting and says it offers increasingly diverse opportunities

THE skin is the largest organ of the body. It is a highly visible organ and the most important organ for social functioning.[1] Dermatology involves the study, research, diagnosis and management of normal and abnormal disorders, diseases, cancers, cosmetic and ageing conditions of the skin, hair, nails, oral and genital membranes. Dermatology is regarded as a hybrid specialty. It affects individuals of all ages and races. It encompasses a vast range of acute, chronic and inherited disease, infectious disease and neoplasms. There are in excess of 2,000 disorders affecting the skin and its appendages.[2]

Prevalence and impact of skin disease

Skin disease is highly prevalent with approximately 54% of the population affected by skin disease at any one time.[1] Skin disease represents 34% of childhood disease, with atopic eczema being the most prevalent.[3] In Ireland half of the dermatology workload in secondary care is skin cancer.[1] The remainder of the workload in secondary care includes chronic inflammatory disease, reactive disease, genetic disorders, metabolic diseases, infectious disease and psycho-cutaneous disorders. Skin cancer is the most common cancer in Ireland with almost 11,000 new cases diagnosed per annum.[4]

As these figures demonstrate, the burden of skin disease is significant. In 2010 and 2013 skin conditions ranked as the fourth-leading cause of non-fatal disease burden and disability worldwide.[5] Some 15-20% of general practice consultations are skin related.[1] This represents in the region of 712,500 to 950,000 consultations per annum.[1] It is estimated that in Ireland 33% of the population at any one time has a condition that would benefit from medical intervention.[1]

The significant burden of skin disease has led to high demand for dermatology services. This consequently has led to lengthy waiting lists and times. To meet the challenge of dermatology service provision, two national programmes were established in 2011. The first, the National Clinical Programme in Dermatology was established to improve and standardise patient care delivery. The second, the National Cancer Control Programme (NCCP) focused on the delivery of skin cancer management services. Both of these programmes have emphasised the importance of dermatology nurses and have sought to establish new dermatology nursing posts.

Dermatology nursing as a specialty

Dermatology nursing is a varied role with many subspecialties. Those subspecialties include paediatric dermatology, skin cancer nursing, skin surgery and phototherapy.[6] Within the specialty there are staff nurses, clinical nurse specialists and advanced nurse practitioners. The visible nature of skin disease aids the development of specialist and advanced nursing skills. Many nurses will report that seeing their patients respond to treatment is particularly satisfying.[7]

The majority of dermatology nurses in Ireland are based in secondary care.[1] The majority of those services are outpatient based. However, in other healthcare jurisdictions dermatology nurses are employed in the community, academic and aesthetic settings, as well as secondary care.[8] Future measures to improve access to dermatological care are likely to include the development of community-based dermatology nursing posts.

On a day-to-day basis, dermatology nurses provide education, therapeutic interventions and monitoring clinics. Patient education is an important part of the role as it empowers patients with chronic disease to self manage.[9] Health promotion is also an important facet of the role, especially in relation to skin cancer surveillance.

Therapeutic interventions include phototherapy, photodynamic therapy, cryosurgery, topical therapy and laser services.

The role of the dermatology nurse has evolved in diagnostic services in recent years with nurses being trained in surgery and dermoscopy.[8] With the evolution of nurse prescribing, dermatology nurses have become involved in drug monitoring clinics.[10] Many of these patients have a chronic disease, and dermatology nurses are well placed with their practical skills to support and empower them.

To support the development of dermatology nursing there are a number of educational programmes. Professional organisations such as the Irish Dermatology Nurses Association (IDNA), the British Dermatology Nursing Group (BDNG) and the European Academy of Dermatology and Venerology (EADV) offer specialist study days. The BDNG and EADV offer short courses and online webinars. Academic courses in dermatology nursing are available in Dublin City University and University College Dublin. A master's degree in clinical dermatology is available at the University of Hertfordshire in the UK.

Dermatology nursing is a rewarding career choice. As a hybrid specialty there are many facets of dermatology where nurses can gain specialist skills. This unique skill set equips the dermatology nurse to work in many clinical settings, including primary and secondary care and academia. For many the first step in gaining dermatology skills is through working in a specialist centre.

As a dermatology nurse you will have unique opportunities to empower, educate and support your patients. With increased funding the role of the dermatology nurse continues to diversify. The specialty now offers fantastic opportunities for professional development and job satisfaction.

Sheila Ryan is a dermatology advanced nurse practitioner at University of Limerick hospitals

References on request from nursing@medmedia.ie
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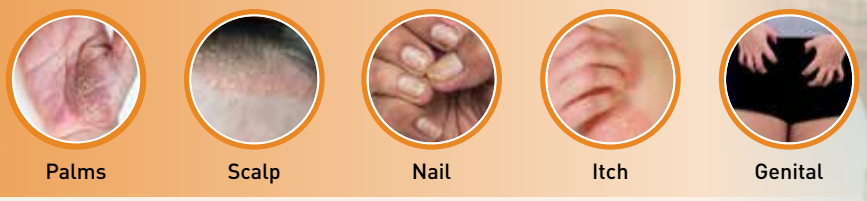

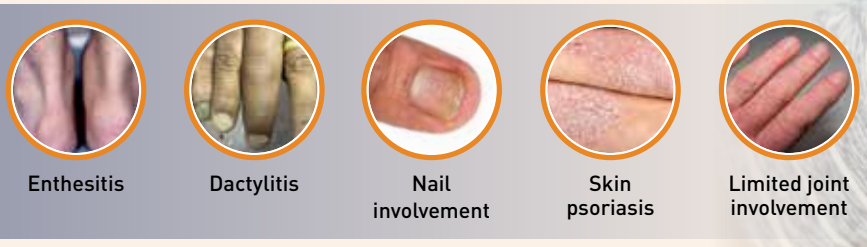

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Indications: Psoriatic arthritis: OTEZLA, alone or in combination with Disease Modifying Antirheumatic Drugs (DMARDs), is indicated for the treatment of active psoriatic arthritis (PsA) in adult patients who have had an inadequate response or who have been intolerant to a prior DMARD therapy. Psoriasis: OTEZLA is indicated for the treatment of moderate to severe chronic plaque psoriasis in adult patients who failed to respond to or who have a contraindication to, or are intolerant to other systemic therapy including ciclosporine, methotrexate or psoralen and ultraviolet-A light (PUVA).
Dosage and administration: Treatment with OTEZLA should be initiated by specialists experienced in the diagnosis and treatment of psoriasis or psoriatic arthritis. The recommended dose of OTEZLA is 30mg twice daily taken orally in the AM and PM, approximately 12 hours apart, with no food restrictions. The film-coated tablets should be swallowed whole. An initial dose titration is required per the following schedule: Day 1: 10mg in the AM; Day 2: 10mg in the AM and 10 mg in the PM; Day 3: 10mg in the AM and 20mg in the PM; Day 4: 20mg in the AM and 20mg in the PM; Day 5: 20mg in the AM and 30mg in the PM; Day 6 and thereafter: 30mg twice daily in the AM and PM. No re-titration is required after initial titration. If patients miss a dose, the next dose should be taken as soon as possible. If it is close to the time for their next dose, the missed dose should not be taken and the next dose should be taken at the regular time.
Patients with severe renal impairment: The dose of OTEZLA should be reduced to 30mg once daily in patients with severe renal impairment (creatinine clearance of less than 30mL per minute estimated by the Cockcroft-Gault equation). For initial dose titration in this group, it is recommended that OTEZLA is titrated using only the AM doses and the PM doses be skipped. Paediatric population: The safety and efficacy of OTEZLA in children aged 0 to 17 years have not been established. No data is available.
Contraindications: Hypersensitivity to the active substance(s) or to any of the excipients. OTEZLA is contraindicated in pregnancy. Pregnancy should be excluded before treatment can be initiated.
Special warnings and precautions: Diarrhoea, nausea and vomiting: Severe diarrhoea, nausea, and vomiting associated with the use of OTEZLA have been reported. Most events occurred within the first few weeks of treatment. In some cases, patients were hospitalized. Patients 65 years of age or older may be at a higher risk of complications. Discontinuation of treatment may be necessary. Psychiatric disorders: OTEZLA is associated with an increased risk of psychiatric disorders such as insomnia and depression. Instances of suicidal ideation and behaviour, including suicide, have been observed in patients with or without history of depression. The risks and benefits of starting or continuing treatment with OTEZLA should be carefully assessed if patients report previous or existing psychiatric symptoms or if concomitant treatment with other medicinal products likely to cause psychiatric events is intended. Patients and caregivers should be instructed to notify the prescriber of any changes in behaviour or mood and of any suicidal ideation. If patients suffered from new or worsening psychiatric symptoms, or suicidal ideation or suicidal attempt is identified, it is recommended to discontinue treatment with OTEZLA. Severe renal impairment: See dosage and administration section. Underweight patients: OTEZLA may cause weight loss. Patients who are underweight at the start of treatment should have their body weight monitored regularly. In the event of unexplained and clinically significant weight loss, these patients should be evaluated by a medical practitioner and discontinuation of treatment should be considered. Lactose content: Patients with rare hereditary problems of galactose intolerance, total lactase deficiency or glucose-galactose malabsorption should not take this medicinal product.
Interactions: Co-administration of strong cytochrome P450 3A4 (CYP3A4) enzyme inducer, rifampicin, resulted in a reduction of systemic exposure of OTEZLA, which may result in a loss of efficacy of OTEZLA. Therefore, the use of strong CYP3A4 enzyme inducers (e.g. rifampicin, phenobarbital, carbamazepine, phenytoin and St. John's Wort) with OTEZLA is not recommended. In clinical studies, OTEZLA has been administered concomitantly with topical therapy (including corticosteroids, coal tar shampoo and salicylic acid scalp preparations) and UVB phototherapy. OTEZLA can be co-administered with a potent CYP3A4 inhibitor such as ketoconazole, as well as with methotrexate in psoriatic arthritis patients and with oral contraceptives.
Pregnancy, lactation and fertility: Women of childbearing potential should use an effective method of contraception to prevent pregnancy during treatment. OTEZLA should not be used during breast-feeding. No fertility data is available in humans.
Undesirable effects: Psychiatric disorders: In clinical studies and post-marketing experience, uncommon cases of suicidal ideation and behaviour, were reported, while completed suicide was reported post-marketing.
The most commonly reported adverse reactions with OTEZLA in these indications are gastrointestinal (GI) disorders including diarrhoea (15.7%) and nausea (13.9%). These GI adverse reactions generally occurred within the first 2 weeks of treatment and usually resolved within 4 weeks.
Adverse reactions reported in the psoriatic arthritis and/or psoriasis clinical trial programme and post marketing experience include: very common (≥1/10) diarrhoea*, nausea*; common (≥1/100 to <1/10) bronchitis, upper respiratory tract infection, nasopharyngitis*, decreased appetite*, insomnia, depression, migraine*, tension headache*, headache*, cough, vomiting*, dyspepsia, frequent bowel movements, upper abdominal pain*, gastroesophageal reflux disease, back pain*, fatigue; uncommon (≥1/1,000 to <1/100) hypersensitivity, suicidal ideation and behaviour, gastrointestinal haemorrhage, rash, urticaria, weight loss; not known (cannot be estimated from the available data) angioedema. *At least one of these adverse reactions was reported as serious. Please consult the SPC for a full description of undesirable events.
Pharmaceutical Precautions: Do not store above 30°C. **Legal category:** POM. **Presentation and Marketing Authorisation Numbers:** Initiation pack containing 27 film coated tablets (4 x 10mg, 4 x 20mg, 19 x 30mg) - EU/1/14/981/001; 30mg film coated tablets in a pack size of 56 tablets - EU/1/14/981/002. **Marketing Authorisation Holder:** Amgen Europe B.V. Minervum 7061, 4817 ZK Breda, The Netherlands. Further information is available from Amgen Ireland Limited, 21 Northwood Court, Santry, Dublin D09 TX31. OTEZLA is a trademark owned or licensed by Amgen Inc., its subsidiaries, or affiliates.
Date of preparation: April 2020 (Ref: IE-OTZ-2000019).

Adverse reactions/events should be reported to the Health Products Regulatory Authority (HPRA) using the available methods via www.hpra.ie. Adverse events should also be reported to Amgen Limited on +44 (0)1223 436441.

Abbreviations: PDE4, phosphodiesterase-4; PsA, psoriatic arthritis; PsO, psoriasis.

References: 1. OTEZLA (apremilast). Summary of Product Characteristics; **2.** Kavanaugh A, et al. *Arthritis Res Ther.* 2019;21:118; **3.** Augustin M, et al. *J Eur Assoc Dermatol Venereol.* 2021;35:123–134; **4.** Wollenhaupt J, et al. Presented at EULAR 2020; 3–6 June 2020; Virtual: Poster FRI0365; **5.** Crowley JA, et al. Presented at the 73rd Annual Meeting of the American Academy of Dermatology; 20–24 March 2015; San Francisco, CA: P894; **6.** Rich P, et al. *J Am Acad Dermatol.* 2016;74(1):134–142; **7.** Reich K, et al. *Dermatol Ther.* 2022;12:203–221.

Amgen Ireland Ltd., 21 Northwood Court, Santry, Dublin 9

IE-OTZ-0622-00004

Date of preparation: August 2022

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Focus on: Psoriasis research

WIN takes a look at some recent results of the EMBRACE study

MANIFESTATIONS of psoriasis in special areas are difficult to treat and are associated with a high disease burden and significant quality of life (QoL) impairment. Topical therapies may be inadequate for these patients, necessitating systemic treatment.

The objective of the EMBRACE study was to evaluate the impact on QoL, efficacy and safety of apremilast 30mg BID in patients with limited skin involvement with plaque psoriasis manifestations in special areas and impaired QoL.

EMBRACE was a phase IV, randomised, placebo-controlled, multinational study. The patients enrolled had plaque psoriasis that was not controlled by topical therapy; lack of response, contraindication or intolerance to conventional first-line systemic therapy; psoriasis in ≥ 1 special area (including visible locations, scalp, nails, genital areas or palmoplantar areas); Psoriasis Area and Severity Index (PASI) ≥ 3 to ≤10; and Dermatology Life Quality Index (DLQI) > 10. The primary endpoint was DLQI response (≥ 4-point reduction) at week 16.

Manifestations of plaque psoriasis can occur in specific areas, including the scalp, nails, palms, soles, genitals or visible locations such as the face, neck, hairline or dorsal hand. These manifestations are common; psoriasis of the scalp and face each occur in more than half of patients, and genital psoriasis is reported in up to 63% of patients.[1,2,3] These areas are difficult to treat and are associated with a high disease burden.[1] Significant disease-related QoL impairment as a result of psoriasis in special areas can be disproportionate to the extent of body surface area involved.[4,5] For example, scalp psoriasis and psoriasis in visible locations may lower the self-esteem of patients and affect their social activities. Also, pain from nail and palmoplantar psoriasis can limit the ability to do daily tasks.[1]

While topical therapies are the first-line treatment for psoriasis, they can provide an inadequate response in patients with psoriasis in specific areas and application of topical preparations can be messy and burdensome.[1,6,7] According to a European consensus, the presence of specific disease manifestations in visible areas, the scalp, genitals, palms and/or soles, or nails that are not adequately controlled by topical therapy alone in patients with otherwise mild disease may shift the psoriasis classification towards greater disease severity.[8]

According to the International Psoriasis Council, patients may require systemic treatment if psoriasis is present in special areas.[9] The recognition of impactful psoriasis manifestations is considered best practice according to the people-centred healthcare concept of the World Health Organization.[10]

Apremilast is an oral phosphodiesterase 4 inhibitor that has been shown to be effective in treating psoriasis, including symptoms of scalp and nail psoriasis.[11,12]

EMBRACE enrolment was conducted in France, Germany, Great Britain, Italy, Spain and Switzerland. Patients were randomised 2:1 to receive apremilast or placebo. After five days of dose titration, patients received apremilast 30mg BID or placebo for 16 weeks, followed by a 36-week active treatment phase. Concomitant psoriasis medications, including topicals, conventional systemic therapies, biologic agents and phototherapies, were not permitted. Unmedicated skin moisturisers were permitted for body lesions only but could not contain urea or salicylic acid.

Of 277 randomised patients (apremilast: n = 185; placebo: n = 92), 221 completed week 16 (apremilast: n = 152; placebo: n = 69). The primary endpoint (≥ 4-point reduction in DLQI at week 16) was met by significantly more patients receiving apremilast (73.3%) versus placebo (41.3%; p < 0.0001). Significantly greater improvement in affected body surface area and PASI was observed with apremilast versus placebo at week 16. There were also significantly greater improvements with apremilast versus placebo in itch numeric rating scale (-2.5 versus -0.9, p < 0.0001) and skin discomfort/pain visual analogue scale (-21.5 versus -5.4, p = 0.0003) and greater achievement of Patient Benefit Index ≥ 1 (77% versus 40%, p < 0.0001) at week 16. No new safety signals were observed.

Conclusion

Apremilast significantly improved skin-related QoL in patients with limited skin involvement with plaque psoriasis in special areas and highly impaired QoL.

This research was published in the *Journal of the European Academy of Dermatology and Venereology*.

DOI.org/10.1111/jdv.18689

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KISQALI is not indicated for concomitant use with tamoxifen[4]

1L, first line; **2L,** second line; **ET,** endocrine therapy; **LHRH,** luteinizing hormone-releasing hormone, **aBC**, advanced breast cancer.

ESMO - European society of medical oncology **SABC -** San Antonio Breast Cancer Conference **ASCO -** American Society of Clinical Oncology

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ABBREVIATED PRESCRIBING INFORMATION

Please refer to Summary of Product Characteristics (SmPC) before prescribing.

Kisqali (ribociclib) 200 mg film-coated tablets

Presentation: Film coated tablets (FCT) containing 200 mg of ribociclib and 0.344 mg soya lecithin.

Indications: Kisqali is indicated for the treatment of women with hormone receptor (HR) positive, human epidermal growth factor receptor 2 (HER2) negative locally advanced or metastatic breast cancer in combination with an aromatase inhibitor or fulvestrant as initial endocrine-based therapy, or in women who have received prior endocrine therapy

In pre or perimenopausal women, the endocrine therapy should be combined with a luteinising hormone releasing hormone (LHRH) agonist.

Dosage and administration:

Adults: The recommended dose is 600 mg (3 x 200 mg FCT) taken orally, once daily for 21 consecutive days followed by 7 days off treatment, resulting in a complete cycle of 28 days.

Kisqali should be used together with 2.5 mg letrozole or another aromatase inhibitor or with 500 mg fulvestrant.

When Kisqali is used in combination with an aromatase inhibitor, the aromatase inhibitor should be taken orally once daily continuously throughout the 28 day cycle. Please refer to the Summary of Product Characteristics (SmPC) of the aromatase inhibitor for additional details.

When Kisqali is used in combination with fulvestrant, fulvestrant is administered intramuscularly on days 1, 15 and 29, and once monthly thereafter. Please refer to the SmPC of fulvestrant for additional details.

Treatment of pre and perimenopausal women with the approved Kisqali combinations should also include an LHRH agonist in accordance with local clinical practice.

Management of severe or intolerable adverse reactions (ARs) may require temporary dose interruption, reduction or discontinuation of Kisqali. Please see section 4.2 of SmPC for recommended dose modification guidelines.

Kisqali can be taken with or without food (see section 4.5).The tablets should be swallowed whole and should not be chewed, crushed or split prior to swallowing.

Special populations: ♦*Renal impairment:* Mild or moderate: No dose adjustment is necessary. Severe: A starting dose of 200 mg is recommended in patients with severe renal impairment. Kisqali has not been studied in breast cancer patients with severe renal impairment. Caution should be used in patients with severe renal impairment with close monitoring for signs of toxicity. ♦*Hepatic impairment:* Mild: No dose adjustment is necessary. Moderate or severe: Dose adjustment is required, and the starting dose of 400 mg once daily is recommended. ♦*Elderly (>65 years):* No dose adjustment is required. ♦*Pediatrics(<18 years):* Safety and efficacy have not been established.

Contraindications: Hypersensitivity to the active substance or to peanut, soya or any of the excipients.

Warnings/Precautions: ♦***Neutropenia*** was most frequently reported AR. A complete blood count (CBC) should be performed before initiating treatment. CBC should be monitored every 2 weeks for the first 2 cycles, at the beginning of each of the subsequent 4 cycles, then as clinically indicated. Febrile neutropenia was reported in 1.4% of patients exposed to Kisqali in the phase III clinical studies. Patients should be instructed to report any fever promptly.Based on the severity of the neutropenia, Kisqali may require dose interruption, reduction, or discontinuation. ♦***Hepatobiliary toxicity*** - increases in transaminases have been reported. Liver function tests (LFTs) should be performed before initiating treatment. LFTs should be monitored every 2 weeks for the first 2 cycles, at the beginning of each of the subsequent 4 cycles, then as clinically indicated. If grade ≥ 2 abnormalities are noted, more frequent monitoring is recommended.

Recommendations for patients who have elevated AST/ALT grade ≥ 3 at baseline have not been established. Based on the severity of transaminase elevations, Kisqali may require dose interruption, reduction, or discontinuation. ♦***QT interval prolongation*** has been reported with Kisqali. The use of Kisqali should be avoided in patients who have already or who are at significant risk of developing QTc prolongation. The ECG should be assessed prior to initiation of treatment. Treatment with Kisqali should be initiated only in patients with QTcF values <450 msec. The ECG should be repeated at approximately Day 14 of the first cycle and at the beginning of the second cycle, then as clinically indicated. In case of QTcF prolongation during treatment, more frequent ECG monitoring is recommended Appropriate monitoring of serum electrolytes (including potassium, calcium, phosphorous, and magnesium) should be performed prior to initiation of treatment, at the beginning of the first 6 cycles, and then as clinically indicated. Any abnormality should be corrected before the start of Kisqali treatment. Based on the observed QT prolongation during treatment, Kisqali may require dose interruption, reduction, or discontinuation. Based on the E2301 study QTcF interval data, Kisqali is not recommended for use in combination with tamoxifen. ♦***Critical visceral disease.*** The efficacy and safety of ribociclib have not been studied in patients with critical visceral disease. ♦***Severe cutaneous reactions*** Toxic epidermal necrolysis (TEN) has been reported with Kisqali treatment. If signs and symptoms suggestive of severe cutaneous reactions (e.g. progressive widespread skin rash often with blisters or mucosal lesions) appear, Kisqali should be discontinued immediately. ♦***Interstitial lung disease/pneumonitis*** ILD/pneumonitis has been reported with CDK4/6 inhibitors including Kisqali. Based on the severity of the ILD/pneumonitis, which may be fatal, Kisqali may require dose interruption, reduction or discontinuation as described in SmPC.

Patients should be monitored for pulmonary symptoms indicative of ILD/pneumonitis which may include hypoxia, cough and dyspnoea and dose modifications should be managed in accordance with Table 5 (see section 4.2)

♦***Blood creatinine increase*** ribociclib may cause blood creatinine increase – if this occurs it is recommended that further assessment of the renal function be performed to exclude renal impairment.

♦***CYP3A4 substrates.*** ribociclib may interact with medicinal products which are metabolised via CYP3A4, which may lead to increased serum concentrations of CYP3A4 substrates (see section 4.5). Caution is recommended in case of concomitant use with sensitive CYP3A4 substrates with a narrow therapeutic index and the SmPC of the other product should be consulted for the recommendations regarding co administration with CYP3A4 inhibitors.

Pregnancy, Fertility and Lacation

♦***Pregnancy:*** Pregnancy status should be verified prior to starting treatment as Kisqali can cause foetal harm when administered to a pregnant woman.

♦***Women of childbearing potential*** who are receiving Kisqali should use effective contraception (e.g. double-barrier contraception) during therapy and for at least 21 days after stopping treatment with Kisqali. ♦***Breast feeding:*** Patients receiving Kisqali should not breast feed for at least 21 days after the last dose. ♦***Fertility:*** There are no clinical data available regarding effects of ribociclib on fertility. Based on animal studies, ribociclib may impair fertility in males of reproductive potential.

♦***Effects on ability to drive and use machines*** Patients should be advised to be cautious when driving or using machines in case they experience fatigue, dizziness or vertigo during treatment with Kisqali.

Interactions: ♦Concomitant use of strong CYP3A4 inhibitors should be avoided, including, but not limited to, clarithromycin, indinavir, itraconazole, ketoconazole, lopinavir, ritonavir, nefazodone, nelfinavir, posaconazole, saquinavir, telaprevir, telithromycin, verapamil, and voriconazole. Alternative concomitant medicinal products with less potential to inhibit CYP3A4 should be considered. Patients should be monitored for ARs. If concomitant use of a strong CYP3A4 inhibitor cannot be avoided, the dose of Kisqali should be reduced (see section 4.2 of SmPC). ♦Grapefruit or grapefruit juice should be avoided. ♦Concomitant use of strong CYP3A4 inducers should be avoided, including, but not limited to, phenytoin, rifampicin, carbamazepine and St John's Wort *(Hypericum perforatum)*. An alternative medicinal product with no or minimal potential to induce CYP3A4 should be considered. ♦Caution is recommended when Kisqali is administered with sensitive CYP3A4 substrates with narrow therapeutic index (including, but not limited to, alfentanil, ciclosporin, everolimus, fentanyl, sirolimus, and tacrolimus), and their dose may need to be reduced. ♦Concomitant administration of Kisqali at the 600 mg dose with the following CYP3A4 substrates should be avoided: alfuzosin, amiodarone, cisapride, pimozide, quinidine, ergotamine, dihydroergotamine, quetiapine, lovastatin, simvastatin, sildenafil, midazolam, triazolam. ♦Caution and monitoring for toxicity are advised during concomitant treatment with sensitive substrates of drug transporters P-gp, BCRP, OATP1B1/1B3, OCT1, OCT2, MATE1 and BSEP which exhibit a narrow therapeutic index, including but not limited to digoxin, pitavastatin, pravastatin, rosuvastatin and metformin. ♦Co-administration of Kisqali with medicinal products with known potential to prolong the QT interval should be avoided such as anti-arrhythmic medicinal products (including, but not limited to, amiodarone, disopyramide, procainamide, quinidine and sotalol) and other medicinal products known to prolong the QT interval including, but not limited to, chloroquine, halofantrine, clarithromycin, ciprofloxacin, levofloxacin, azithromycin, haloperidol, methadone, moxifloxacin, bepridil, pimozide and intravenous ondansetron. **Kisqali is not recommended for use in combination with tamoxifen.**

Adverse reactions: ♦Very common: Infections, neutropenia, leukopenia, anaemia lymphopenia, decreased appetite, headache, dizziness, dyspnoea, cough, nausea, diarrhoea, vomiting, constipation, stomatitis, abdominal pain, dyspepsia alopecia, rash, pruritus, back pain, fatigue, peripheral oedema, asthenia, pyrexia, abnormal liver function tests. ♦Common:, thrombocytopenia, febrile neutropenia, hypocalcaemia, hypokalaemia, hypophosphataemia, vertigo, lacrimation increased, dry eye, syncope, dysgeusia, , hepatotoxicity, erythema, dry skin, vitiligo, dry mouth, oropharyngeal pain, blood creatinine increased, electrocardiogram QT prolonged. ♦Please refer to SmPC for a full list of adverse reactions.

Legal Category: POM

Pack sizes: Unit packs containing 21, 42 or 63 FCTs. Not all pack sizes may be marketed.

Marketing Authorisation Holder:
Novartis Europharm Limited
Vista Building, Elm Park, Merrion Road, Dublin 4 Ireland

Marketing Authorisation Numbers:
EU/1/17/1221/003 & 005.

Full prescribing information is available on request from Novartis Ireland Ltd, Vista Building, Elm Park Business Park, Dublin 4. Tel: 01 2601255 or at www.medicines.ie

Prescribing information last revised: April 2022

Reporting suspected adverse reactions of the medicinal product is important to Novartis and the HPRA. It allows continued monitoring of the benefit/risk profile of the medicinal product. All suspected adverse reactions should be reported via HPRA Pharmacovigilance, website www.hpra.ie. Adverse events could also be reported to Novartis preferably via www.report.novartis.com or by email: drugsafety.dublin@novartis.com or by calling 01 2080 612.

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Breast cancer cases

Two stage 1 breast cancer case studies demonstrate how taking individualised treatment approaches can best fit the patient's needs

THE following cases are examples of women with stage 1 breast cancer, who had different treatments. These cases show the importance of an individualised treatment plan for each patient so as to optimise the oncological outcomes and to minimise treatment-related morbidity.

In recent years, significant progress has been made with breast cancer treatments. Traditionally many patients would have had surgery, chemotherapy, radiotherapy and hormonal treatment if they had a breast cancer greater than 1cm in size. However, modern breast cancer treatment has changed from maximally tolerated treatments to minimally effective treatments. There is less emphasis on re-excising margins, fewer axillary dissections and significantly less chemotherapy.

Case 1

A 62-year-old woman was diagnosed with a 15mm grade 2 invasive ductal cancer in the right upper outer quadrant after a routine screening mammogram with BreastCheck. An ultrasound scan of her axilla was negative. The histology revealed a grade 2 invasive ductal cancer that was ER positive, PR positive and HER2 neu negative. A multidisciplinary team meeting discussion advised surgery.

A LOCalizer, a wire-free guidance system, was placed and an image-guided wide local excision and a sentinel lymph node biopsy was performed (*see Figure*). The final histology confirmed a 15mm grade 2 invasive ductal cancer with negative margins and two sentinel nodes were negative. A subsequent Oncotype DX recurrence score was 12, meaning that she could safely avoid chemotherapy and she was recommended to have hormonal treatment along with radiotherapy.

Traditionally, such a patient might have had chemotherapy 20 years ago but the Oncotype DX test is a genomic test that looks at the gene expression profile in breast cancers. Patients can be categorised as high risk, intermediate risk or low risk. Only the high risk cancers in post-menopausal women need chemotherapy.

At least one-third of women who previously would have had chemotherapy can now avoid it with this technology. This is both predictive and prognostic. However, it is worth remembering that low risk does not mean no risk – it means there is no additional benefit to chemotherapy in such patients.

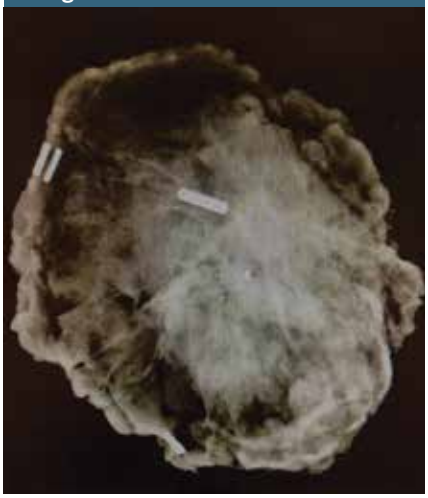
Case 2

A 52-year-old premenopausal woman had a wide local excision and a sentinel lymph node biopsy for a 19mm grade 2 invasive ductal cancer that was ER positive, PR positive and HER2 neu negative, and one of her two sentinel nodes was positive. This woman was pre-menopausal and she had chemotherapy followed by radiation and hormonal treatment.

The RxPONDER trial has shown that among premenopausal women with one to three positive lymph nodes and a recurrence score of 25 or lower, those who received chemotherapy and endocrine therapy had longer invasive disease-free survival and distant relapse-free survival than those who received endocrine-only therapy. However, postmenopausal women with similar characteristics did not benefit from adjuvant chemotherapy.

Traditionally such patients would have had an axillary clearance if they were node positive. However, the Z11 study published in 2011 indicated that not all patients need an axillary clearance even if their sentinel node is positive. For certain patients undergoing breast conservation, if they have two or fewer nodes positive, they might avoid an axillary clearance, provided they fulfil a certain set of criteria. In the Z11 study, there was no difference in terms of long-term survival with such a strategy and the axillary recurrence rates were similar whether the patient had an axillary clearance or whether they had a sentinel node biopsy.

Figure: Breast wide local excision



Breast wide local excision where a LOCalizer – a wire-free guidance system – was used to target the lesion

Only women who are definitely post-menopausal are suitable for treatment with aromatase inhibitors. Tamoxifen is the only anti-oestrogen therapy advisable for women who are premenopausal. Patients who are premenopausal at the time of diagnosis are almost certainly going to be rendered postmenopausal after chemotherapy. It is likely they would be commenced on tamoxifen initially and would transition to aromatase inhibitor once a postmenopausal status is confirmed. Younger women undergoing chemotherapy are more likely to regain ovarian function and have regular menstruation after chemotherapy.

Ian Nyamangodo is a surgical registrar and Martin O'Sullivan is a consultant surgeon, both at Cork University Hospital

Role of immunotherapy in treating solid tumours

Immunotherapy is a significant innovation in cancer care and should be embraced, despite the impact on resources, writes **Kathell Geraghty**

IN RECENT decades, the development and implementation of immunotherapy in the treatment of solid tumours has changed the face of oncology care.[1] Immunotherapies encompass different types of treatments including cancer vaccines, monoclonal antibodies and checkpoint inhibitors – all of which detect and destroy cancer cells through immune stimulus.[2]

The use of immunotherapy in clinical settings has allowed for the treatment of solid tumours, and is proving a more beneficial response than traditional chemotherapy and radiation in terms of reduced toxicities while theoretically creating lasting immunity.[3] However, with the advent of such innovative treatments, immunotherapies have their own challenges relating to our health services with regards to resource provision. This includes financial constraints, outreach services and beyond.[4] In providing such therapies healthcare professionals must be aware of the challenges related to immunotherapy in healthcare and how best to support patients, identifying complications at an early phase.

The origins of immunotherapies are credited to German physicians Busch and Fehleisen who noted significant regression in tumours post infection, discovering T cells and immune stimulation response.[5] Immunotherapy has evoked a paradigm shift in the treatment of solid tumours with ipiluminab being the first immune checkpoint inhibitor that demonstrated progression free survival (PFS) in patients with metastatic melanoma, renal cell carcinoma and latterly urothelial cell carcinoma.[6,7] Currently immunotherapy is being used in a wide selection of solid tumours, for example its use in head and neck squamous cell cancer has been well documented in recent studies.[8] As head and neck cancer is characterised by immune defects including infection with HPV (human papillomavirus), it is a good candidate for immune based treatments, stimulating the immune system to attack cancer cells.[9]

Immune checkpoint inhibitors including pembrolizumab have shown effectiveness in patients with metastatic or recurrent head and neck cancer with significant PFS rates, its approval has been based on tumour response as seen in the Keynote-012 study and CheckMate 141 trial.[10] This intervention provides significant promise to lowering the mortality rate of this prevalent disease. Immunotherapy vaccines also provide benefit to patients with prostate cancer.[11] Simons and Sacks[12] noted that the use of the GVAX vaccine, made using allogenic tumour cells, showed significant responses in prostate tumours, influencing adaptive immune responses to boost T-cell response reducing the level of prostate specific antigens (PSA) while aiding tissue repair.

In the current landscape of healthcare as patients become less respondent to chemotherapy agents, the number of treatment options may become limited to specific patient groups, for example pancreatic cancer.[13] Armin et al[14] observed that patients treated with immunotherapy following surgery for pancreatic cancer had a significant overall survival rate of four months compared to those patients who did not receive immunotherapy. Indeed, there is future scope for the treatment of pancreatic cancer and so further research is required into the use of immunotherapy in solid tumours.

Combination therapy

Currently in clinical practice combining immunotherapy with chemotherapy is a new and innovative strategy for tackling solid tumours.[15] Increasing evidence now supports the theory of chemotherapy promoting cell death with subsequent antigen release, priming the solid tumour for immune-related therapies.[16] The Keynote-021 study demonstrated that pembrolizumab combined with carboplatin and pemetrexed proved beneficial and is associated with PFS in patients with non-small cell lung cancer (NSCLC).[17] 'Combination therapy' provides patients with wider treatment options and has been proposed to promote survival and improve patients' quality of life.[17] This collective therapy has become a standard treatment in the UK where lung cancer is the third most common solid tumour.[18] Gomes et al[19] suggested that a phased approach combining immunotherapy with chemotherapy can provide a more favourable toxicity profile than either treatment option alone, allowing for a better tolerance of treatment.

Challenges

Although the presented research has proposed that immunotherapy plays a significant role in treating solid tumours many challenges persist in our health systems. Such challenges include the cost of immunotherapy drugs in clinical practice. The National Institute for Health and Care Excellence (NICE) estimated that the cost of pembrolizumab is approximately £84,000 per patient per course of treatment.[20] Certainly, with the growing demand for immunotherapy such expenses should not be ignored. Verma et al[21] proposed the use of biomarkers as a means of promoting cost effectiveness in immunotherapy. The research suggested that using PDL1 (programmed death ligand 1) status to treat patients with NSCLC with immunotherapy improved patient outcomes including PFS and quality of life, with reduced healthcare costs. However, Chiang et al[22] argued that in order to be cost effective the median survival benefit for immunotherapy drugs post treatment would need to be longer than 12 months. This research complements a growing body of literature demonstrating the challenge of balancing cost of immunotherapy versus the health benefits of patients.

Economic models can provide a valuable tool when estimating the cost of treating solid tumours with immunotherapy, however they fail to examine the individual benefits of patients and so the exact value of immunotherapy in treating solid tumours can be lost. Worku and Hewitt[23] mention two economic models used to assess the cost effectiveness of immunotherapy: the partitioned survival (PS) and the Markov model. Such models expect to calculate the cost effectiveness ratio between patients' quality and quantity of life and the associated costs of immunotherapy. However, in an ideal health system immunotherapy should be accessible despite its cost.

Arguably, even with cost effective metrics in mind, the prevalence of solid tumours with a globally ageing demographic will inevitably stretch the current and future finances of healthcare systems.[24] However, in clinical practice patients may find themselves receiving immunotherapy drugs on the grounds of such compassionate access programmes or clinical trials, providing them with potentially lifesaving treatment.[25] Nevertheless, not all hospitals participate in such trials and compassionate access is not available to all patients and so care is not standardised across the board in terms of resource provision. As funding for immunotherapy may not always be available in the clinical setting, patients may potentially self-fund their immunotherapy treatment – this is an unfortunate reality in clinical practice that can prove to be both a financial burden on individuals with already poor health outcomes.[26] In order to overcome financial challenges oncologists must embody a multiprofessional approach engaging with stakeholders including pharmaceutical companies to help optimise financial funding for immunotherapy drugs in hospitals.[27] In an ideal setting, healthcare systems should be more willing to fund immunotherapy drugs even if it is to benefit a small minority of the population, hopefully finding an appropriate balance between expensive therapeutics and patient healthcare.

However, it is not just financial challenges that clinicians need to consider when looking at healthcare resources and provision with relation to immunotherapy. Many cancer infusion units across the UK and Ireland have limited capacity in small units to deliver immunotherapy to an ever-growing population in a timely manner, with many patients on waiting lists to receive immunotherapy, providing a strain on resource provision.[28] Alongside this Prang et al[29] document the division between public and private healthcare with a controversial view that patients will be treated in a timelier manner in the private setting. This view is inaccurate however with the increasing incidence of solid tumours, there is a growing need for cancer care developments in private healthcare systems.[30]

Furthermore, patients may encounter other challenges in accessing immunotherapy treatment such as more practical issues including lack of transportation, with many cancer centres of excellence being unavailable to them. Conway et al[31] acknowledges these more practical service challenges with a need to potentially restructure cancer systems across different countries – perhaps looking at community care to make ambulatory immunotherapy available to patients in more rural areas, providing fair access to resources.

Measuring response

Although immunotherapy drugs are innovative, on a more practical level, it may be more difficult to measure their clinical response pattern in comparison to chemotherapy agents. Research has proposed that patients undergoing immunotherapy for solid tumours, for example NSCLC, may experience a temporary deterioration of their disease followed by improvement or indeed stabilisation.[32] Facchinetti et al[33] note that this pseudo progression occurs due to an increase in inflammation causing enlargement of tumour mass and lymph nodes. This can present as a challenge in healthcare as clinicians need to be aware of pseudo progression so that immunotherapy treatment is not halted before it has taken effect, enabling the multiprofessional management of cancer. Lang et al[34] proposed that using a PET scan before and after immunotherapy treatment can detect plausible cellular and mass changes and so an appropriate response to treatment can be noted.

Though immunotherapy has evoked a revelation in terms of solid tumour management in healthcare, it is not without further challenges. One of the most prominent trials includes its unique toxicity effects, also called immune-related adverse effects.[35] These effects may result in serious symptoms including skin rashes, colitis and pneumonitis, which if left untreated can lead to patient deterioration and death.[36] Kennedy and Salma[37] hypothesised these effects occur as immunotherapy heightens the immune system leading to an excessive release of proinflammatory cytokines, autoreactive T cells and autoantibodies, causing inflammation to both cancerous and healthy tissues. In the multiprofessional management of cancer, primary or secondary healthcare systems in theory offer the advantage of patient assessment and advice regarding immunotherapy side effects.[38] However, this is not always the case as healthcare professionals may be unaware of the side effects of immunotherapy and how to manage same. This presents as a challenge to our health service as many patients have prolonged and costly admissions as a result of immune-related adverse events.[39]

Practice development

Certainly, this presented research reflects the future challenges that immunotherapy provides with scope for practice development in healthcare systems. In order to deliver a more robust healthcare system, patients must also be adequately educated, supported and assessed throughout their course of immunotherapy treatment.[40] Hoffner and Rubin[41] noted that all patients undergoing immunotherapy should have access to an oncology triage system where patients who are symptomatic can contact a triage

line to be assessed and treated in hospital if needed, thus, reducing the incidence of immune-related adverse events. Moreover, Jennings et al[42] observed that pharmaceutical companies and hospitals alike should offer a specialist nursing service to support patients as required. Although this is an ideal in clinical practice there may not always be the necessary resources available within the health service and so clinicians need to ensure that patients are adequately educated on such effects so that any concerns presented are dealt with in a timely manner, preventing fatal and irreversible illnesses.[43]

As immunotherapy moves to the forefront of cancer care, developing, acknowledging and utilising healthcare resources that have the potential to support patients through their cancer journey and allow for future growth, confidence and expertise in the management of solid tumours.

Conclusion

As the presented research suggests immunotherapy is the future foundation in the treatment of solid tumours. As the incidence of many solid tumours increase, we must recognise and plan for the many challenges that face our health service in the future and present climate as outlined above. Although immunotherapy presents as costly and challenging to our health service the benefits to patients, no matter how subjective, far outweigh the challenges. As clinicians we must embrace immunotherapy as a significant innovation in cancer care, as we anticipate a more promising future for the treatment of solid tumours.

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Melanoma treatment

Advances in staging, treatment options, new pigmented lesion clinics and enhanced surveillance pathways have all helped to improve melanoma survival rates, write **Leonie Mahon** and **Patrick Ormond**

MELANOMA is a potentially serious type of skin cancer that develops in the pigment producing skin cells called melanocytes. Melanocytes produce a protein called melanin, which protects skin cells by absorbing ultraviolet (UV) radiation. Normal melanocytes are in the basal layer between the epidermis and the dermis. Melanocytes are found in equal numbers in dark and pale skinned people.

Melanoma is the third most common skin cancer in Ireland and it accounts for more cancer deaths than all other skin cancers combined. Around 1,100 new cases of melanoma are diagnosed in Ireland each year, with approximately 160 deaths.[1] This article will look at staging and adjuvant treatment of melanoma.

Staging

Stage 0 (also known as melanoma in situ)

- The tumour is confined to the epidermis – the outermost skin layer
- After wide local excision (WLE) is completed with 0.5mm margin, patient is discharged to GP if no high risk factors.

Stage I

- The primary melanoma is still only in the skin and not spread to any lymph nodes. Divided into two subgroups, IA or IB, depending on Breslow depth/thickness (BT) and if ulceration is present.

Stage IA

- The tumour is BT < 0.8mm without ulceration and are not considered for sentinel lymph biopsy as risk of its positivity is < 5%.[2] WLE performed with 1-2cm margin. Stage IA has a low risk of recurrence.[3]

Stage IB

- The tumour is BT < 2mm may or may not be ulcerated. No evidence of regional or distant metastases[4]
- Staging with a sentinel lymph node biopsy (SLNB) is considered with a BT > 0.8mm if the patient is a suitable candidate. Stage IB has a low risk of recurrence.[11]

Stage II

- The primary melanoma has a BT > 2mm extending through the epidermis, into the dermis. No evidence of regional or distant metastases, but it has a higher chance of spreading. Divided into three subgroups A, B or C depending on Breslow depth and if ulceration is present. Staging scans may be required.[4] Clinical follow up depends on the subgroup and if SLNB completed
- Stage IIA has a low risk of recurrence
- Stage IIB and stage IIC have a moderate risk of recurrence[3]
- Adjuvant systemic treatment outside of a clinical trial is not recommended for Stages I and II.[4]

Stage III

- Melanoma has spread locally or through the lymphatic system to a regional lymph node basin located near the primary tumour site. Can present as a skin site on the way to a lymph node, called in-transit metastasis, satellite metastasis or microsatellite disease. Divided into four subgroups A, B, C or D, depending on Breslow depth, the size and number of lymph nodes positive with melanoma, the primary tumour has satellite or in-transit lesions, and the presence of ulceration[4]
- Guidelines recommend considering systemic adjuvant treatment for all stage III melanoma diagnoses. Resected stage IIIA have lower risk disease of recurrence than stages IIB and IIC, and the toxicity of adjuvant treatment may outweigh the benefit[4]
- Stage IIIB has a moderate risk of recurrence[3]
- Stage IIIC has a high risk of recurrence[3]
- Stage IIID has a very high risk of recurrence.[3]

Stage IV

- Melanoma has spread through the bloodstream to other parts of the body, such as distant locations on the skin or soft tissue, distant lymph nodes, or organs, ie. lung, liver, brain, bone or gastrointestinal tract

Table 1. Predicted 5- and 10-year melanoma-specific figures with the AJCC V8 staging criteria[2]

Clinical stage	5-year survival rate	10-year survival rate
IA	99%	98%
IB	97%	94%
IIA	94%	88%
IIB	87%	82%
IIC	82%	75%
IIIA	93%	88%
IIIB	83%	77%
IIIC	69%	60%
IIID	32%	24%

• Stage IV has a very high risk of recurrence and is further evaluated based on the location of distant metastasis.[3] Surveillance is clinically tailored on a case by case basis.[5]

Adjuvant treatments

Melanoma has been shown to be one of the most sensitive malignancies to immune modulation. As a result, the treatment of metastatic melanoma has undergone a revolution in the past decade. A 2018 Cochrane report confirmed both immune therapy and targeted therapy advances have significantly improved patient prognosis.

In February 2021, the National Cancer Control Programme (NCCP) extended the approval adjuvant criteria to all stage III melanoma patients.

The development of immune checkpoint inhibitors such as the anti-CTLA4 ipilimumab and the anti-programmed death 1 agents (anti-PD-1) nivolumab and pembrolizumab has increased treatment options. A combination of therapy groups such as ipilimumab and nivolumab have led to overall further improvements in survival.[6]

Advances in targeted treatments are a result of studies identifying a non-inherited mutation in the BRAF gene in 66% of malignant melanomas, particularly those arising in younger patients. Metastatic melanomas known to have a specific BRAF V600 driver mutation can be treated with a combination of a BRAF and MEK inhibitors.[7] Based on the COMBI-AD study, a combination of dabrafenib (BRAF inhibitors) and trametinib (MEK inhibitors) is NCCP approved for adjuvant treatment for BRAF mutant resected stage III and stage IV melanoma.[8]

Adjuvant radiation therapy (RT) may be considered for stage III patients at high risk of nodal basin recurrence. Predicting factors include multiple nodes with melanoma (more than three nodes), large nodes (> 3cm), the location or the presence of extracapsular extension. Adjuvant RT is used in cases of thick tumours in hard to resect locations such as the head and neck, where adequate margins have not been achieved.[9]

A few small trials show adjuvant RT in stage IV patients with brain metastases have reduced intracranial progression and improved duration of functional independence.[10] The National Comprehensive Cancer Network (NCCN) recommends consideration be given to potential interactions between radiation and systemic therapy.[11]

Table 2. Recommendations for stages I to IV melanoma[11]

Melanoma stage	Follow-up
IA	• Year 1: Consider two clinic appointments, with discharge at the end of year 1. Do not routinely offer screening investigations (including imaging and blood tests) as part of follow-up
IB	• Year 1: Offer two clinic appointments and consider adding two ultrasound (US) scans of the draining nodal basin if sentinel lymph node biopsy (SLNB) was considered but not done • Year 2 & 3: Offer one clinic appointment each year and consider adding one US scan of the draining nodal basin each year if SLNB was considered but not done • Year 4 & 5: Offer one clinic appointment each year. Discharge at the end of year 5
IIA	• Year 1 & 2: Offer two clinic appointments each year and consider adding two US scans of the draining nodal basin each year if SLNB was considered but not done • Year 3: Offer one clinic appointment and consider adding one US scan of the draining nodal basin is SLNB was considered but not done • Year 4 & 5: Offer one clinic appointment each year. Discharge at the end of year 5
IIB	• Year 1 & 2: Offer four clinic appointments each year and consider two whole-body and brain contrast-enhanced CT (CE-CT) scans each year. Consider adding two US scans of the draining nodal basin each year if SLNB was considered but not done • Year 3: Offer two clinic appointments and consider two whole-body and brain CE-CT scans. Consider adding two US scans of the draining nodal basin if SLNB was considered but not done • Year 4 & 5: Offer one clinic appointment each year and consider one whole-body and brain CE-CT scan each year. Discharge at the end of year 5
IIC	• Year 1 & 2: Offer four clinic appointments and two whole-body and brain CE CT scans each year. Consider adding two US scans of the draining nodal basin each year if SLNB was considered but not done • Year 3: Offer two clinic appointments and two whole-body and brain CE-CT scans. Consider adding two US scans of the draining nodal basin if SLNB was considered but not done • Year 4 & 2:Offer one appointment and one whole-body and brain CE-CT scan each year. Discharge at the end of year 5
IIIA to IIIC not currently having adjuvant therapy	• Year 1 to 3: Offer four clinic appointments and two whole-body and brain CE-CT scans each year. Consider adding two US scans of the draining nodal basin each year if the person has a positive sentinel lymph node • Year 4 & 5: Offer two clinic appointments and one whole-body and brain CE-CT scan each year. Discharge at the end of year 5
IIID and resected IV not currently having adjuvant therapy	• Year 1 to 3: Offer four clinic appointments and four whole-body and brain CE-CT scans each year. • Year 4 & 5: Offer two clinic appointments and two whole-body and brain CE-CT scans each year. Discharge at the end of year 5
IIIA to IIIC, IIID and resected IV having adjuvant therapy	• During adjuvant therapy, base follow-up on therapeutic requirements

Survivalship and surveillance

Survival rates for melanoma have greatly improved due to the advances in staging and treatment pathways. The new predicted five- and 10-year melanoma specific figures with the AJCC V8 staging criteria are set out in *Table 1*.[12]

Routine follow up clinic reviews with full examination of the skin, regional lymph nodes and imaging is an essential part of melanoma management according to the clinical stage. As international recommendations on the intervals of follow up appointments vary, the NCCP is in the process of developing national surveillance guidelines.

In September 2019 the European Society of Medical Oncology (ESMO) guidelines recommended tailoring the follow up pathways of clinical visits and imaging

according to the individual risk and needs of the patient. Recommendations of ultrasound surveillance in sentinel node positive patients and advise regular ultrasound of nodal basins in clinical stage IIB/C, due to the high risk of relapse and a mortality of approximately 20% at 10 years.[13]

The 2015 NICE guideline NG14, *Melanoma: assessment and management,*[3] was updated in July 2022, to incorporate the new AJCC version 8 and the significant advances in treatment options and outcomes. Recommendations for stages I to IV are set out in *Table 2*.[3]

These recommendations are challenging to achieve considering the resources required and are constantly being updated. Recurrence disease rates in high-risk patients is most likely to occur within the first three years post-surgery.

At least 60% of all recurrences occur within this period, with the risk reducing significantly into the fourth year and thereafter.[12]

Conclusion

Melanoma is a very aggressive cancer with survival rates having greatly improved in the past decade. This can be attributed to advances in clinical staging, new treatment options, the introduction of pigmented lesion clinics and enhanced surveillance pathways.

The projected increase of 67% of newly diagnosed cases of melanoma by 2045 will result in a huge cost burden on the HSE.[14] Early detection remains the best prognosis.

With 86% of all melanomas preventable, the HSE/NCCP national SunSmart campaign and understanding the importance of risk factors are key to educating the Irish population.[15]

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Migraine matters

In part two of a series, **Esther Tomkins** looks at migraine management and the role of the specialist nurse

MIGRAINE is a common and complicated neurological disorder. It is considered to be a primary headache disorder and most patients have a genetic predisposition (positive family history). It affects up to one-fifth of the general population and there are currently more than a billion people with this condition.

In the main, migraine is misdiagnosed, underdiagnosed and undertreated by healthcare professionals. Migraine can be very disabling,[1] especially when it becomes chronic (defined as headache and migraine symptoms on more than 15 days each month for three months). It can disrupt many aspects of normal day to day life. For example, it often affects the ability of patients to function at work (*see Figure 1*).

Medication overuse (defined as use of painkillers/analgesics, triptans or NSAIDs on 10-15 days each month or more) is a common complication of migraine, especially in those patients attending specialist headache clinics. Migraine attacks are often triggered, especially by stress or hormone fluctuations, and approximately three-quarters of our patients are female.

General migraine management

The management of headache/migraine involves a multidisciplinary approach, with specialist nursing and medical colleagues working together. This partnership represents the core of patient care. For optimal management, it is essential that a holistic view of the patient is considered. This includes factors such as: family history, personal circumstances (working life, school, college, etc), lifestyle factors (eg. exercise and hobbies) and other co-existing medical conditions. Initially, the diagnosis of migraine needs to be confirmed and then the patient should be involved in all aspects of their care, within reason.

Firstly, when a patient presents to a GP or to a headache/migraine service with recurrent headaches and associated symptoms, a detailed clinical history should be taken and they should be advised to keep a daily diary with specific items recorded. The diary should include details such as: average severity of the headache each day (pain score graded on a scale of 1-10) or a crystal clear day if applicable, associated symptoms or neurological features, acute treatments (painkillers) used, effect on lifestyle and possible triggers.

The diary is a useful tool that provides essential clinical information which can help confirm the diagnosis and it can also be used as a self-help approach for patients to help manage their condition. Most patient support groups, such as the Migraine Association of Ireland (MAI), provide headache diaries for patients.

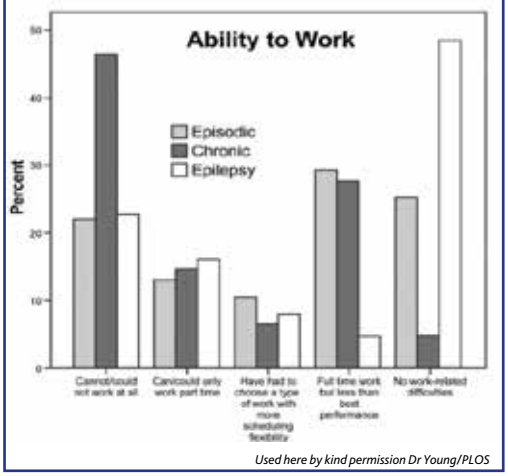
Medicine management

Acute migraine treatments, including painkillers/analgesia, non-steroidal anti-inflammatories drugs (NSAIDs) and triptans, should be used no more than six to eight days per month in order to avoid medication overuse (MO) and medication overuse headache (MOH) in the context of migraine. Codeine or opiate-based medication should be avoided altogether.

Daily migraine preventive oral therapies are usually indicated for patients who have headache and associated neurological symptoms on at least six to 10 days per month (moderate frequency episodic migraine) for at least three to six months, and are at least of moderate/severe intensity or cause at least moderate disability.

These oral treatments have been the standard of care for several decades. Overall impact on quality of life and associated disability should definitely be considered when deciding on whether a patient should be put on a daily preventive therapy. Conventional oral preventive medications used for migraine prevention include: anti-seizure or epilepsy medication (such as topiramate); anti-depressant medication (venlafaxine or amitriptyline); hypertensive medication (candesartan or propranolol); and others. Vitamin and mineral supplementation may also be effective in reducing migraine frequency, although the evidence is weak.

Figure 1: Patient reported ability to function at work with migraine



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Patients should be advised that most oral preventive medications do not work effectively in the presence of medication overuse. In addition, most preventive therapies are unsafe in pregnancy, and this is important as approximately 75-80% of our patients are female and many are in the age group 18-50 years old.

For optimal efficacy, it is recommended that for each oral preventive agent:[2]

- Start at a low dose.
- Slowly increase the dose every two to 12 weeks
- Give an adequate trial for two to three months at the highest tolerated dose
- Avoid overuse of analgesics, triptans or painkillers (MO)
- Discuss contraception with women of child-bearing age and the potential risk of

preventive medications during pregnancy and breastfeeding
- Consider co-morbid medical conditions and aim to use a single medication that may treat multiple disorders if possible (for example, use candesartan in a patient with hypertension and frequent migraine)
- Re-evaluate therapy at a reasonable interval of three to six months, preferably with the help of a migraine diary.

Patients should be involved in the decision regarding the choice of preventive treatment. Patient information sheets (detailing dosages, possible side effects and rationale for preventive therapy) can be provided to patients to help them make this choice. This discussion and the consultations should include the realistic benefits of preventive treatment in the hope of improving compliance.

Specialist nurses can help to support this model of care by running nurse-led clinics (with the option of face-to-face or virtual/phone consultations). A realistic goal is that a migraine preventive drug should give at least 30%-50% improvement in overall disability, without having significant side effects. If this level of improvement is not achieved at the maximum tolerated dose after two to three months, the preventive medication should be weaned slowly over a period of one to six months (the higher the dose, the longer the wean period). An alternative can then be considered.

Other short- and more long-term specialist preventive options for persistent daily or chronic migraine (CM) include greater occipital nerve blocks (GONB), quarterly Botox injections (PREEMPT Protocol[3]), neuromodulation (electronic devices), and dihydroergotamine (DHE) or lidocaine infusions as an inpatient.

The most promising new preventive treatments for patients with at least moderately disabling episodic migraine (EM) or chronic migraine are the calcitonin gene-related peptide (CGRP) pathway inhibitors. It is known that CGRP (a small peptide which is found throughout the body and nervous system) levels are raised in migraine patients, and it is believed that the CGRP system plays a fundamental role in migraine pathology. CGRP can precipitate a migraine attack experimentally.

Four different monoclonal antibodies (MAb) targeting CGRP or the CGRP receptor have been developed after significant research over the past four decades and they are now available in Ireland for the past three to four years. Three are reimbursed by the HSE for patients who meet strict criteria for treatment-resistant chronic migraine. The future for those with more chronic migraine is more positive today given the arrival of these new molecular preventive treatments.

Additional strategies

As part of the specialist nursing role, it is important to also emphasise to patients the value of conservative management strategies in conjunction with oral migraine preventive medication or other medical treatments. This includes: healthy lifestyle, daily exercise (moderate intensity for a minimum of 20-30 minutes at least five days a week), a balanced diet, regular eating pattern, good hydration, moderate caffeine intake, good sleep hygiene and appropriate stress management (coping skills).

Lifestyle factors may improve headache frequency and severity in some cases. Each patient therefore plays a significant role in helping themselves. The MAI provides helpful information and support in this regard, and it is often useful to inform patients of this resource. The website **www.migraine.ie** also has a section specifically for healthcare professionals and it arranges training and research days for doctors, nurses and other clinical staff who care for migraine patients.

In addition, other management strategies for migraine sufferers, including physiotherapy (vestibular rehabilitation), psychology and acupuncture should be considered on a patient-by-patient basis. Alternative migraine therapies including biofeedback, mindfulness and reflexology may also be helpful for some patients.

Role of the specialist nurse

The specialist nurse, starting from clinical nurse specialist (CNS) level and evolving to advanced nurse practitioner (ANP), represents a fundamental aspect of patient care and is an invaluable member of the team. The partnership between the specialist nurse and medical colleagues is at the core of the service and is essential for optimal management of headache/migraine patients.[4]

Specialist nurses and doctors complement one another, have different skills and offer slightly different perspectives for patients. Ideally, trained specialist nurses should be present at all neurology clinics where headache/migraine patients are seen in order to support their care. This is important when one considers that approximately 30% of all referrals to neurology clinics are for headache and most of these patients have migraine. However, training to be a relatively independent or autonomous specialist nurse (hopefully working at advanced practice level) takes some years and involves many hurdles including: learning to take a detailed history, prescribing many different medications, education and training in headache medicine, diagnostics, neuroscience education, and various headache specific protocols.

Headache medicine is changing and improving all the time with ongoing research, and the specialist nurse must keep up with this evolving landscape.

Education of patients and other healthcare professionals is a fundamental nursing role. Properly trained and resourced specialist headache/migraine nurses are ideally placed in hospitals and the community to provide this vital service. This includes education and conversations in areas such as general migraine overview, medications and their side effects, medium term adherence, symptom management, identifying triggers, knowing how and when to treat, diet and exercise. Experienced headache nurses should be more than capable of supporting specialist preventive headache/migraine treatments.

Relatively autonomous nurse-led clinics are essential for face-to-face follow-up consultations and virtual telephone support calls, all of which enhance patient care. Appropriate triaging of patients from the primary care arena to the hospital-based specialist headache/migraine clinics helps to improve access for those patients who are most in need of urgent consultations. The specific role of the specialist nurse is designed to support this model of care and, if properly trained and resourced, can make a world of a difference to our patients.

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To find out more, get in touch with an AJOVY® representative

AJOVY® is indicated for prophylaxis of migraine in adults who have at least 4 migraine days *per* month[1]

*Based on the quarterly dosing regimen[1] †In Phase III pivotal studies, fewer migraine days were seen with AJOVY® *vs* placebo as early as Week 1 ($p<0.0001$)[1]
‡Long-acting defined as efficacy over 12 months and is based on data for patients treated with AJOVY® in the HALO extension study (n=1,890)[2]

Please refer to the Summary of Product Characteristics (SmPC) for full details of Prescribing Information.

Ajovy®▼ (fremanezumab) 225mg Solution for Injection in Pre-filled syringe and Ajovy® (fremanezumab) 225mg Solution for Injection in Pre-filled Pen Abbreviated Prescribing Information. **Presentation:** Fremanezumab 225mg solution for injection in pre-filled syringe. Fremanezumab 225mg solution for injection in pre-filled pen. **Indications:** For prophylaxis of migraine in adults who have at least 4 migraine days *per* month. **Dosage and administration:** The treatment should be initiated by a physician experienced in the diagnosis and treatment of migraine. Ajovy is for subcutaneous injection only and can be injected into areas of the abdomen, thigh, or upper arm that are not tender, bruised, red, or indurated. For multiple injections, injection sites should be alternated. Patients may self-inject if instructed in subcutaneous self-injection technique by a healthcare professional. *Adults:* Two dosing options are available: *Monthly dosing*: 225mg once monthly. *Quarterly dosing*: 675mg every three months. When switching dosing regimens, the first dose of the new regimen should be administered on the next scheduled dosing date of the prior regimen. The treatment benefit should be assessed within 3 months after initiation of treatment. Evaluation of the need to continue treatment is recommended regularly thereafter. *Missed dose:* The indicated dose should resume as soon as possible, a double dose must not be administered to make up for a missed dose. *Children*: No data are available. *Elderly*: Limited data available. Based on the results of population pharmacokinetic analysis, no dose adjustment is required. *Renal impairment*: No dose adjustment is required. No data in severe renal impairment. *Hepatic impairment*: No dose adjustment is required. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. **Precautions and warnings:** In order to improve the traceability of biological medicinal products, the name and the batch number of the administered product should be clearly recorded. Anaphylactic reactions have been reported rarely with fremanezumab. Most reactions have occurred within 24 hours of administration although some reactions have been delayed. Patients should be warned about the symptoms associated with hypersensitivity reactions. If a serious hypersensitivity reaction occurs, initiate appropriate therapy and do not continue treatment with fremanezumab. No safety data are available in patients with certain major cardiovascular diseases. **Interactions:** No formal clinical drug interaction studies have been performed. **Pregnancy and lactation:** It is preferable to avoid the use of Ajovy during pregnancy as a precautionary measure. A risk to the breast-fed child cannot be excluded. A decision must be made whether to continue Ajovy therapy while breast-feeding. **Effects on ability to drive and use machines:** No influence on the ability to drive and use machines. **Adverse reactions:** Anaphylactic reaction, hypersensitivity reactions such as rash, pruritus, urticaria and swelling. *Very Common*: Injection site pain, injection site induration and injection site erythema. *Common*: Injection site pruritus. Consult the Summary of Product Characteristics in relation to other side effects. **Overdose:** It is recommended that the patient be monitored for any signs or symptoms of adverse effects and given appropriate symptomatic treatment if necessary. **Legal category:** POM. **Marketing Authorisation Number:** EU/1/19/1358/001. **Marketing Authorisation Holder:** Teva GmbH, Graf-Arco-Str. 3, 89079 Ulm, Germany. **Job Code:** MED-IE-00049. **Date of Preparation:** December 2021.

Adverse events should be reported. Reporting forms and information can be found at **www.hpra.ie**.
Adverse events should also be reported to Teva UK Limited on **+44 (0) 207 540 7117** or **medinfo@tevauk.com**

References:
1. AJOVY® Summary of Product Characteristics. Teva Pharmaceuticals Ireland. **2.** Goadsby PJ *et al. Neurology* 2020; 95(18): e2487–e2499. **3.** Dodick DW *et al. JAMA* 2018; 319(19): 1999–2008. **4.** Silberstein SD *et al. N Engl J Med* 2017; 377(22): 2113–2122.

This material is intended for Ireland healthcare professionals only

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Urology focus

WIN takes a look at some new findings in urology research recently published in the journals

Prevalence, risk factors and mental health effects of overactive bladder

OVERACTIVE bladder (OAB) affects 6% of young adults and causes a negative effect on their mental health, according to a study recently published in the *International Neurourology Journal*.

OAB severely affects quality of life due to frequent toilet use, forced reduction of water consumption, and fear of participating in social activities. A research team from the First Affiliated Hospital of Xinxiang Medical University in China looked at the prevalence and risk factors of OAB in young adults with a secondary aim to explore the association of the disorder with mental health.

More than 14,000 anonymous questionnaires were distributed to first year students at two universities in China between October 2019 and January 2020. The questionnaire included general items and information necessary to calculate the overactive bladder symptom score, the Chinese version of the Pittsburgh Sleep Quality Index score (PSQI), Self-Esteem Scale (SES) score, and Self-Rating Depression Scale (SRDS) score. The relationships between the prevalence of OAB and its risk factors were evaluated.

The study found that the overall prevalence of OAB was 6%, with 4.3% characterised as having dry and 1.7% with wet OAB. The prevalence of mild and moderate OAB was respectively 5.5% and 0.5%. No severe OAB was reported. Prevalence of OAB was higher among females, those who had constipation, and those with primary nocturnal enuresis. No significant relationship was found between OAB prevalence and place of residence, BMI or age ($p > 0.05$).

"Research has shown that constipation is a risk factor for OAB and our study supports this view. Constipation has been postulated to suppress the common nerves of the bladder and intestine, which leads to a lack of central nerve inhibition of bladder activity, resulting in bladder overactivity. Constipation as a risk factor for OAB is not fully understood. We speculate that it may relate to excessive rectal dilatation and detrusor activity caused by faeces remaining in the rectum for a long period of time. Constipation treatment has also been suggested to be necessary during OAB treatment," wrote the researchers.

The OAB group had a higher mean SRDS score and mean PSQI score but had a lower mean SES score compared with healthy controls.

"The results of this study support the view that OAB has negative effects on psychology, such as reducing sleep quality and increasing the incidence of depression and self-abasement. OAB affects mental health, which may be related to the regulation of bladder function by numerous neural pathways. To avoid compromising the privacy of the participants, we did not collect information on other factors that may affect the students' psychology, such as economic conditions, violence and divorce, therefore, the relationship between OAB and psychological disorders requires further study," said the authors.

DOI: https://doi.org/10.5213/inj.2244188.094

New study explains link between diabetes and UTIs

Lower immunity and recurring infections are common in type 1 and type 2 diabetes. Researchers at Karolinska Institutet in Sweden have shown that the immune system of those with diabetes has lower levels of the antimicrobial peptide psoriasin, which compromises the urinary bladder's cell barrier, increasing the risk of urinary tract infection (UTI).

Diabetes compromises the innate immune system, leaving many people with increased susceptibility to regular infections, such as UTIs caused by *E. coli*. In people with diabetes, these are more likely to lead to general blood poisoning, sepsis, originating in the urinary tract.

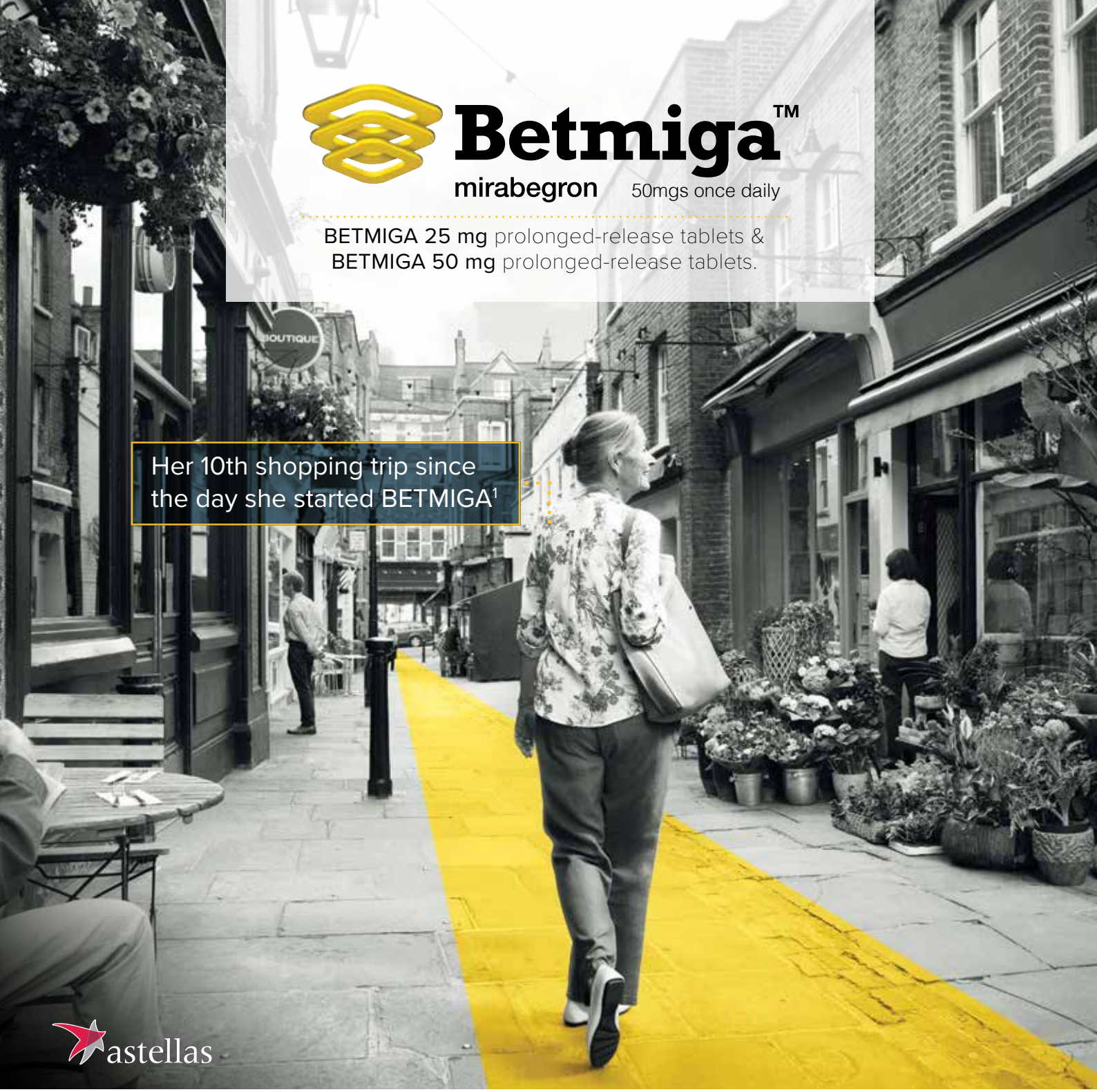
Researchers at Karolinska Institutet investigated whether glucose levels in people with diabetes (type 1, type 2 or prediabetes) are linked with psoriasin, an endogenous antibiotic which is a part of the innate immune system. Using urine, urinary bladder cells and blood serum samples from patients, the researchers analysed levels of psoriasin and other peptides necessary for ensuring that the bladder mucosa remains intact and protects against infection.

"We found that high glucose concentrations reduce the levels of the antimicrobial peptide psoriasin, while insulin has no effect. People with diabetes have lower levels of psoriasin, which weakens the cells' protective barrier function and increases the risk of bladder infection," said Annelie Brauner, professor at the Department of Microbiology, Tumor and Cell Biology, Karolinska Institutet, who led the study.

Prof Brauner's research has previously shown that oestrogen treatment restores the protective function of bladder cells and helps to regulate the immune response to a UTI. The team tested how oestrogen treatment affects infected cells exposed to high glucose concentrations and found that the treatment boosted levels of psoriasin and reduced bacterial populations, indicating that the treatment may have an effect also among patients with diabetes.

"We now plan to probe deeper into the underlying mechanisms of infections in individuals with diabetes. The ultimate goal is to reduce the risk of infection in this growing patient group," said Soumitra Mohanty, researcher at the Karolinska Institutet.

DOI: 10.1038/s41467-022-32636-y



Prescribing Information: BETMIGA™ (mirabegron)
For full prescribing information, refer to the Summary of Product Characteristics (SPC). **Name:** BETMIGA 25 mg prolonged-release tablets & BETMIGA 50 mg prolonged-release tablets. **Presentation:** Prolonged-release tablets containing 25 mg or 50 mg mirabegron. **Indication:** Symptomatic treatment of urgency, increased micturition frequency and/or urgency incontinence as may occur in adult patients with overactive bladder (OAB) syndrome. **Posology and administration:** The recommended dose is 50 mg orally once daily in adults (including elderly patients). Mirabegron should not be used in paediatrics for OAB. A reduced dose of 25 mg once daily is recommended for special populations (please see the full SPC for information on special populations). The tablet should be taken with liquids, swallowed whole and is not to be chewed, divided, or crushed. The tablet may be taken with or without food. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients listed in section 6.1 of the SPC. Severe uncontrolled hypertension defined as systolic blood pressure ≥ 180 mm Hg and/or diastolic blood pressure ≥ 110 mm Hg. **Warnings and Precautions:** Renal impairment: BETMIGA has not been studied in patients with end stage renal disease (eGFR < 15 ml/min/1.73 m^2 or patients requiring haemodialysis) and, therefore, it is not recommended for use in this patient population. Data are limited in patients with severe renal impairment (eGFR 15 to 29 ml/min/1.73 m^2); based on a pharmacokinetic study (see section 5.2 of the SPC) a dose of 25 mg once daily is recommended in this population. This medicinal product is not recommended for use in patients with severe renal impairment (eGFR 15 to 29 ml/min/1.73 m^2) concomitantly receiving strong CYP3A inhibitors (see section 4.5 of the SPC). Hepatic impairment: BETMIGA has not been studied in patients with severe hepatic impairment (Child-Pugh Class C) and, therefore, it is not recommended for use in this patient population. This medicinal product is not recommended for use in patients with moderate hepatic impairment (Child-Pugh B) concomitantly receiving strong CYP3A inhibitors (see section 4.5 of the SPC). Hypertension: Mirabegron can increase blood pressure. Blood pressure should be measured at baseline and periodically during treatment with mirabegron, especially in hypertensive patients. Data are limited in patients with stage 2 hypertension (systolic blood pressure ≥ 160 mm Hg or diastolic blood pressure ≥ 100 mm Hg). Patients with congenital or acquired QT prolongation: BETMIGA, at therapeutic doses, has not demonstrated clinically relevant QT prolongation in clinical studies (see section 5.1 of the SPC). However, since patients with a known history of QT prolongation or patients who are taking medicinal products known to prolong the QT interval were not included in these studies, the effects of mirabegron in these patients is unknown. Caution should be exercised when administering mirabegron in these patients. Patients with bladder outlet obstruction and patients taking antimuscarinics medicinal products for OAB: Urinary retention in patients with bladder outlet obstruction (BOO) and in patients taking antimuscarinic medicinal products for the treatment of OAB has been reported in postmarketing experience in patients taking mirabegron. A controlled clinical safety study in patients with BOO did not demonstrate increased urinary retention in patients treated with BETMIGA; however, BETMIGA should be administered with caution to patients with clinically significant BOO. BETMIGA should also be administered with caution to patients taking antimuscarinic medicinal products for the treatment of OAB. **Interactions:** Caution is advised if mirabegron is co-administered with medicinal products with a narrow therapeutic index and significantly metabolised by CYP2D6. Caution is also advised if mirabegron is co-administered with CYP2D6 substrates that are individually dose titrated. In patients with mild to moderate renal impairment or mild hepatic impairment, concomitantly receiving strong CYP3A inhibitors, the recommended dose is 25 mg once daily. For patients who are initiating a combination of mirabegron and digoxin (P-gp substrate), the lowest dose for digoxin should be prescribed initially (see the SPC for full prescribing information). The potential for inhibition of P-gp by mirabegron should be considered when BETMIGA is combined with sensitive P-gp substrates. Increases in mirabegron exposure due to drug-drug interactions may be associated with increases in pulse rate. **Pregnancy and lactation:** BETMIGA is not recommended in women of childbearing potential not using contraception. This medicinal product is not recommended during pregnancy. BETMIGA should not be administered during breast-feeding. **Undesirable effects:** Summary of the safety profile: The safety of BETMIGA was evaluated in 8433 adult patients with OAB, of which 5648 received at least one dose of mirabegron in the phase 2/3 clinical program, and 622 patients received BETMIGA for at least 1 year (365 days). In the three 12-week phase 3 double blind, placebo controlled studies, 88% of the patients completed treatment with this medicinal product, and 4% of the patients discontinued due to adverse events. Most adverse reactions were mild to moderate in severity. The most common adverse reactions reported for adult patients treated with BETMIGA 50 mg during the three 12-week phase 3 double blind, placebo controlled studies are tachycardia and urinary tract infections. The frequency of tachycardia was 1.2% in patients receiving BETMIGA 50 mg. Tachycardia led to discontinuation in 0.1% patients receiving BETMIGA 50 mg. The frequency of urinary tract infections was 2.9% in patients receiving BETMIGA 50 mg. Urinary tract infections led to discontinuation in none of the patients receiving BETMIGA 50 mg. Serious adverse reactions included atrial fibrillation (0.2%). Adverse reactions observed during the 1-year (long term) active controlled (muscarinic antagonist) study were similar in type and severity to those observed in the three 12-week phase 3 double blind, placebo controlled studies. Adverse reactions: The following list reflects the adverse reactions observed with mirabegron in adults with OAB in the three 12-week phase 3 double blind, placebo controlled studies. The frequency of adverse reactions is defined as follows: very common (≥ 1/10); common (≥ 1/100 to < 1/10); uncommon (≥ 1/1,000 to < 1/100); rare (≥ 1/10,000 to < 1/1,000); very rare (< 1/10,000) and not known (cannot be established from the available data). Within each frequency grouping, adverse reactions are presented in order of decreasing seriousness. The adverse events are grouped by MedDRA system organ class. *Infections and infestations:* Common: Urinary tract infection, Uncommon: Vaginal infection, Cystitis. *Psychiatric disorders:* Not known (cannot be estimated from the available data): Insomnia*, Confusional state*. *Nervous system disorders:* Common: Headache*, Dizziness*. *Eye disorders:* Rare: Eyelid oedema. *Cardiac disorders:* Common: Tachycardia, Uncommon: Palpitation, Atrial fibrillation. *Vascular disorders:* Very rare: Hypertensive crisis*. *Gastrointestinal disorders:* Common: Nausea*, Constipation*, Diarrhoea*, Uncommon: Dyspepsia, Gastritis, Rare: Lip oedema. *Skin and subcutaneous tissue disorders:* Uncommon: Urticaria, Rash, Rash macular, Rash papular, Pruritus, Rare: Leukocytoclastic vasculitis, Purpura, Angioedema*. *Musculoskeletal and connective tissue disorders:* Uncommon: Joint swelling. *Renal and urinary disorders:* Rare: Urinary retention*. *Reproductive system and breast disorders:* Uncommon: Vulvovaginal pruritus. *Investigations:* Uncommon: Blood pressure increased, GGT increased, AST increased, ALT increased. * signifies adverse reactions observed during post-marketing experience. Prescribers should consult the SPC in relation to other adverse reactions. **Overdose:** Treatment for overdose should be symptomatic and supportive. In the event of overdose, pulse rate, blood pressure, and ECG monitoring is recommended. **Basic NHS Cost:** Great Britain (GB)/Northern Ireland(NI): BETMIGA 50 mg x 30 = £29, BETMIGA 25 mg x 30 tablets = £29. Ireland (IE): POA. **Legal classification:** POM. **Marketing Authorisation number(s):** (GB): PLGB 00166/0415-0416. NI/IE: EU/1/12/809/001-006, EU/1/12/809/008-013, EU/1/12/809/015-018. **Marketing Authorisation Holder:** GB: Astellas Pharma Ltd., 300 Dashwood Lang Road, Bourne Business Park, Addlestone, United Kingdom, KT15 2NX. NI/IE: Astellas Pharma Europe B.V. Sylviusweg 62, 2333 BE Leiden, The Netherlands. **Date of Preparation of Prescribing information:** January 2023. **Job bag number:** MAT-IE-BET-2023-00001. **Further information available from:** GB/NI: Astellas Pharma Ltd, Medical Information: 0800 783 5018. IE: Astellas Pharma Co. Ltd., Tel.: +353 1 467 1555. For full prescribing information, please see the Summary of Product Characteristics, which may be found at: GB: www.medicines.org.uk; NI: https://www.emcmedicines.com/en-GB/northernireland/; IE: www.medicines.ie.

United Kingdom (GB/NI)
Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard or search for MHRA Yellow Card in the Google Play or Apple App Store. Adverse events should also be reported to Astellas Pharma Ltd. on 0800 783 5018.

Ireland
Adverse events should be reported. Healthcare professionals are asked to report any suspected adverse reactions via: HPRA Pharmacovigilance, Website: www.hpra.ie or Astellas Pharma Co. Ltd. Tel: +353 1 467 1555, E-mail: irishdrugsafety@astellas.com.

Date of preparation: January 2023

References: 1. Freeman R, et al. Current Medical Research and Opinion 2017. https://doi.org/10.1080/03007995.2017.1419170.

MAT-IE-BET-2023-00002

Taking a holistic approach to menopause

MENOPAUSE has been in the spotlight recently – and not before time. Around half of the population experience the effects of perimenopause, menopause and the aftermath on many aspects of their physical and mental health, affecting life at home, at work and in their relationships. Each experience can be completely different and often women still feel unsupported.

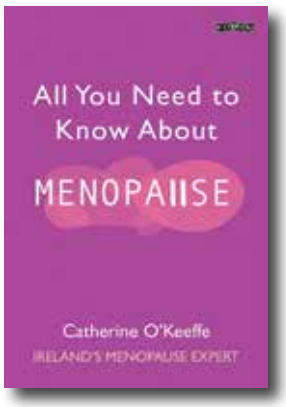
Catherine O'Keeffe is a former investment banker who returned to college to study natural medicine. Dealing with her own struggles with the perimenopause brought her down the road of self-education on menopause matters. Leaving investment banking behind, she immersed herself in becoming an advocate for menopause education and support. She has travelled widely in Ireland talking to women about their experiences.

Ms O'Keeffe is now a menopause workplace consultant, organises an annual national education meeting and has devised an online course. Her new book *All You Need to Know About Menopause* has just been published.

"I have been told on many occasions that I opened the doors to taboo subjects – things women were embarrassed to discuss even with those closest to them. I've seen pure relief when women realised they were not going mad…" she explains in the introduction.

Her book takes a holistic approach to menopause. The first part explains the menopause, what it is and what it isn't. The book then goes on to address the wide range of possible symptoms and explores alternative ways of dealing with these. The next section provides advice on treatments, from HRT on which there is a full chapter, to acupuncture, to cognitive behavioural therapy and other therapies. Exercise, diet and general wellbeing are also covered.

There's an excellent chapter about menopause and work. While remote working can have major benefits for women in this period of their lives, professionals like nurses and midwives don't have this option so finding support in the workplace and with peers is key. This can be a tricky time for women in the prime of their careers.



This useful book includes a comprehensive section on resources and a bibliography for further reading, including books and peer-reviewed research papers. This will be important for nurse and midwife readers who take an evidence-based approach to treatments. There is also a detailed symptom checker, which would be very helpful prior to an appointment with a health professional

"Menopause should not be a dark chapter in a woman's life. With knowledge and support, this is a chapter in which to thrive, renew and embrace a whole new you".

– Geraldine Meagan

All You Need to Know About Menopause by Catherine O'Keeffe is published by O'Brien Press, Dublin. ISBN 978-1-78849-335-2

Experiencing difficulties paying?

For cyber security reasons, in the interests of protecting the integrity of individual banking credentials, new restrictions have been imposed on payment systems. The INMO will no longer be able to accept payments over the phone. Payments can be made by:

- Monthly salary deduction, using the deduction at source form available from INMO (not all work locations offer this facility so an alternative would be by monthly standing bankers order through your bank)
- Monthly standing bankers order, using form available from the INMO
- Cheque payable to INMO
- Postal order payable to INMO
- Bank draft payable to INMO
- Online via our website (using your unique quick payment code available from the INMO).

If paying online, your bank security will require that the billing details on the card you are using are the same as those used to register membership with INMO.

We apologise for any inconvenience, but heightened awareness of cyber security is in all of our interests. We must implement the highest standard of protection for our members.

Take a break with WIN CROSSWORD Competition

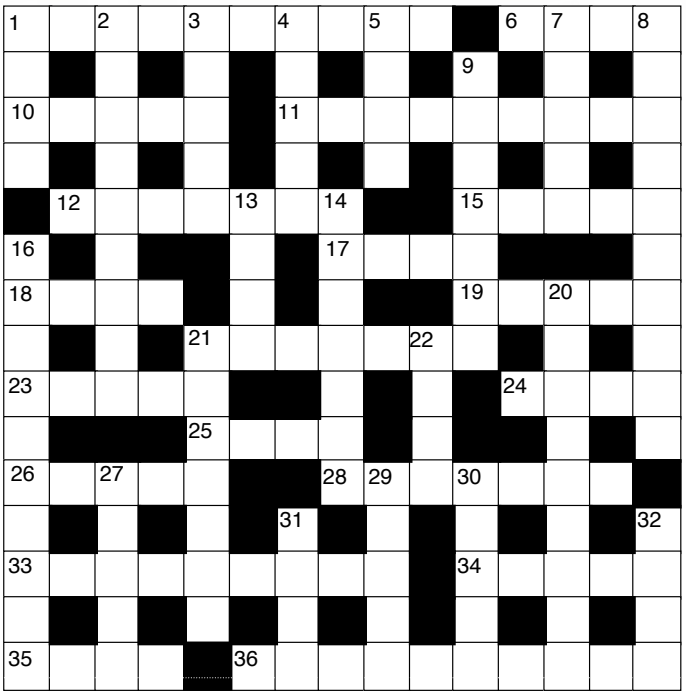
WIN a €50 gift voucher

Across

1 With such diseases, must one distribute fine tonics? (10)
6 & 26a US presidential retreat once known as Shangri-La (4,5)
10 Accommodate or erect (3,2)
11 Tibetan spiritual leader (5,4)
12 Special anniversary celebration (7)
15 Sound-based detection system (5)
17 Nomadic Europeans, or the Italian name for Rome (4)
18 Don't succeed in getting part of Haifa illuminated (4)
19 Scandinavian has you confused, Senor (5)
21 Snuggled up (7)
23 Significantly overweight (5)
24 Martial Art found in Japan, under domes outdoors, initially (4)
25 See 13 down
26 See 6 across
28 Climbs, goes up (7)
33 Bird of prey, the symbol of the USA (4,5)
34 Pick up what's left at a strange angle (5)
35 Amphibians seen in a cleft stick (4)
36 Pan's leased out these promenades (10)

Down

1 Little devils (4)
2 Ribbons of pasta that my be cut in feet, literally (9)
3 Italian island famous for its Blue Grotto (5)
4 Music that is not mainstream, seen first in North Dakota, is exciting (5)
5 The world's longest river (4)
7 Once more (5)
8 "Pig!", I roared about this creature (7,3)
9 & 21d Is paraesthesia caused by tailors equipment? (4,3,7)
13 & 25a This body of water is drained by the Niagara river (4,4)
14 African state, formerly a province of Ethiopia (7)
16 Within one's financial means (10)
20 Did such a Cromwellian have a spherical skull? (9)
21 See 9 down
22 Heroic tale, saga (4)
27 Grassy plains of South Africa (5)
29 This metal may be 'stainless' (5)
30 English nobleman whose name is applied to the Marbles taken from the Parthenon (5)
31 Grows older (4)
32 Burden, responsibility (4)



Name: .....

Address: .....

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You can email your entry to us at **nursing@medmedia.ie** by taking a photo of the completed crossword with your details included and putting *'Crossword Competition'* in the subject line. Closing date: **March 21, 2023.** If preferred you can post your entry to: WIN Crossword, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Dublin A96E096

February crossword solution

Across: Err 3 Rabbit hutch 8 Double helix 9 Smallest 10 Noddy 11 Xylem 13 Motif 15 Risings 16 Put back 20 Lough Ree 21 Ghoul 23 Cacti 24 Volatile 25 Mozart 26 Chess pieces

Down: 1 Endangering 2 Rounders 3 Rally 4 Basmati 6 The Old Vic 7 Hut 12 Milk thistle 13 Mogul 14 Flush 17 Armchair 18 Burmese 19 Goalie 22 Lutes 23 Cross

The winner of the February crossword sponsored by MedMedia is: Hillary Feehily, Ennis, Co Clare

Roscommon Palliative Care Unit officially opens to patients

THE Roscommon Palliative Care Unit welcomed its first patients on February 13, just over a year after the unit was launched by the Minister for Health and just three years after the opening of the Mayo Hospice in Castlebar.

The unit has been built on a site owned by the Mayo Roscommon Hospice Foundation. The eight-bed inpatient unit with full day-care facilities came in under budget at €6.3 million. Both hospices were developed and paid for by fundraising (a combined €15.5 million).

The Mayo Roscommon Hospice Foundation was founded in 1993 and exists to provide palliative care services to people with life-limiting illnesses and their families in Co Mayo and Co Roscommon. Over the past 30 years, the palliative care teams have assisted in the care of more than 20,000 patients.

The palliative care unit will be under the governance and full operational management of Roscommon University Hospital. Patients in the unit, and their families, will have access to care from specialist medical, nursing and health and social care professionals, including physiotherapy, occupational therapy, social work, dietetics, speech and language therapy and pastoral care.

The Roscommon Palliative Home Care Team, which is under the governance of HSE Community Healthcare West, will also be based in the new unit and will work closely with the unit's inpatient team.

Mike Smith, chairperson of the Mayo Roscommon Hospice Foundation, said: "I'm thrilled that Roscommon Hospice is open to the public. The Mayo Roscommon Hospice Foundation is 30 years old this year and what better way to start the year. The local community have played a vital part in making it all happen.

"Palliative care services are badly needed in Roscommon and I'm delighted the first patients will be welcomed by staff this week. There is a wonderful team to look after each individual's needs and we wish all staff the very best of luck in the Roscommon Hospice."

Martina Jennings, chief executive of the Mayo Roscommon Hospice Foundation, said: "It would not be possible to bring this vital service to the people of Roscommon without the generosity of so many communities across both counties. Everyone involved in fundraising was determined to ensure that patients with life-limiting illnesses from Mayo and Roscommon have the best possible facilities, where they can be cared for with dignity and respect. I'm very proud of what this community has achieved.

"Our palliative care teams in the community saw a significant increase in new patients in 2022, and unfortunately, we expect this trend to continue. We are committed to continuing to fund, support and develop this service and we will need to continue fundraising to keep palliative care services running in the community and at our hospices," she added.

Anyone who wishes to make a donation to the Mayo Roscommon Hospice Foundation can do so by visiting **hospice.ie** or calling 094 93 88666.

Free nicotine replacement therapies made available by HSE

NICOTINE replacement therapies (NRTs) are now available free of charge from local 'stop smoking clinics', the HSE has announced.

The free NRTs are offered as part of a package of supports for people who quit smoking through the HSE QUIT service, the HSE said in a statement on National No Smoking Day, February 22.

NRTs are licensed medicines that safely give you lower levels of nicotine to alleviate withdrawal symptoms and help you resist cravings. They can double a smoker's chances of quitting for good, according to the HSE.

In 2022, almost one in five people in Ireland were smokers, according to research conducted by Healthy Ireland, which revealed that the prevalence of smoking in Ireland remains at 18% and has not declined since 2019.

Dr Paul Kavanagh, HSE Public Health Medicine Lead with the Tobacco Free Ireland Programme, said: "We sometimes talk about smoking as a choice but the reality is that it is an addiction. Nicotine makes cigarettes addictive and hard to give up. You will double your chances of quitting for good if you get support from **QUIT.ie** and use NRTs, which are now provided free from local stop smoking clinics.

"NRTs are safer than smoking because they don't contain poisonous chemicals like tar and carbon monoxide, which are present in tobacco smoke," he explained.

"They come in many different forms like patches, gum, lozenges, inhalers and mouth sprays, and often work best when you combine them together in a way that suits you. For example, use a long-acting patch combined with a short-acting nicotine mouth spray or lozenge.

"Using NRTs, over a full course of 12 weeks, doubles your chances of quitting smoking in combination with all the encouragement, emotional and behavioural support available from HSE Stop Smoking advisors before and after you quit smoking. I would recommend anyone who is thinking about stopping smoking

to consider making a quit attempt with help from NRTs and a stop smoking advisor to give themselves every chance of staying off smoking for good.

NRT products are checked for safety by the Health Products Regulatory Agency (HPRA) in Ireland, according to Dr Kavanagh, and following a comprehensive assessment by the Health Information and Quality Authority (HIQA), they are recommended as a safe, effective and clinically sound way to stop smoking in the National Stop Smoking Guidelines.

Visit **QUIT.ie** for more information.

New NMBI president elected

Dr Louise Kavanagh McBride was previously NMBI vice president

THE Nursing and Midwifery Board of Ireland (NMBI) has announced that Dr Louise Kavanagh McBride has been elected as its new president following a board meeting in January.

Dr Kavanagh McBride has served on the Board of NMBI since 2015, when she was appointed by the Minister for Health as the Technological Higher Education Association (THEA) Institutes of Technology representative. She has been vice president of the NMBI since 2017.

During her time on the Board, Dr Kavanagh McBride served as chair of the education, training and standards committee, and has also served as a member of the business, strategy and finance and fitness to practise committees.

Originally from Duleek, Co Meath and living in Co Donegal, Dr Kavanagh McBride is a registered general nurse and nurse tutor, specialising in orthopaedics and emergency nursing. She is currently head of the Department of Nursing and Healthcare at Atlantic Technological University, Donegal. She is currently involved in funded research projects in the area of mental health and wellbeing among third-level students, in partnership with University of Ulster.

Dr Louise Kavanagh McBride, NMBI president

In her new role, Dr Kavanagh McBride will oversee the implementation of NMBI's new Statement of Strategy 2023-2025.

Dr Kavanagh McBride said: "I am privileged and honoured to become president of NMBI. As I step into this role, from vice president, I recognise both the opportunities and challenges that exist within the nursing and midwifery professions and look forward to working with the Board, NMBI's executive and key stakeholders as we promote and protect the integrity of the professions.

"I am delighted to have been elected by my Board colleagues to take up the position of president. I want to thank my former colleague and outgoing President, Essene Cassidy, for her leadership over the past seven years. I look forward to using my knowledge of the Board and my professional, academic experience and practice to further NMBI's mission to protect the public and uphold the highest standards of nursing and midwifery education and practice."

NMBI chief executive Sheila McClelland said: "I want to offer my sincere congratulations to Louise on her election as president. I have worked closely with Louise over the past number of years and I know that she is strongly committed to furthering our work to support registered midwives and nurses to provide patient care to the highest standard. I look forward to continuing to work alongside our Board to achieve our new strategic objectives."

NMBI publishes new education standards for DXA scanning

THE Nursing and Midwifery Board of Ireland (NMBI) has published new educational standards and requirements to regulate the practice of dual energy x-ray absorptiometry (DXA) scanning by nurses.

DXA combines x-rays, a computer and software that provides quantitative and qualitative assessment of body tissues. Nurses in Ireland can undertake the practical aspects of DXA scanning if they have completed the education programme, which addresses safety standards for protection against the dangers arising from exposure to medical ionising radiation.

NMBI developed these standards following a European directive that requires new education standards to ensure public and staff safety when nurses perform bone density scans using x-ray.

The new requirements aim to ensure a standardised approach to DXA education programmes and that nurses are competent in administering a DXA scan to adult service users following completion of the education programme.

NMBI is responsible for approving and monitoring nursing and midwifery education programmes to ensure the programmes meet high standards. The document explains the legislative frameworks and the standards required for education bodies and the healthcare providers delivering educational programmes.

NMBI chief executive Sheila McClelland said: "I am pleased to launch this publication, which will guide education bodies in developing education programmes for nurses carrying out DXA scans, in line with Irish and EU legislation. The standards focus on the safety of the person receiving a DXA scan to minimise exposure to radiation, ensuring patient safety is always at the forefront of nursing practice. NMBI is the first regulator in the country to introduce standards of this kind. We hope they will contribute to public safety and provide nurses with the required training and competence in DXA scanning."

Carolyn Donohoe, NMBI director of education, policy and standards added: "The development and implementation of standards of practice and education is a key function of our role as a regulator. This document aims to support education bodies and associated healthcare providers to develop high-quality training and education for nurses in this area of practice, which will ensure quality and safe services to all patients."

The standards were developed with the support of a national interdisciplinary group, including representatives from the HSE and the Irish DXA Society, and in consultation with the Environmental Protection Agency and HIQA.

Nurses Undertaking the Practical Aspects of Dual Energy X-Ray Absorptiometry (DXA) Scanning for Adults is available at: **https://bit.ly/3YK6y8a**

March

Saturday 4
Midwives Section meeting via Zoom

Tuesday 7
Care of the Older Person Section conference. Midlands Park Hotel, Portlaoise. See also *page 12*

Tuesday 14
Telephone Triage Section meeting. 11am via Zoom

Monday 20
ANP/CNS Section meeting. Richmond Education and Event Centre. 11am

Wednesday 22
Retired Section Dublin Bay Cruise tour. From 11am. Dublin City to Dun Laoghaire. Departing from Sir John Rogerson's Quay/Samuel Beckett Bridge. Book online at **www.dublinbaycruises.com**

Tuesday 28
ODN Section meeting via Zoom. 7pm

Thursday 30
RNID Section conference. Richmond Education and Event Centre. See *page 6* for further details

April

Monday 3
Nurse/Midwife Education Section meeting on Zoom

Tuesday 18
Retired Section meeting. Richmond Education and Event Centre and on Zoom

Wednesday 19
RNID Section meeting via Zoom. To include educational talk

Wednesday 19
Retired Section outing to National Maritime Museum. Contact Ger: 087 279 4701

Saturday 22
Midwives Section meeting. The Richmond. 9.30am

Saturday 22
SEN Section meeting. 10am

Saturday 22
PHN Section meeting. 10.30am via Zoom

Monday 24
CIT Section meeting via Zoom

Tuesday 25
National Children's Nurses Section meeting on Zoom. 11am

Tuesday 25
Radiology Nurses Section meeting on Zoom. 7pm

Wednesday 26
CPC Section meeting. 11am on Zoom

Thursday 27
Assistant Directors Section meeting on Zoom. 2.30pm

For further details on any listed meetings or events, contact jean.carroll@inmo.ie (unless otherwise indicated)

INMO Membership Fees 2023

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

Condolences

- Members of the INMO in the Ballinasloe Branch held a minute's silence at their recent AGM in memory of their late colleague and friend Lorraine Nestor, née Simon, who worked in the emergency department in Portiuncula Hospital. May she rest in peace.
- The INMO Limerick Branch and the Limerick Office extend condolences to Sally Hogan, INMO rep and senior staff nurse on the dialysis unit at University Hospital Limerick, on the recent passing of her mother Margaret Hogan. We also extend condolences to Margaret's former colleagues at Croom Orthopaedic Hospital, who have recalled to the INMO that as the matron/director of nursing at Croom Orthopaedic Hospital, Margaret is remembered fondly for her kindness, professionalism and advocacy for both nurses and patients. May she rest in peace.

CUH children's nursing conference

The Cork University Hospital (CUH) Annual Child and Family Nursing Conference 2023 will take place this year on Tuesday, April 25, in the main auditorium at CUH. The theme is *'Sharing Insights and Empowering Excellence'.*

Guest speakers will include Prof Donal O'Shea, consultant endocrinologist and national clinical lead on obesity; Suzanne Cullen, executive coach and mentor, Children's Health Ireland (CHI), Dublin; Dr Eoin McNamara, research analyst, Growing Up in Ireland, Economic and Social Research Institute; Nuala Clarke, group sepsis, assistant director of nursing, CHI, Dublin; and Dr Ray Healy, Nursing and Midwifery Board of Ireland.

Submission deadline for oral and poster abstracts is Friday, February 10.

Nurse On Call

Nursing services and recruitment

Nurses, midwives, student nurses and healthcare assistants: we all want more flexibility in our work lives, and that's what **Nurse On Call** offers.

- Do you want to be able to work around family life and work when it suits you?
- Do you want to be in charge of your own work schedule?
- Do you want to make some extra money for holidays or for something special?
- Do you want to avoid a stressful work environment?
- Do you want to try out a hospital/worksite before committing to a permanent position?

Join Nurse On Call, an approved supplier of agency nurses, student nurses and HCAs to every HSE/HSE-funded worksite in the Republic of Ireland – we would love to have you!

For more information, email **interviewer@nurseoncall.ie** or **corkoffice@nurseoncall.ie** if you are based in the south.

**Zoom interviews Monday to Friday 8:30am-5pm.
Please text your address to **087 1437417** for an application form or download one from our website: **www.nurseoncall.ie****

Practice nurse required

- Practice Nurse required for friendly GP clinic practice in Dublin 2
- Competitive salary package for right candidate with free parking
- Hours can be flexible for right candidate, preferably 3 morning sessions between 8 to 20 hours per week
- Candidates must be RGN registered.

Job description
Childhood immunisation, flu vaccination, phlebotomy, smear testing, ear syringing, ECT, 24h BP monitor, dressing and chronic disease management. Training can be provided.
Job type: Permanent/part-time
Salary: From €30.0 per hour (depending on experience)
Schedule: Monday to Friday.

Benefits
- Onsite parking
- Training
- Flexible hours.

For further details, email **doctor@aungierclinic.ie**

Irish Cancer Society Night Nurses

The Irish Cancer Society are seeking Registered General Nurses who can provide a minimum of 6 nights per month and have some palliative experience.
Training will be provided.
Job description on **www.cancer.ie**
Email CV to **recruitment@irishcancer.ie**
Informal enquiries to Amanda on 01-2310532 or **awalsh@irishcancer.ie**

Irish Cancer Society

Irish Nurses Rest Association

A committee of management representing the Guild of Catholic Nurses of Ireland, the INMO, the Association of Irish Nurse Managers and Director of Public Health Nursing exists to administer the funds of the Irish Nurses Rest Association. It's open for applications from nurses in need of convalescence or a holiday for a limited period who are unable to defray expenses they may incur or for the provision of grants to defray other expenses incurred in purchase of a wheelchair/other medical aids.

Please send applications to:
Ms Margaret Philbin, Rotunda Hospital, Dublin 1.
email: mphilbin@rotunda.ie

Eagraíocht Cúram Sláinte Pobail
Tuaisceart Chathair & Tuaisceart Chontae Baile Átha Cliath

Community Healthcare Organisation
Dublin North City & County

Nursing Positions Available

Who are we?
CHO Dublin North City and County (CHO DNCC) is responsible for providing care and services to a population of around 621,405 people. Community Health Services are the broad range of health services delivered outside of the acute hospital setting. They are delivered through the HSE and its funded agencies to people in local communities, as close as possible to their homes.

Our services
Primary Care; Older Persons; Disabilities; Mental Health and Wellbeing; Quality, Safety and Service Improvement

Our current vacancies
We have excellent opportunities for nurses: Staff Nurse, Clinical Nurse Specialists, Clinical Nurse Managers and ADON etc. If you are interested in providing quality care and developing a career in nursing, we offer a wide range of opportunities with many benefits.

We welcome applications from all qualified individuals who meet the eligibility criteria for these roles. Further information is available by emailing chodncc.recruit@hse.ie Search 'Rezoomo CHO DNCC Jobs' or visit **Rezoomo CHO DNCC Jobs** for all our current vacancies.

Gobnait O'Connell Award Nominations

Nominations for our Gobnait O'Connell award are now open!

This award is presented every year at ADC to an INMO member for their exceptional contribution to the union.

The nominee may have been particularly effective and dynamic in recruiting members, highlighting the Organisation's activities to others, developing best practice and policies on behalf of their section/special interest group, negotiating improvements in working conditions for nurses and midwives or making an exceptional contribution to INMO activities in a spirit of loyalty and dedication.

Nominating a member for this award must come from her/his branch or section and the nomination must be submitted via email to **necactivities@inmo.ie** by **12pm, Wednesday 29th March 2023**.

For more details on nominating criteria, contact your branch, section or Industrial Relations Official.

Financial assistance available to INMO members

The International Council of Nurses (ICN) and the Canadian Nurses Association (CNA) will co-host the 29th ICN Congress from July 1-5, 2023 in Montreal, Canada. With the theme 'Nurses together: a force for global health', the ICN 2023 Congress will bring together the powerful force of 28 million nurses worldwide. For four days, nurses will unite to learn, share and network in order to build a better future for the nursing workforce and our healthcare systems. The INMO will be formally represented at the ICN's Congress by the President of the Organisation, Karen McGowan, and the Deputy General Secretary Edward Mathews. In keeping with past practice, the Executive Council will provide some assistance (to a maximum of €2,000) subject to criteria laid down by the Executive Council for two INMO members who may wish to travel to this worldwide gathering of nurses.

Criteria are as follows:

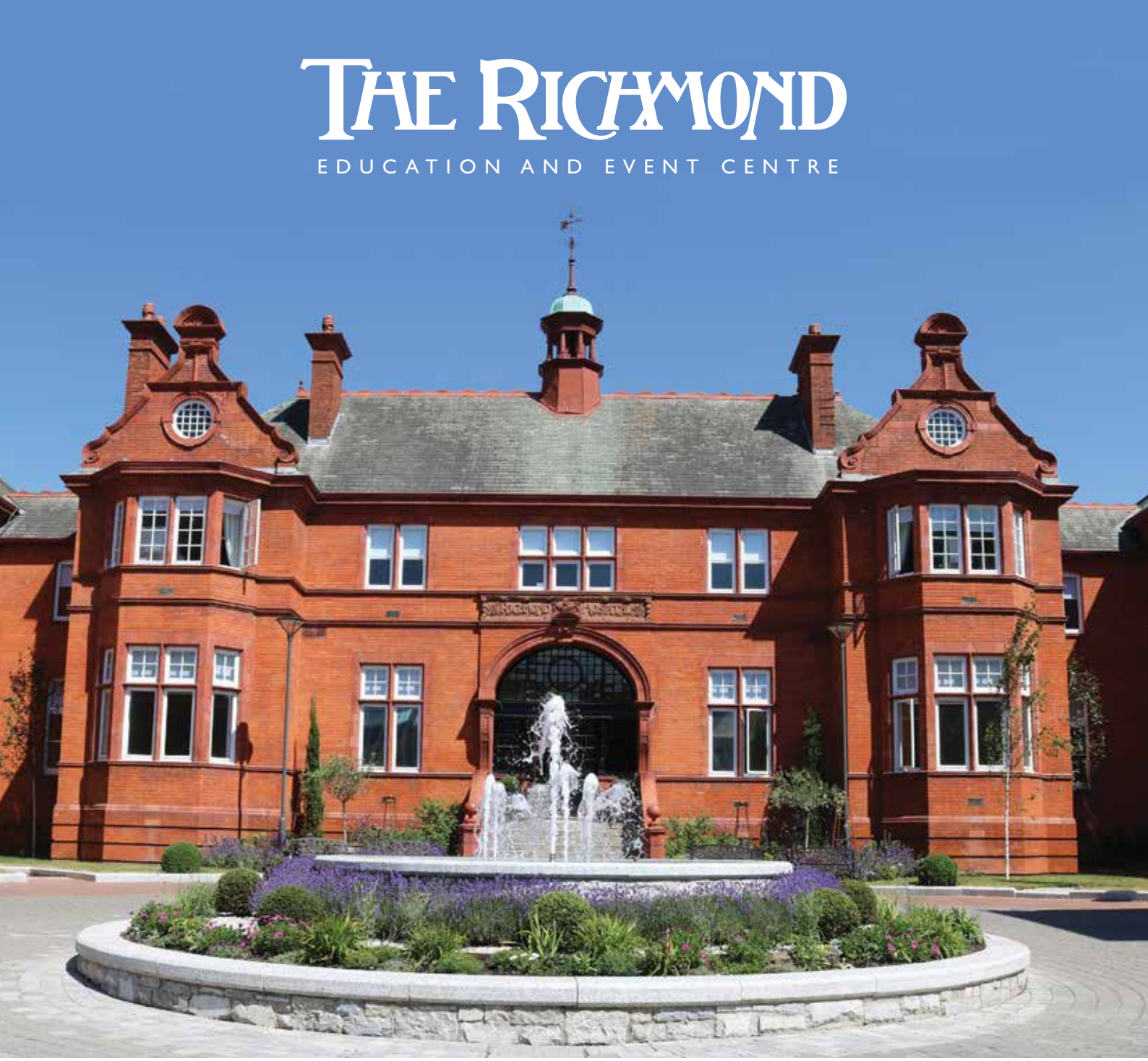
- The member must be fully paid up and have been in membership for at least three years.
- The applicant should have attended at least one annual delegate conference and/or have been active in local branch/workplace INMO activities
- Each applicant, before sign-off, must be the subject of support, from a local representative/branch/section officer to confirm their involvement in the Organisation's day-to-day activities.

Members who fit the criteria and who are interested in attending should send an email containing not more than 200 words on why they would like to attend to the General Secretary's office gspaoffice@inmo.ie before 12.00 noon on Friday, 10th March 2023.

The registration fee for members is €650 and €800 for non-members. More information can be found at **www.icncongress2021.org**

THE RICHMOND

EDUCATION AND EVENT CENTRE



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