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WIN

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

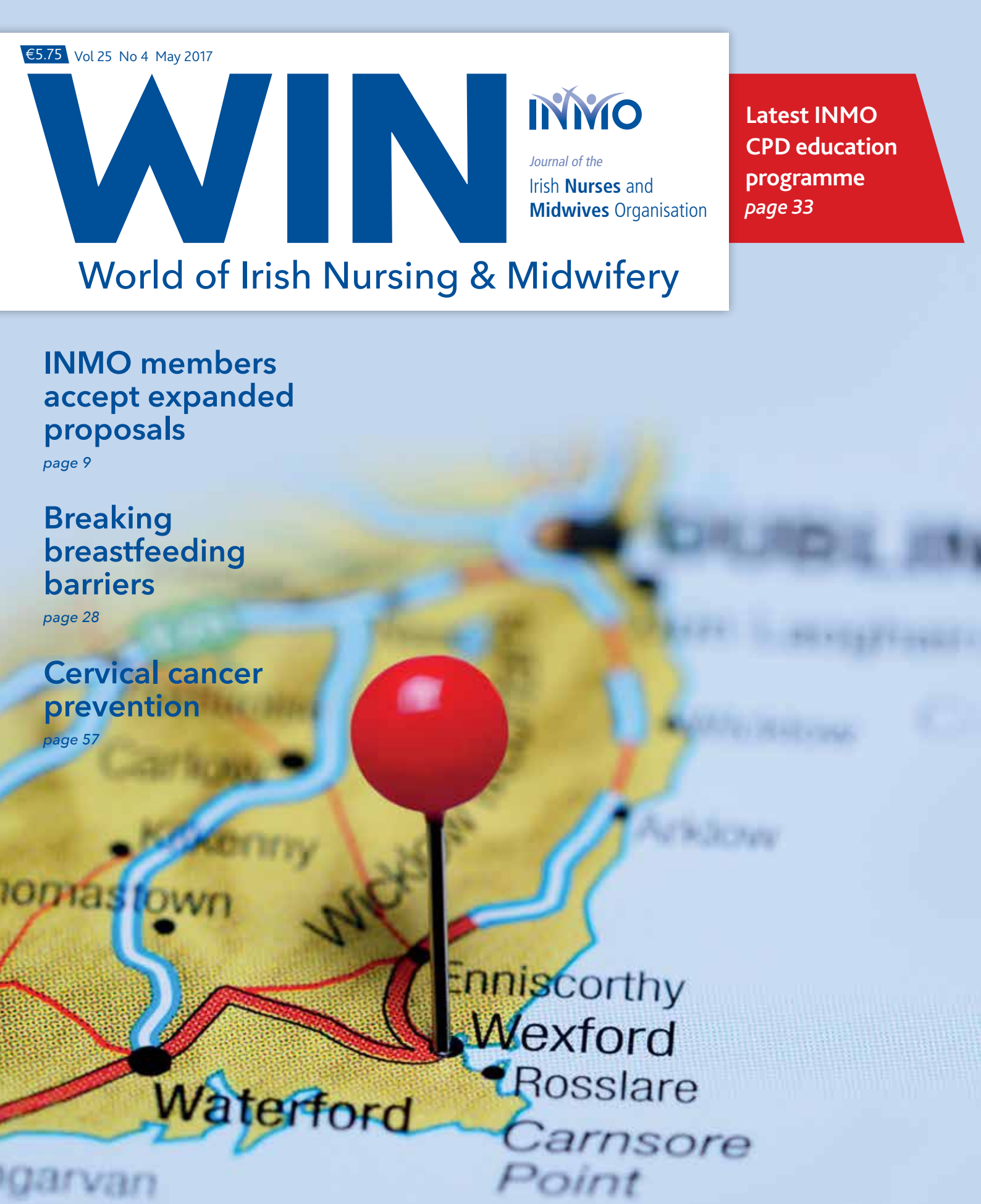
World of Irish Nursing & Midwifery

Latest INMO CPD education programme
page 33

INMO members accept expanded proposals
page 9

Breaking breastfeeding barriers
page 28

Cervical cancer prevention
page 57



All roads lead to Wexford

More than 350 delegates gather for 98th ADC

NEWS & VIEWS

FEATURES

CLINICAL

LIVING

JOBS & TRAINING

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Conference faces critical decisions

AS YOU receive this issue of *WIN,* more than 350 delegates from the Organisation's branches and sections across the country, will shortly be gathering in Wexford for our 98th annual delegate conference (ADC) taking place on May 3-5.

The delegates are gathering very shortly after the recent nationwide ballot, on proposals on staffing/recruitment/retention, which showed an 82% majority of members in favour of accepting the proposals as a first step in beginning to address the staffing crisis. This year's conference is also taking place just before negotiations between the government and public service unions are due to commence on a new public service pay agreement.

Against this background, it is easy to see why delegates will have many important decisions to make with regard to the Organisation's approach to the critical, and linked, issues of pay and staffing in the coming months.

The immediate priority, following the acceptance of the staffing/recruitment/retention proposals, is that every element of the measures are implemented, without delay, leading to an improvement in staffing levels in wards/communities across the country. We recently met with the Minister for Health on this issue and I can assure members that the INMO will be demanding full implementation of all elements of the proposals.

At the ADC, ahead of engagement on a new public service pay agreement, the Executive Council will be tabling an emergency motion highlighting our twin priorities going into these talks. The first priority will be that, in conjunction with all public service unions, we secure the unwinding of the FEMPI legislation and achieve the restoration, in full, of all cuts to pay imposed in recent years.

The second priority will be to secure a separate engagement with government on the severe labour market challenges, which continue to affect nursing/midwifery, and the quality of services available to patients. This is in the context of our claim for parity, in terms of pay and hours, with colleague public servants who hold similar professional qualifications. On this priority, it is likely that the emergency motion will state that if the proposals emerging from any talks on public service pay, do not include substantial progress on both of these issues, the Executive Council will not recommend them for acceptance when those proposals are put out to a ballot of members.

In addition to these critical areas, this year's conference will also see more than 60 other motions for debate under the broad headings of Industrial, Professional, Educational and Social Policy.

As we approach the end of the Lansdowne Road Agreement, it is clear that our members are tired of hearing about the economy improving while their working lives, in terms of their pay and conditions, remain far behind where they were a decade ago. It is for this reason that this year's conference – and the motions to be debated – will clearly map out the policies and approaches of this Organisation to the forthcoming pay negotiations and to all engagements with government and employers in the coming 12 months.

In the eyes of many politicians and commentators, the time is never right for nurses and midwives to receive anything other than warm words of praise – never to be translated into proper levels of pay and conditions of employment – however the time is up for these people. I am sure that this year's ADC will see our delegates direct the Organisation to adopt a very assertive, demanding and unapologetic approach in all negotiations in the coming months.

This staffing crisis cannot be solved without dealing, once and for all, with the issue of nurses and midwives' pay. The government has a chance to do this in the coming weeks. The INMO will not wait any longer and our approach to any new pay deal will be determined by progress on this critical issue.

Liam Doran
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

Proposals set out roadmap for nursing and midwifery

YOU will know by now that 82% of members voted in favour of the expanded proposals for staffing/recruitment/retention which endorses the Executive Council's recommendation of acceptance. I would like, on behalf of the management team and the Executive Council, to thank you all, for taking the time to come to the many national information sessions – 13 in total – and the facilitated workplace information sessions that were provided, so that your decision was based on accurate and timely information. The INMO prides itself on ensuring that procedurally the democratic process is upheld.

The expanded proposals are important, in what I would consider to be the first step towards correcting the continued haemorrhage of nurses and midwives from the Irish healthcare system. This is not to say that the proposals are 'the be all and end all', as in many instances they fall short of the required measures that are necessary to safeguard the nursing and midwifery workforce into the future and that is the reality of the uphill struggle that we face. The funded workforce plan is seismic, as for the first time it places legal obligations on the HSE to recruit. Indeed, as I write this report the HSE is in London actively doing just that. The crux of this is that the HSE must now report to the Oireachtas Committee on progress, or the lack of it, and this places an onus of responsibility on non-clinical management to rationalise either their adherence to, or inaction on, the proposals.

As funding will have been ring-fenced in advance so it cannot be spent on anything else, no wriggle room is allowed. I look forward to responding to the Minister for Health's address at ADC and will leave him in no doubt as to the next steps in the process with regard to pay and staffing for our members.

ODN 50th Anniversary Celebrations

THE Operating Department Nurses Section 50th annual conference was held in the Crowne Plaza, Dublin in March. It was a show case of excellence in theatre nursing marking the section's historic 50th anniversary. Time has not stood still in theatre nursing as technologies and specialisms have advanced and developed over the past two decades, bringing with them opportunities. On a professional front you can now undertake a higher diploma in perioperative nursing. The conference enabled members to highlight issues, which in turn were discussed and debated in a forum that has the potential to influence policy spanning the public, political, legislative, cultural and social media arenas. The section is represented on EORNA (European Operating Room Nurses Association), which represents the broader voice for safety and quality at a European wide level. I extended my sincere thanks to the section officers: Audrey Al-Kaisy, section chair; Allison O'Connell, vice chair and former Executive Council member; Teresa Herrity, secretary; and Monica Griffin, education officer.

105th general assembly of the EFN

IN MARCH I attended my second EFN general assembly meeting in Malta, accompanied by Elizabeth Adams, in her capacity as EFN first-vice president, a task which she executed with professional competence and ease. The EFN is influential regarding the formulation of European Policy therefore, it is vital at this time, that we are actively involved. There was a packed agenda but I was particularly struck by an item on the EU *Blueprint for the Nursing Profession* and I intend to track developments in this area over the coming months. Please visit **www.efnweb.org** for more information.

NMBI Statement of Strategy Launch

I ATTENDED the launch of the new NMBI Statement of Strategy 2017-2019 in April. Minister for Health, Simon Harris, was in attendance and strongly welcomed the strategy, which will facilitate the provision of leadership through innovative and proactive professional regulation of registered nurses and midwives to help them deliver safe care. President of the NMBI, Essene Cassidy, said: "This new strategy reflects our drive now to strengthen our relationship with our registrants, to make our work more transparent, and to make sure we are equipped to meet the needs of our registrants, the public and other stakeholders going forward."

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

Quote of the month

"Ask yourself if what you are doing today Is getting you closer to where you want to be tomorrow"
- Anonymous

Report from the Executive Council

THE INMO Executive Council met on April 3 and 4. Among the items discussed were the National Campaign and motions for ADC. This year's ADC focuses on shaping the healthcare agenda and clearly places nurses and midwives as pivotal to this process. Council will set the tone in the tabling of an emergency motion on pay parity, ahead of discussions on a new public service pay agreement.

With more than 60 motions to be debated, it is important that proposers and seconders to motions are prepared in advance and adhere to time requirements as set out by the standing orders committee.

I am looking forward, along with my fellow Executive Council members, to listening to the many and varied issues set to be debated. I can promise you, the ADC in Wexford will be engaging and will set out the new roadmap for nursing and midwifery in Ireland.

Get in touch

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

National joint committee to oversee implementation of staffing proposals

AN INMO delegation met with the Minster for Health Simon Harris on April 14, 2017 to begin the process to ensure implementation of all elements of the staffing/recruitment/retention proposals.

The INMO delegation included president Martina Harkin-Kelly, general secretary Liam Doran, deputy general secretary Dave Hughes and director of IR Phil Ní Sheaghdha. The Health Minister was accompanied by senior officials from both the Department of Health and the HSE.

At the meeting the Minister confirmed his absolute commitment to implement all elements of the proposals, and said it was a key priority for 2017 for the health service.

In that context it was decided that a joint implementation group, involving senior officials from both sides, would be established, and meet monthly, to oversee implementation of the proposals.

It was also decided that the first meeting of this group would take place in the week beginning April 24, with the Minister, to agree a timetable for future meetings, to monitor implementation between now and the end of the year. At this meeting, it was also negotiated that there would be immediate engagement on the following:

- CNM1 posts – direct engagement on agreeing the future requirements for the further establishment of CNM1 posts at ward level, to re-establish the line management structure recommended by the Commission on Nursing
- RNID – direct discussion to complete the review of the number of RNID posts working alongside/supervising social care worker posts, that now fall to be regraded to CNM1
- Undergraduate/postgraduate initiatives – it was agreed that the Department of Health, through the office of the chief nurse, would immediately finalise the process providing for the increase in undergraduate places (an additional 130 this September) and the commencement of postgraduate (conversion) courses in 2018. This will be further reviewed at the first meeting of the national implementation committee
- Permanent contracts – it was agreed that the HSE would immediately move to issue permanent full-time contracts, to all nurses/midwives currently on panels, and to all 2016 undergraduates (where this has not already taken place) and to 2017 graduates (subject to graduating).

The meeting also discussed the issuing, by Ministerial order, of a Directive, under Section 10 of the Health Act 2004, which directs the HSE to implement the funded workforce plan (providing for a nursing/midwifery workforce of 37,048 posts) by the end of the year. In this regard the Minister confirmed:

- The order was being finalised and would be issued shortly
- The implementation of the funded workforce plan will be subject to quarterly reports (end of June/September/December) which must be laid before the two Houses of the Oireachtas
- The relevant circulars, giving sanction to various aspects of what has now been accepted, will also issue shortly.

Overall, the INMO delegation felt that this was a constructive engagement with the Minister, clearly indicating his full commitment to implementing the proposals without delay.

Further updates will issue, via news updates to members, beginning with the first meeting of the National Implementation Group scheduled to take place in the week beginning April 24, 2017.

INMO welcomes Minister's view on future of health

THE INMO, which represents almost 40,000 nurses and midwives in Ireland, welcomes much of the recent comments by Minister for Health Simon Harris to the Oireachtas Committee on the future of healthcare. In particular, the INMO welcomes the Minister's comments proposing:

- A slimmed down management bureaucracy within the Irish health system
- Organisational reform leading to integrated care across the country
- A greater role for clinicians working in the frontline, in the management and delivery of healthcare and health services generally.

The INMO has, together with the Irish Congress of Trade Unions, called – in both its written and oral submissions to this Oireachtas Committee – for a radical reform of the health service delivering, within 10 years, the following:

- A single-tiered public health service where access is determined solely by need and not ability to pay
- Four Regional Health Authorities providing integrated care for the entire population
- The removal of the layers of bureaucracy currently impeding clinical decision making and empowerment of professionals in the frontline
- The funding of healthcare maintained at a minimum of 10% of GDP through a central funding arrangement.

The Minister's comments, at the committee meeting last month, essentially reflect similar thinking to the INMO. The Organisation has called on the committee to propose this radical change when it issues its report in the coming weeks.

INMO general secretary Liam Doran said: "It is imperative that this Oireachtas Committee recognises in its report the inherent unfairness, perverse incentives and inequities that currently exist as a direct result of our two-tiered health service. It is patently wrong that an ability to pay guarantees the individual quicker access to essential diagnostics and treatments, if required, than the person who is solely reliant on the public health service.

"Political consensus must emerge as part of this process. This must remove health from the battleground of elections and political ideology, and place it firmly in the space of a world class public health service being a social good which strengthens our economy. The change will take time, and there will be resistance, and political leadership will be required. However the rewards, for every citizen of Ireland, regardless of income or need, will be significant."

At the count: *INMO general secretary Liam Doran overseeing the recent ballot count at INMO HQ in Dublin – members voted by a margin of 82% to accept the proposals, which emerged from talks at the WRC, to begin addressing the staffing/recruitment/retention crisis in nursing and midwifery*

Members accept expanded proposals

Plan will begin to address staffing/recruitment/retention crisis

INMO members voted by a margin of 82% to accept proposals to begin addressing the staffing/recruitment/retention crisis in nursing and midwifery.

The proposals, which emerged following talks chaired by the Workplace Relations Commission, contain a number of measures including:

- Increasing the nursing/midwifery workforce by more than 1,200, to over 37,000 before the end of this year
- A funded workforce plan to be subject to quarterly reviews under Ministerial order
- The offering of permanent posts to all nurses/midwives currently on panels, and all nurse/midwife graduates from 2016/2017
- Increased incentives to attract Irish nurses/midwives back from overseas, particularly from the UK
- Miscellaneous other measures including more flexible permanent contracts, a pre-retirement scheme, and increased numbers of undergraduate and postgraduate places for nurses and midwives
- The restoration of allowances which had been removed from new entrants, as part of the forthcoming public service pay talks
- Restoration of the time plus one-sixth premium payment, for nurses working in older person/ID services, following determination by an independent chair.

The INMO will now immediately move to progress the following:

- Full implementation, of the proposals, overseen by a national implementation group involving senior officials from the Department of Health/HSE and the INMO
- Complete engagement with the Public Service Pay Commission and its specific examination of the labour market challenges affecting nursing/midwifery
- Finalise, through a full debate at the INMO annual delegate conference in Wexford on May 3-5, the Organisation's approach to the talks between public service unions and government, expected to begin in May
- As part of these talks to have direct engagement with government on the specific issues of nursing/midwifery pay in the context of the continued inability of the Irish public health service to recruit and retain nurses and midwives.

In relation to the ongoing labour market challenges the INMO has noted the recently released independent survey findings, which again confirm:

- One in four nurses/midwives, currently working in the health service, is actively looking to leave
- The lengthy delays in filling vacant posts despite public competition
- The ongoing haemorrhage of Irish educated nurses and midwives to other countries, including the UK, despite the uncertainties with Brexit.

INMO president Martina Harkin-Kelly said: "Our members, in accepting these proposals, are stating quite clearly, that they represent just the first step, in a three year programme, which must see nurse/midwife employment levels increase to over 40,000 from its current level of 35,600. Our members have also said to us, in the many workplace meetings that took taken place over the balloting process, that, in addition to these measures, the issue of pay must be prioritised, progressed and addressed as part of the public service pay talks scheduled for May. The Organisation is now preparing for these talks and the government must move from simply talking about the recruitment/retention crisis and agree concrete measures, which must involve pay, when we engage with them in May."

Commenting on the ballot outcome, INMO general secretary Liam Doran said: "The three weeks of the balloting process saw the Organisation engage with thousands of members in workplaces across the country. The pressure on our members, due to staffing shortages, was again brought forward at every meeting.

"These proposals now fall to be implemented, overseen by a joint high level group, which must ensure nationwide roll out immediately. The pay of nurses and midwives now moves front and centre. The forthcoming talks must result in direct engagement on the obvious need to significantly improve the pay of nurses/midwives. The government must act and the May talks provides them with the opportunity as nurses/midwives will not wait any longer."

INMO and NMBI to meet regularly on issues of interest and concern

AN INMO delegation, led by INMO president Martina Harkin-Kelly, met with NMBI president Essene Cassidy and NMBI CEO Mary Griffin, on April 5 to discuss current issues of interest and concern.

This was the latest in a series of regular meetings designed to improve communications between the NMBI and INMO in the interests of registrants and the two professions. The issues discussed at the meeting are outlined below.

Annual retention fee

The NMBI team reported that 2,258 registrants had recently been removed for non-payment of the annual retention fee and that, to date, only 300 had been restored.

In the course of the subsequent discussion, it was collectively agreed that this level of removal was a subject of concern as it could not be explained simply by those who would have passed away or retired during 2016.

The concern is that this might be further evidence of the continuing large number of registered nurses/midwives emigrating and therefore not requiring their Irish registration for 2017.

As part of the discussion, the NMBI also confirmed that it was working towards introducing a new flexible payment system in relation to the annual retention fee, which would take effect in June this year. The NMBI is in the process of finalising this system and will make it known to all registrants via its website and direct publication to registrants. This will be covered in *WIN* once it is finalised.

Public consultations

The Board confirmed that it was currently involved in public consultations in relation to:

- Removal of the inactive register and the introduction of new registration rules
- The two draft policy documents recently launched by the Chief Nursing Officer in the Department of Health in relation to advanced practice and the role of nursing in the community.

Registration/certification of verification figures

At the meeting the INMO requested, and the NMBI agreed to forward, a detailed breakdown of all registrations for the period 2016/2017 and the number of certificates of verification for 2016 and, to date.

The INMO sees this information as critical to workforce planning in relation to nursing/midwifery and delivering on the funded workforce plan recently agreed with the Department of Health/HSE.

Competency Assurance Scheme

The NMBI confirmed that it was shortly to appoint an officer who would lead out on the competency assurance scheme. The Board confirmed that it was too early to provide any definitive timeframe for the introduction of a national competency assurance scheme but it was likely to be late 2018/2019.

In relation to this, the INMO repeatedly stressed that it was essential for the NMBI to ensure that any scheme should highlight and require that all employers of nurses and midwives are obliged to facilitate the attainment of whatever assurance requirements are laid down by the Board. In response, the Board committed to continue ongoing consultations with the INMO on this matter.

CPC ratios

The INMO raised the issue of the ratio of clinical placement coordinators (CPC) to undergraduate students (the recommendation is one to 30 in nursing and one to 15 in midwifery). The Organisation believes that these posts were lost during the recruitment moratorium and have not yet been fully replaced.

In response the senior team from the NMBI agreed to review this matter as a matter of urgency, and to revert to the INMO with a full update on the current ratios in operation across the clinical areas.

Other issues

The meeting also considered a range of other issues including:

- The review of medication management standards
- Applications for privacy before the fitness to practise committee
- Examination of all adaptation programmes now available to nurses and midwives arriving in this country.

It was agreed that open lines of communication would be maintained and that the next meeting would take place to discuss all relevant matters in approximately three months.

Maintaining open lines of communications:
INMO president Martina Harkin-Kelly (left) and NMBI president Essene Cassidy

NMBI elections due to take place in September

THE NMBI is currently finalising arrangements for elections to fill the five seats whose term of office expires at the end of this year. The five seats to be filled are:

- Midwifery
- Intellectual disability
- Care of the older person
- Public health nursing
- Mental health.

The Board has confirmed that e-voting will again be used in this election and it is currently tendering for same.

It was also confirmed that the draft timetable surrounding the elections provides for nominations to be around the end of May, with the election due to take place over a defined period in September.

The INMO Executive Council considered this development at its most recent April meeting. As a result, the Organisation is now moving to finalise its list of supported candidates, for these five seats, and is aiming to announce the candidates at the forthcoming annual delegate conference in Wexford from May 3-5.

Further details on the NMBI elections will be circulated as they are available.

ADC 2017: All roads lead to Wexford

Major decisions expected on INMO's pay and staffing agenda

THE INMO's 98th annual delegate conference will see more than 350 delegates gather in Wexford to debate more than 60 motions.

Under the theme *'Nurses and midwives – together shaping healthcare'*, major decisions will be made on the Organisation's approach to pay and staffing. An emergency motion will be tabled by the Executive Council on Thursday, May 4 on the restoration of pay, parity of pay and working hours with other professions, which will set the agenda for the next year.

The full text of motions for debate can be viewed on **www.inmo.ie**, where members can also access updates from the proceedings throughout the three days.

Just before the opening of the ADC, a press conference will be held at 12.15pm on May 3 where the agenda for the three days will be outlined and the main issues highlighted. As well as debate on motions, other events over the three days, in the order in which they will take place, include:

Wednesday, May 3

- Martina Harkin-Kelly, INMO president, will launch a competition for a badge logo for the 2019 centenary of the INMO
- Edward Mathews, INMO director of regulation and social policy, will launch the INMO's social media fora
- Acknowledgement of Annette Kennedy, ICN third vice president and candidate for ICN president 2017
- Dinner at 8pm followed by a raffle and quiz in aid of a local charity.

Thursday, May 4

- Elizabeth Adams, INMO director of professional development, will give an update on the Richmond Education and Event Centre
- Dinner at 8pm followed by presentation to winners of the Gobnait O'Connell Award, CJ Coleman Research Award and the Preceptor of the Year Award.

Friday, May 5

- Dave Hughes, deputy general secretary, will present a review of the year
- Address by Minister for Health Simon Harris at 2.30pm
- INMO president Martina Harkin-Kelly will address delegates and respond to the Minister
- Drinks reception at 7.30pm followed by the annual gala dinner.

Building The Richmond Education and Event Centre: *Elizabeth Adams will give an update on The Richmond Education and Event Centre at the ADC. She is pictured above with INMO general secretary Liam Doran and the construction team outside the former Richmond Hospital which is currently being transformed into the new education and continuing professional development hub for nurses and midwives*

Speaking ahead of the ADC, INMO general secretary Liam Doran said: "Delegates at our 98th annual delegate conference will have major decisions to make in the lead in to negotiations between the government and public service unions, which are due to commence on a new public service pay agreement. The INMO will be approaching the planned discussions on a successor to the Lansdowne Road Agreement, requiring that any new agreement is constructed to ensure that the labour market challenges facing nursing/midwifery can, and will, be addressed in a manner which will resolve the recruitment/retention issue in the medium to long term.

"At this conference we will unite in pursuit of the goal of fair, proper and appropriate pay for every nurse and midwife in this country. This must reflect their role, their responsibility and the international labour market so that we can attract, retain and reward nurses and midwives here in Ireland."

TORL campaign success: *General secretary Liam Doran is pictured here along with representatives of the many other Irish organisations which supported the Turn Off the Red Light campaign over recent years*

TORL celebrates as Act commenced

THE Criminal Law (Sexual Offences) Act 2017 came into law in March, following its commencement by Tánaiste Frances Fitzgerald. The legislation decriminalises the sale of sex and criminalises the purchase in Ireland. It recognises the harm inherent in the sex trade and targets demand for paid abuse.

If enacted properly, these laws will mean women, children and men are prevented from ever entering the sex industry and experiencing its violence in Ireland.

The Turn Off the Red Light (TORL) campaign, an umbrella group of charities and groups against the selling of sex, including the INMO, described the commencement of the laws as "an historic day" which they believe will help "vulnerable women, children and men in prostitution access support".

TORL chair, Denise Charlton, said it is important because, for the first time, those involved in prostitution will no longer be criminalised by the law but instead protected by it.

Ms Charlton also paid tribute to the members of the campaign saying: "The diverse group with wide-ranging priorities has worked together over an extended period. It is testament to the passion, drive and authentic motivation of all those who've contributed."

March trolley figures at a record high

ANALYSIS of the INMO trolley watch figures for March 2006-2017 has shown that March 2017 figures are the highest ever for that month, with 9,459 admitted patients being cared for on trolleys.

While the overall figure was up by 1%, the analysis showed that hospitals in the Eastern area, down 29%, fared better than those in the rest of the country, which were up by 16%. However, figures in St James's Hospital, Dublin more than doubled on the same month last year with 162 on trolleys in March 2016 compared to 336 in March 2017.

Many hospitals outside the capital are struggling significantly with overcrowding. The highest figures recorded were:

- Cork University Hospital – 716
- University Hospital Limerick – 699
- University Hospital Galway – 638
- Midlands Regional Hospital, Tullamore – 537
- South Tipperary General Hospital – 496.

While the INMO welcomed the Winter Initiative Plan, which had an allocation of an additional €40 million and a maximum target of 236 for the number of patients on trolleys each day, the March figures were 82% over target. This proves that the measures taken to date are not enough.

INMO general secretary Liam Doran said: "The figures for March are very disappointing. The Winter Initiative Plan included extra acute beds, transitional care beds and step-down beds, as well as additional homecare packages and the expansion of community intervention teams. Unfortunately, as outlined by the INMO at the time, the plan, by failing to address the difficulties in recruiting and retaining nursing staff, ran the risk of falling short in terms of implementation. Additional services depend on there being additional nursing staff.

"The recent deal on staffing/recruitment/retention represents the first step in a three-year programme that must see nurse and midwife employment levels increase from its current level of 35,600 to 40,000. These proposals now fall to be implemented, overseen by a joint high level group, which must ensure nationwide roll-out immediately."

Table. INMO trolley and ward watch analysis (March 2006 – 2017)

Hospital	March 2006	March 2007	March 2008	March 2009	March 2010	March 2011	March 2012	March 2013	March 2014	March 2015	March 2016	March 2017
Beaumont Hospital	514	598	615	744	937	610	655	581	342	643	721	294
Connolly Hospital, Blanchardstown	244	288	176	288	170	375	257	573	364	452	300	239
Mater Misericordiae University Hospital	598	416	422	375	496	311	380	262	264	541	356	419
Naas General Hospital	478	286	225	384	234	778	240	227	234	389	426	338
St Colmcille's Hospital	216	32	34	155	219	210	189	150	n/a	n/a	n/a	n/a
St James' Hospital	670	95	257	234	136	210	75	216	152	335	162	336
St Vincent's University Hospital	413	464	429	515	594	560	456	404	178	599	672	131
Tallaght Hospital	734	339	381	686	509	643	211	389	392	409	506	485
Eastern	**3,867**	**2,518**	**2,539**	**3,381**	**3,295**	**3,697**	**2,463**	**2,802**	**1,926**	**3,368**	**3,143**	**2,242**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	42	39	146	79
Cavan General Hospital	355	238	121	113	312	489	249	125	36	65	117	31
Cork University Hospital	467	341	373	331	586	843	596	308	304	412	550	716
Letterkenny General Hospital	228	275	42	11	86	51	43	180	277	281	191	450
Louth County Hospital	12	12	26	1	2	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo University Hospital	281	163	148	48	216	68	220	203	186	247	235	200
Mercy University Hospital, Cork	200	145	98	163	135	186	172	292	222	251	194	362
Mid Western Regional Hospital, Ennis	71	128	38	38	27	81	27	58	n/a	14	36	22
Midland Regional Hospital, Mullingar,	6	11	11	28	230	331	288	403	250	562	468	434
Midland Regional Hospital, Portlaoise,	56	39	78	63	24	90	55	60	166	217	260	358
Midland Regional Hospital, Tullamore,	4	0	0	5	68	224	158	199	396	204	568	537
Monaghan General Hospital	3	45	37	35	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nenagh General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	15	7	5
Our Lady of Lourdes Hospital, Drogheda	405	386	194	398	356	541	660	333	474	533	474	216
Our Lady's Hospital, Navan	41	100	55	105	66	249	117	175	60	75	46	235
Portiuncula Hospital	78	23	38	16	74	71	105	162	45	99	86	259
Roscommon County Hospital	108	36	95	91	55	121	n/a	n/a	n/a	n/a	n/a	n/a
Sligo Regional Hospital	161	46	77	96	153	156	104	242	238	235	213	301
South Tipperary General Hospital	111	88	55	53	89	104	150	158	250	233	552	496
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	n/a	48	49	214	265	284	357	364
University Hospital Galway	258	189	209	305	443	626	409	401	387	634	539	638
University Hospital Kerry	159	30	148	12	69	81	34	118	76	125	89	232
University Hospital Limerick	223	42	188	199	237	269	319	924	499	558	710	699
University Hospital Waterford	n/a	n/a	19	69	64	148	110	102	352	289	306	420
Wexford General Hospital	294	86	112	159	34	348	127	273	42	194	94	163
Country total	**3,521**	**2,423**	**2,162**	**2,339**	**3,326**	**5,125**	**3,992**	**4,930**	**4,567**	**5,566**	**6,238**	**7,217**
NATIONAL TOTAL	**7,388**	**4,941**	**4,701**	**5,720**	**6,621**	**8,822**	**6,455**	**7,732**	**6,493**	**8,934**	**9,381**	**9,459**

Comparison with total figure only:

Increase between 2016 and 2017: 1%
Increase between 2015 and 2017: 6%
Increase between 2014 and 2017: 46%
Increase between 2013 and 2017: 22%
Increase between 2012 and 2017: 47%
Increase between 2011 and 2017: 7%
Increase between 2010 and 2017: 43%
Increase between 2009 and 2017: 65%
Increase between 2008 and 2017: 101%
Increase between 2007 and 2017: 91%
Increase between 2006 and 2017: 28%

Phil Ní Sheaghdha, INMO director of industrial relations,

Travel and subsistence rates review

A REVIEW of civil service travel and subsistence rates took place recently in accordance with section 2.28 of the Haddington Road Agreement. An Adjudicator ruling was issued in late 2016.

Following on from the agreement on subsistence rates in 2015, the public service trade unions engaged in a review of the methodology used to calculate motor travel rates. Motor travel rates are not intended to be a source of emolument or profit. They are intended to reflect the cost of both overhead and running costs of worker using his/her own vehicle for official purposes. The main factors taken into account in the revised methodology are:

- The average cost of a new car
- An assumption that the car is replaced every four years
- Insurance costs
- Car tax, based on the new CO_2 emissions bands
- Servicing and repair costs
- Fuel costs
- Replacement of tyres.

In apportioning the overhead costs the revised formula begins apportioning this cost after the initial 1,500km.

This is on the basis that it was considered that this better targets the overhead costs of purchasing and replacing a new vehicle every four years towards those public servants who are effectively required to fund the replacement of their vehicle due to the level of travel undertaken for their employer.

The recoupment in the first 1,500km in the new formula takes full account of all running costs including fuel, servicing and insurance. The point at which the 'cut off' should be applied was the subject of much discussion between the union side and the employer. Ultimately, it was decided that the matter would be determined by binding third party adjudication.

Under the previous regime, there were two distance bands.

Table. New civil service motor travel rates

Engine size		0-1,200cc	1,200-1,500cc	1,500cc & over
Band	Km range	Cents per km		
1	0-1,500	37.95	39.86	44.79
2	1,501-5,500	70.00	73.21	83.53
3	5,501-25,000	27.55	29.03	32.21
4	> 25,000	21.36	22.23	25.85

Under the revised formula, there are four bands.

The revised rates *(see Table)* reflect the finding of the adjudicator. While the rates in the first 1,500km have been reduced to reflect the restructuring, subsequent rates have been increased and there are significant advantages for members who need to use their cars more often on the business of their employer.

These new rates for travel apply from April 1, 2017 in the civil service. The INMO and other health sector unions met with the HSE and the Department of Health on March 28, 2017, seeking an update on implementation. Normally, the civil service rates are applied across the public service. The INMO does not have negotiation rights in the civil service and therefore was not party to these negotiations. The HSE advised that it is aware of the changes and is awaiting instructions from the Department of Public Expenditure and Reform.

Bereavement leave revised

In addition, bereavement leave in the civil service was recently revised and improved. The INMO and other health sector unions lodged the claim to have these revisions applied within the health service on March 28, 2017. The HSE is to revert to the INMO and other health sector unions. To view this policy, go to the quarterly industrial relations update on **www.inmo.ie**

New pay scales

Circular 06/2017 issued by the Department of Health on April 1, 2017 outlines adjustment to pay rates for certain public servants to include an additional payment from April-August 2017 inclusive, for those earning up to €65,000, the continued application of the €1,000 annualised payment from September 1, 2017 for those earning up to €65,000 and the first phase of pay restoration for public servants who were subject to pay adjustment under the FEMPI. New consolidated salary scales will be available on the Department of Health website, **www.health.gov.ie**

Revised Garda vetting procedures

THE INMO has been advised that new regulations (SI No 223 of 2016) have been issued across the public sector relating to the retrospective Garda Síochána vetting. These regulations state the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012 to 2016 provide a statutory basis for the vetting of persons carrying out relevant work with children or vulnerable persons.

The Act stipulates that a relevant organisation shall not permit any person to undertake relevant work or activities on behalf of the organisation, unless the organisation receives a vetting disclosure from the National Bureau of the Garda Síochána in respect of that person. The Acts define relevant work or activities as "any work or activity which is carried out by a person, a necessary and regular part of which consists mainly of the person having access to, or contact with, children or vulnerable adults".

The INMO and other health service unions met with the HSE on March 28 to agree protocol and procedures in respect of this new legal requirement. It was confirmed that:

- There is no charge applicable to this process for the individual
- Each individual not previously vetted, if deemed in the category of relevant work with Children and Vulnerable Persons (Section 21) will be required by their manager to have submitted the Garda Síochána vetting request no later than December 2017.

Currently, the INMO and other unions are negotiating the process. When finalised, agreed documentation will issue to the health sector management and members should note that they may, if not previously vetted, be requested to complete this process if they are determined to be covered by section 21 in their current role. For further details see the quarterly industrial relations update on **www.inmo.ie**

reports on current national IR issues

Issues progressed at WRC

THE INMO was in the Workplace Relations Commission during February and March for conciliation with HSE management on the following issues:

- Implementation of the emergency department agreement of 2016
- Application of the injury at work grant.

ED agreement

A review of the implementation of the 2016 ED agreement is being overseen by the WRC. Outstanding issues include:

- WTE nursing figures for admitted patients
- Advanced clinical role development
- CNM1 posts – full application
- Time in lieu – two days 2016/17
- Security reports – copies to be provided to the INMO
- Triage escalation policy – reviewed.

Injury at work

On March 16, 2017 the INMO and HSE management met at the WRC in relation to injury at work, specifically the application of the injury grant. The outcome from this conciliation included that the injury at work grant will be incorporated into the single scheme pension for new entrants, covered by that pension scheme.

It was also confirmed that the HSE's HR section, CERS, is in the process of developing advisory documentation, based on the pensions ombudsman determination, PO140920574, involving a claim taken by the INMO on behalf of a nurse member.

This clarified and confirmed that a person who is temporarily incapacitated and therefore out of work, resulting in their capacity to contribute to their own support being completely impaired, it was inappropriate to apply a degree of impairment in these cases. Therefore, the HSE will confirm that there is no requirement for a medical assessment of a person's degree of impairment in cases of temporary incapacity.

The HSE understands that the INMO is seeking a retrospective review of cases treated in a manner that varied from this judgement.

Safeguarding vulnerable adults

THE INMO, along with other nursing unions, has referred the matter of the HSE policy on safeguarding vulnerable persons at risk of abuse to the WRC for conciliation. Unions have raised issues on specific areas of the policy, including:

- Examination of the current definition of abuse, which differs from that in Trust in Care
- Peer on peer allegations
- Need to amend the safeguarding policy to reflect that the Trust in Care is the only agreed policy in place to investigate allegations
- Amendment of the safeguarding policy to ensure that only one preliminary screening is required and will satisfy requirements under both the Safeguarding and Trust in Care policies
- The procedure to be followed for residential and community services needs to be clearly set out and needs to reflect the different language used in Older Persons and Disabilities.

The WRC conciliation conference will take place on May 18, 2017.

Congress focus on gender pay gap

TO mark International Women's Day on March 8, 2017, the Irish Congress of Trade Unions launched **#BeBoldForChange** – its campaign to promote a more inclusive, gender-equal world of work.

According to Congress: "The World Economic Forum has predicted the gender gap will not be closed until 2186 – this is too long to wait". Congress has called for new, concrete measures to tackle the ongoing gender pay gap, after new figures showed Ireland sits only slightly ahead of the EU 28 average in overall earnings for women, and has failed to make major progress on closing the pay gap over recent years.

Among the measures called for by Congress are to make pay gap reporting compulsory for large employers, introduce mandatory action plans to close the gap, and sanctions for those who refuse to comply.

Analysis by Congress has revealed that the average woman has to wait nearly one-fifth of a year (66 days) before she starts to get paid compared to the average man. The current gender pay gap for all full-time and part-time male and female employees stands at 18%.

For more information on International Women's day, go to **www.internationalwomensday.com**

World news

Nurses and midwives in action around the world

Argentina
- Nurses camp in the centre of Neuquén over salary dispute

Australia
- NSW Nurses and Midwives Association calls on state government to improve nurse to patient ratios

Brazil
- At risk of wage cuts, nurses press Emanuel

Canada
- Region and Ontario Nurses Association ratify contract

Dominican Republic
- Puerto Plata nurses go on strike over deplorable conditions at the Ricardo Limardo Hospital
- Hospital nurses demand wage increase

Honduras
- Delayed salaries in Honduran health sector continue

Kenya
- Nurses and doctors at Busia Hospital threaten strike over unhygienic conditions

Mexico
- Nurses dismissed for denouncing crisis in the health system, they start a hunger strike demanding to be reinstalled

New Zealand
- Nurse assault sparks hospital staff safety fears
- Nurses spending their own money to help patients - union

Spain
- Unions demand more staff and space in the psychiatric area of the hospital

UK
- Nurses to be consulted on industrial action over continuing pay cap
- The fight for better pay goes on, RCN says
- Number of NHS nurses employed in Wales on the rise

Delegates at this year's ADC will consider a motion for the INMO to support the RCM in becoming a member of the Irish Congress of Trade Unions

INMO and RCM build closer ties

AS THE UK government attempts to negotiate its exit of the EU (Brexit), delegates to the INMO annual conference this year will consider a strengthening of the bond between the Royal College of Midwives and the Irish Nurses and Midwives Organisation.

The INMO and the RCM for the past 19 years have run an all-Ireland conference for midwives. The bonds between the two organisations and the friendly relationship have always been strong.

Over the years, the RCM has developed its trade union ethos and, as a result of its involvement in collective bargaining, has decided to affiliate to the various congresses of trade unions for the countries comprising the UK and for Ireland.

The RCM has already affiliated to the TUC of England, Wales and Scotland. In the case of Ireland, the Irish Congress of Trade Unions is a 32-county organisation and under a memorandum of understanding, which will be presented to delegates at this year's ADC, the INMO will support the RCM in becoming a member of the Irish Congress. By doing so, the co-operation between the two organisations can grow into a much greater partnership, whether or not Brexit happens.

The RCM is a world leader in terms of research and education for midwives. Through RCM i-learn, its members have access to free online courses and an e-portfolio system.

Under the proposed partnership agreement, INMO members will also have free access to the 80 courses provided on the RCM i-learn platform, including all of its updates and educational resources.

The INMO will pay a licence fee for this facility and access to the RCM library of 15,000 reports/conference proceedings and 600 journals. INMO midwife members will also have full access to the latest evidence-based guidelines, e-books and journals, the midwives' magazine and free online webinars.

The partnership agreement, if ratified by delegates at the INMO ADC, will represent a unique relationship between two independent trade unions in different countries and its value to the RCM may be even greater if Brexit proceeds.

Currently, both the INMO and the RCM are members of the European Federation of Midwives and the European Public Services Union. Although it is not entirely clear how Brexit will affect such representative roles, it is likely that UK-based representative bodies will no longer be able to participate fully at such European fora.

In such circumstances, the collaboration with the INMO will allow the RCM to keep up to date with European developments and on shared policies, and have a voice in Europe.

In the wider economy, there is much debate about the potential impact of Brexit on Ireland. The biggest fears seem to emanate from our agricultural sector, with the UK market being an important customer for the Irish food producing industries.

On the other side, there is growing evidence that commercial organisations and legal and banking firms are looking to Dublin and other large Irish cities as their European base, and, in a hard Brexit, Ireland might become a very attractive proposition for some other manufacturing or service industries.

The recognition by key European negotiators and the UK government of the special relationship between the Republic of Ireland and the UK, is an important start to the Brexit negotiations. In addition, the European investment in the peace process of Northern Ireland should prove significant assistance to Ireland achieving some special status for its relationship with the UK.

The agreement, if ratified between the RCM and the INMO, is a hugely positive development for midwives in the Republic of Ireland. It is further evidence of the INMO's vision and commitment to being the complete package for all nurses and midwives working in the Republic of Ireland.

– Dave Hughes, INMO deputy general secretary

Demand for reduced hours

The INMO has initiated engagement with HSE management at the University Maternity Hospital Limerick to address the excessive waiting time for midwives/nurses to access reduced working hours. Members who have remained at the hospital have been waiting for six years plus for access to reduced hours, while others have resigned their posts to take up part-time posts elsewhere.

– Mary Fogarty, INMO IRO

Final proposals on new Limerick ED

At a further meeting on April 7 between INMO representatives and HSE management under a process chaired by Janet Hughes as the external IR consultant, progress has been made on agreeing the management proposals on staffing and rostering arrangements for the new Limerick emergency department.

Other matters related to policies, security, risk assessment, etc. were scheduled to be notified to the INMO at a meeting with the project manager on April 10.

At the time of going to press the INMO had not received a proposal regarding the placement of admitted patients or the staffing arrangements.

It has been acknowledged within the Expert Group Review of Nurse Staffing Levels in Emergency Departments, undertaken following the national WRC ED agreement, that this cohort of patients was often the most complex with high dependency needs.

It will be essential therefore that the HSE secures in advance of a move to the new facility the dedicated nursing cohort on a specific roster for these patients.

A meeting of all INMO members will take place on **Monday, May 8 at 8pm in the INMO Office, Raheen** to discuss the full set of final proposals emanating from the HSE.

All available members are requested to attend this important meeting.

– Mary Fogarty, INMO IRO

Operating Department Nurses Section – 50 years and still strong

Celebrating 50 years of advocating for operating department nurses

THE growing complexity of problems arising for operating theatre nurses prompted the formation of the INMO Operating Department Nurses Section, the inaugural meeting of which was held on March 5, 1967. The first officers elected were Frances Flynn, Maureen O'Rourke and Cecily Normoyle.

International profile

The ODN Section has a high international profile and its members are well represented in the European Operating Room Nurses Association (EORNA), including a founding member, Anne O'Callaghan and laterally Caroline Higgins, who served as president of the EORNA for two terms.

Irish nurses have been recipients of several top EORNA awards including Elizabeth Adams, INMO director of the professional development, who won the first Klinidrape EORNA Perioperative Nursing Foundation Award.

The ODN Section was honoured to host the fourth EORNA Congress, which was held in Dublin in 2006. This Congress saw the highest number of delegates recorded at any EORNA Congress.

Irish nurses representing us in EORNA developed a number of position statements and Guidelines for Perioperative Nursing Practice Part 1 to enable member countries to have common guidelines for safe patient care.

Issues

Many different issues pertaining to perioperative nurses were raised over the decades, including standby and on-call allowances, location and qualification allowances, payments to night superintendents, the establishment of the role of theatre superintendent, cleaning services for theatres, skill mix in operating theatres and more recently, the role of the operating department practitioner.

Today, many issues remain. The role of the perioperative nurse is complex, requiring skill and specialist nursing and technical knowledge across all specialties, to ensure a safe surgical journey for patients. This should be adequately remunerated. As Brid O'Brien (2012) postulated, perioperative nurses demonstrate a special skill known as "anticipatory vigilance" which is a skill unique to nurse training, and of huge significance to patient safety..

In happy mood at inaugural meeting of Operating Theatre Nurses' Section, left to right: Miss Frances Flynn, Chairman, O.T.N. Section—County Hospital, Sligo. Miss Maureen O'Rourke, Vice-Chairman, O.T.N. Section—Sir Patrick Dun's Hospital. Miss Margaret M. Brophy Information Officer, Irish Nurses' Organisation. Miss J. Eames, R.G.N., Adelaide Hospital, Dublin, 3.

Section activity

In May 1967, following representations by the (then) INO, refresher courses for operating theatre nurses were organised by An Bord Altranais. The Section's first seminar was held in May 1984 in the Mater Hospital in Dublin, which has since evolved into the very successful annual conference.

The Section has produced and supported a wide range of publications, policies and guidelines for perioperative nurses, ranging from the 1990 document on *Safety and Health in the Operating Theatre* up to the 2011 position statement on the role of the operating department practitioner in theatre.

The first study of the implementation of the safe surgery checklist in the world was produced by the INMO in 2010.

As the Section moves into the next 50 years, their mission continues and the ODN Section encourages members to become more involved, to share their passion and expertise to strengthen the role of ODNs, to ensure the survival, expansion and quality of what is a specialist and essential nursing presence in operating departments.

We are envied the world over for maintaining the nurse's role as the registered care giver in the operating department.

ODN conference 2017

This year's conference commenced with Dr Una Geary discussing current perspectives on healthcare quality and safety – a topic highly relevant to ODNs in this era of audits.

The first day of the conference concluded with a section

AT THE INAUGURAL MEETING OF THE O.T.N. SECTION (front row): Miss C. Normoyle, newly elected Hon. Secretary of the Section, Mrs. M. Lambert, Theatre Sister, Meath Hospital, Miss S. McCarthy, Theatre Staff Nurse, G.U. Unit, Meath Hospital, Miss Mgt. Reidy, Nursing Officer, Department of Health, Miss Julia O'Brien, Theatre Staff Nurse, St. Brendan's Hospital, Dublin.

our environment for lint causing materials. Lint particles can cause blood clots, amplified inflammation, poor wound healing, risk of dehiscence, excessive scaring, damage to visual acuity, granulomas, adhesions and infections.

The final session of the conference was opened by Dr Olwyn McWeeney, barrister at law. Legal issues are a constantly requested topic and Ms McWeeney outlined the principles of negligence, the duty of care, expert opinion, general approved practice, and the importance of maintaining accurate clinical records. Examples of Irish cases including theatre incidents were also presented.

Dr Wava Truscott followed with a detailed presentation on the trauma patient and their needs through the various stages of trauma.

The final speaker, Corinne Hutton, a sepsis survivor and quadruple amputee, enthralled the audience with her story of how a simple cold led to her current situation.

She described her thoughts and feelings through her long and arduous hospital journey. She went on to describe how she set up her charity Finding your Feet, which exists to support fellow amputees and to raise awareness of limb difference and the need for public awareness. She received a standing ovation at the end of her very inspirational address.

The conference closed with the presentation of awards for the scientific poster competition, which was sponsored by Teckno Surgical.

The Section extends its congratulations to all who entered, the standard was extremely high.

meeting followed by a celebratory dinner to mark the 50-year anniversary.

Previous Section officers who have contributed greatly to the ODN section over the years, as well as INMO president, Martina Harkin-Kelly and Elizabeth Adams, INMO director of professional development, were all in attendance.

The second day of the conference began with president, Martina Harkin-Kelly addressing delegates on where we have come from and where we are going.

Prof Donal Brennan gave a talk on the evolution of laparoscopic surgery. This very interesting lecture looked at surgery past and present, the studies into the benefits of laparoscopic surgeries, both from a patient benefit point of view and a cost benefit.

Dr Gerard Colleran gave an extremely well received presentation on microbiology, giving delegates a very real insight into such infectious agents as *C. diff* and CRE etc. Perioperative nurses have always been alert to the need for sterility and for preventing contamination and cross infection and considering recent publications by the HSE in relation to the decontamination of semi-invasive and non-invasive probes, this topic was very timely.

A presentation from Dr Wava Truscott relating to the consequences of lint particles in the operating theatre, gave a fascinating insight into the problems this can cause, and included simple ways to test

50 years of the INMO ODN Section: *(opposite page top) A photo from 1967 showing members of the then OTN Section; (bottom left) Elizabeth Adams, INMO director of The Richmond Education and Events Centre, and Margaret Begley, then theatre sister in the Cardiac Theatres of the Mater Hospital in the 1980s. (This page top left) INMO president Martina Harkin-Kelly with Elizabeth Adams at the 50th Anniversary celebration; (top right) A photo taken at the inaugural meeting of then OTN Section some 50 years ago; (second right) Caroline Higgins, Sandra Norton and Liz Waters; (third right) Caroline Higgins addressing the EORNA Congress in Rome in 2015; (bottom right) Sandra Morton, Allison O'Connell, Teresa Herity, Martina Harkin-Kelly, Audrey Al-Kaisy, Liz Waters and Monica Griffin, all from the Operating Department Nurses Section*

Addressing nursing care rationing

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

IN 2016 the INMO funded research into missed care in community nursing with Dr Amanda Phelan, University College Dublin as principal investigator. The EU have also funded further work in the area of missed care through the EU COST projects. The launch of the COST *Rationing - Missed nursing care: An international and multidimensional problem* took place in September 2016 in Brussels.

The RANCARE Action includes participants from 32 countries (EU and international) from across disciplines including nursing, psychology, philosophy, ethics, health economics and health management. Ireland is participating in the action through the School of Nursing and Human Sciences in DCU and the School of Nursing, Midwifery and Health Systems at UCD. Dr Marcia Kirwan (DCU) and Dr Amanda Phelan (UCD) represent Ireland on the management committee of the project.

Rationing of nursing care occurs when resources are insufficient to provide necessary care to all patients. This may be a result of reduced staff numbers, skill mix variation, increased demands for care or a changing patient profile. It is a result of decision making by clinicians who are faced with reduced resources while striving to provide care and often involves choices that affect care delivery and patient safety.

There is increasing evidence that the prevalence of rationing of nursing care is high in acute care hospitals internationally and that it is consistently associated with negative patient, nurse and organisational outcomes.

The Rationing of Care (RANCARE) action aims to facilitate discussion about rationing of nursing care based on a cross-national comparative approach with implications for practice and professional development. This will be achieved by advancing collaboration and networking, and exchange of expertise and knowledge at both European and wider international levels and by integrating different disciplines and approaches including nursing, ethics and healthcare studies in general and economics and social policy.

The activities of the RANCARE Action will be run via four working groups and two horizontal committees that will oversee the various activities planned during the four-year lifetime of the project. Each working group will focus on a different area:

- Conceptualisation, organisational and methodological issues (working group one)
- Evidence-based interventions and designs (working group two)
- Ethical dimensions of rationing of nurse care (working group three)
- Educational issues and training (working group four).

The expected outcomes include advancing the knowledge of how care is being rationed, the factors contributing to this phenomenon and the development of policies that aim for the delivery of safe care to patients.

The first RANCARE conference of the COST action took place in Limassol, Cyprus in February 2017. Some 80 healthcare professionals from 31 different countries from Europe, the US, Australia and New Zealand participated in this multidisciplinary conference. The participants were representing 27 countries from the EU and seven universities from the aforementioned countries.

During the conference, nurse academics and researchers addressed the challenges of nursing care rationing during a scientific programme which included 19 presentations. The conference provided the opportunity for the participants to build relationships and to disseminate knowledge and leadership across disciplines and countries.

It also facilitated the debate between academics and clinicians on the conceptualisation of the care rationing phenomenon, the methodological challenges and the outcomes of nursing care rationing on patient safety and quality of care.

The conference concluded with the announcement of the strategies for the exploration of the several aspects of the phenomenon through developing a joint teaching and research agenda. The

RANCARE Action will also provide the opportunity to young researchers to participate in short-term scientific missions and a training school related to methodological, organisational and ethical issues associated with rationing of nursing care. The final conference of the RANCARE Action will take place in DCU in 2020.

Full details on the RANCARE Action, the membership and working group details, the short-term scientific missions and the training schools can be found at **www.rancare-action.eu/**

Further information is available from marcia.kirwan@dcu.ie or amanda.phelan@ucd.ie

ICN Congress 2017

The International Council of Nurses (ICN) 2017 Congress will be held in Barcelona from May 27 to June 1, 2017.

The ICN has worked in partnership with Prof Dr Máximo A González Jurado, president of the Spanish General Nursing Council, and his team to deliver one of the largest dynamic and innovative congresses for nursing globally. The theme is 'nurses at the forefront – transforming care'. Details of the scientific programme and themes to be addressed are available at **www.icncongress.com**

The plenary sessions will be dedicated to exploring the theme, with particular focus on the sustainable development goals, human resources for health, universal health coverage and safe staffing. Featured main sessions will offer the most recent expertise on patient-centred healthcare, evolving scopes of practice, climate change, infectious as well as non-communicable diseases, mental health, migration, human rights, patient safety, policy, technology, leadership, education and history. Themes for abstract submissions (concurrent sessions, symposia and posters) will address these issues plus developments in healthcare systems, health promotion, nursing workforce, disasters and regulation.

The Congress will also be the venue for ICN network meetings. Registration is now open on the Congress website at **www.icncongress.com**

Elizabeth Adams is INMO director of professional development

European Federation of Nurses Associations general assembly

INMO president Martina Harkin-Kelly and I attended the EFN general assembly which was held in Malta at the end of March. Established in 1971, the EFN represents over four million nurses across 34 European countries represented by national nursing associations. The assembly was attended by 27 members, with three in proxy which equals a voting capacity of 30 members out of 34 countries.

As a member of the EFN, the INMO is central to a number of significant projects and policy developments. Issues concerning health, patient care, mobility of health professionals, education, technology and health funding continue to be central to the EU debate and the culmination of these debates result in legislation which all member states have to implement. It is therefore imperative that the EFN, in representing 34 EU countries' national nursing associations, is strengthened and empowered to influence the EU political agenda, particularly in the current economic climate.

The EFN Executive Committee is made up of seven members – president, vice president (Elizabeth Adams), treasurer and four delegates elected by the EFN members' national nurses associations. The Committee meets at least twice a year, between each general assembly, to discuss key issues for the EFN, to prepare recommendations for the general assembly and to follow up on the general assembly decisions.

The EFN general assembly at the end of March covered a number of key issues in the assembly and through their three sub committees – Workforce Committee, Professional Practice Committee and Public Policy Committee. The main topics and items discussed included:

- Implementation of the EFN Strategic and Operational Lobby Plan 2014 – 2020
- Research on measuring compliance with the Directive 2013/55/EU which was to be transposed into national legislation by January 18, 2016. Many member states have not transposed the Directive into national legislation yet and are far from translating Article 31 into the nursing curricula.

The European Commission will make an assessment of the new/amended national legislations and will plan infringement procedures if necessary. It is within this context that the EFN is planning to measure the (non-) compliance with the Directive based on an online questionnaire with a set of legal/professional questions.

At the EFN Madrid GA a revised EFN Matrix 3+1 definitions and qualifications sections was presented by the Working Group on Specialist Nurses and Advanced Roles. The working group met online three times and came up with a concrete proposal of amended definition and qualifications' sections of the Matrix 3+1.

The working group also included a principles section, which describes the differences between specialist nurses and advanced nurse practitioners. The EFN general assembly reviewed the documents within the three committees and were endorsed by the general assembly.

The general assembly also included discussion and presentation by the directors of the European Nursing Research Foundation and the governance framework within the Constitution and Internal Regulations.

The European Commission agenda on Skills – the *New Skills Agenda for Europe* was launched at the assembly and the meeting was informed that a blueprint for sectoral co-operation on skills that the EFN had been asked by the European Commission to engage in is being developed.

The following draft policy statement and position papers were discussed:

- EFN policy statement and position paper on nurses' liability and indemnity in the context of changing roles and demands of nurses and the need to protect and understand the issues
- EFN policy statement and position paper on robotics in nursing in the context of artificial intelligence
- EFN policy statement and position paper on the value of health and social care ecosystems.
- EFN policy statement and position paper on public health virtual coaching.

The next meeting of the general assembly will take place in September in Brussels. Further information is available at **www.efnweb.be**

Q and A Bulletin Board

With INMO director of industrial relations Phil Ní Sheaghdha

Query from member

I heard that rules around compassionate leave have changed. Is this true and if so what changes have been made?

Reply

Bereavement leave in the civil service has recently been revised and improved. The INMO and other health sector unions lodged the claim to have these revisions applied to all health sector employees on March 28, 2017. The HSE is to revert to the INMO and other health sector unions on this matter. Please access our quarterly industrial relations update at **www.inmo.ie**

Query from member

I currently work as an RGN in the community and work weekends. The health centre is closed and I have always claimed mileage from home during weekend cover. My DPHN has now advised me of changes in respect of this, and has requested that I claim from the health centre, even though it is closed. Should I contact my IRO or is this an issue that I have leeway in?

Reply

This is an issue that is coming up frequently and it would appear that different interpretations of a Revenue circular are emerging in different areas of the HSE. The INMO referred this matter as a national issue requiring agreement and a meeting was held on Friday, March 24 with the HSE financial personnel and HR. Issues discussed included the implications in relation to revenue of claiming mileage for planned essential calls, grades of PHN and community RGNs at weekends and the revenue/audit implication for fixed rate mileage, which is the method of application of payment for urban areas. The HSE's concern relates to the possible revenue implications regarding mileage from home to first call and from last call to home when base is closed at weekends.

The INMO position is that home is the base as per the circulars regarding weekend working. In addition, PHN/RGN and palliative care nurses interact with clients from home by phone, giving advice, advising on preparation to undertake prior to the visit etc. As the health centre is closed, home is the only base at weekends.

It was agreed that the HSE and the INMO will meet with Revenue and seek a clear direction in respect of their requirements of the HSE as an employer, which has to maintain compliance with national revenue rules. In the meantime, you should contact your INMO official who will be aware of this issue and they can advise your director of public health nursing in writing in respect of this national process and request that no changes are made until the national process has concluded.

Know your rights and entitlements

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

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

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

Lessons to be learned

Edward Mathews discusses a recent long-running fitness to practise case where an NMBI decision to strike off registrants was quashed by the High Court

EARLIER this year Justice Ní Raifeartaigh in the High Court delivered an important judgment where two nurses, subject to a decision by the Nursing and Midwifery Board of Ireland (NMBI) that their name be erased from the Register, were successful in quashing that decision on the basis that the NMBI had insufficient regard to mitigating factors in the case.

The case arose out of the death of a service user in 2006, and the actions and omissions of the nurses thereafter. The matter did not come before the Fitness to Practise Committee (FTPC) of the NMBI until some nine years later, and following a hearing the Committee recommended that the nurses be censured, ie. be subjected to the severest form of written warning. Later the NMBI recommended that the sanction be increased to erasure from the Register. The subject of the appeal did not challenge the findings of the Fitness to Practise Committee but instead the sanction proposed by the NMBI.

While several issues arose in this appeal the theme of interest is the nine-year delay in the proceedings and the effect of this, alongside the role of mitigating factors, in deciding on a sanction. The facts giving rise to the hearing occurred in June 2006 and the director of nursing brought the matter to the attention of the NMBI in August 2006. Various exchanges of correspondence took place and in May 2007 the FTPC decided that a full inquiry should take place.

Delay

It then took three years for the NMBI to issue the nurses with the papers associated with the inquiry. An attempt was made by the Board to explain this period of delay under various headings; the complexity of the case, the reticence of the Board to use its powers to compulsorily acquire documents and the necessity to compile comprehensive documentation ahead of a hearing. The High Court was not persuaded by these arguments and noted that for an entire year no action appeared to have been taken in the case, save one letter issuing, and overall found that the time lapse was excessive and that the NMBI was entirely responsible for the delay. This brought the matter to May of 2010.

Between May 2010 and March 2015, when the Board's final decision was communicated to the nurses, there were a number of developments, including; adjournments at the request of the nurses, a nine-month duration for 10 days of hearing, a threatened court case in relation to the Committee's findings, a Board meeting where the issue of sanction was considered and a period between two Board meetings where the parties were exchanging correspondence and dealing with issues. These periods of time, while clearly extensive in so far as almost five years elapsed, were not regarded as blameworthy on the part of the NMBI and the Court generally found the time periods understandable given the specific facts of the case. However, this then brought the matter to March of 2015 where the NMBI informed the nurses that they had considered the findings of the FTPC and had reached a decision.

Finding

The FTPC had found that both nurses had engaged in professional misconduct, albeit that they also found that a number of allegations were not proven. Often the FTPC makes a recommendation as to the appropriate sanction which should follow such findings and in this case recommended the both nurses be censured.

While the Committee recognised that there had been serious failings, they also had regard to the fact that they were faced with a singular incident, that there was no local policy governing the response to unexpected deaths and both nurses had shown insight at the inquiry in terms of the inadequacy of documentation following the death of the resident.

Sanction

When the FTPC makes a recommendation as to sanction this is then considered by the NMBI which is empowered ultimately in terms of which sanction it determines is appropriate and, in some cases, which sanctions it brings before the High Court. In this case, the Board decided that the sanction should be increased to erasure from the Register considering that; the seriousness of the misconduct was at the upper end of the scale, the conduct would undermine the reputation of, and public confidence in, the profession and generally that not disclosing, or withholding, information was very serious. Arising from this determination both nurses applied to the High Court seeking cancellation of the decision of the NMBI.

The High Court was called upon to consider a number of legal points in deciding how it should approach a review of the sanction decided upon by the NMBI. While the detail of the analysis of the judgment is welcome, the same detail forbids extensive analysis here, save to say that the Court concluded that it should not disturb a determination of the NMBI unless the sanction proposed was clearly disproportionate or arrived at in a manner that was not legally sound. In reaching this conclusion the Court also had regard to pre-existing case law which points to factors relevant to the determination of sanction, which include; seriousness of the conduct, deterrence to others, protection of the public and leniency to the registrant in terms of mitigating factors. The first

three of these factors are interrelated, and it is to the Court's consideration of those that we now turn.

In approaching the interrelated matters of seriousness, deterrence and public safety as related to the type of conduct that would justify erasure from the Register, the Court considered another High Court case involving a nurse where that nurse was shown to be incompetent in terms of basic nursing care, this had affected patients, she had been dishonest and had shown no insight or willingness to admit wrongdoing. The facts of the current case were quite different in that the findings of the FTPC had been accepted and the Committee had commented on the insight shown by the two nurses.

Proceeding to consider cases involving doctors, it was noted that certain cases had considered serious deficiencies in the standard of care yet had not countenanced erasure. However, importantly the Court conceptualised the significance of this case as resting on the issue of failing to disclose information and the significant breach of trust arising. This coupled with deficits in care caused the Court to conclude that they agreed that the misconduct in question fell at the upper end of the scale. The Court concluded that the misconduct was of sufficient seriousness, and the question then fell to be decided with reference to the fourth factor in deciding any sanction, the leniency to be displayed considering the mitigating factors in each case.

Mitigation

The first mitigating factor was the delay issue. Importantly, the Court recognised that delay raises issues of fairness for registrants whose professional and personal affairs may be affected by the ongoing process. Furthermore, the Court accepted that delay can be a relevant mitigating factor in terms of the sanction to be imposed. In terms of what delay should be considered, in this case, and indeed relevant for other cases, it is blameworthy delay on the part of the NMBI which is the relevant consideration, that being the first four years in this case. The Court was critical of the Board's letter indicating the decision as it did not refer to delay, just general mitigating factors. In light of the degree of submissions received by the Board on the matter, the Court was of the view that the delay should have been referenced in its reasoning. Ultimately, the Court could not be satisfied that the issue of delay had received appropriate attention by the NMBI when determining the ultimate sanction.

The Court then turned to the mitigating factors included in the FTPC report, namely; a once-off incident, the absence of a policy dealing with responses to unexpected deaths and the insight shown by the registrants. Again, the Court was critical of the NMBI's reference to mitigation in its letter of determination where it referred generally to mitigating factors but not, as mentioned, to delay, nor to the individual issues referred to by the FTPC. The failure to particularise these matters led the Court to conclude that they may not have been given sufficient weight when the Board reached its conclusion. Specifically, the NMBI had indicated in correspondence that the seriousness of the misconduct was not in any way lessened by being a once-off incident. The Court concluded this was an error on the part of the NMBI, and that the Board should have taken into account that neither nurse had been accused of professional misconduct previously, nor was their behaviour part of a pattern of continuing conduct.

The Court also concluded that the issue of insight was highly relevant both in terms of the potential for rehabilitation of a professional and as to the likelihood of whether there would be a re-occurrence of the type of conduct in question. On this point the NMBI had submitted that it was open to a person erased from the Register to apply for restoration at a later date. The Court rejected this submission and clearly indicated that insight is a relevant mitigating factor, relating to the state of mind of the nurse in relation to what occurred, which must be considered when contemplating the ultimate sanction of erasure.

On the final factor, the absence of a hospital policy dealing with unexpected deaths, the Court agreed that this was a relevant consideration. The Court uses the term 'corporate context' to describe the background against which the misconduct occurred and felt this context was relevant to the level of culpability of the nurses – as distinct from insight which related to their state of mind. While the Court accepted that the NMBI may have been of a different mind to the FTPC as to the relevance of, or weight to be attached to this factor, again the absence of any reference to the issue specifically in the Board's determination left the Court at a loss to understand the consideration, if any, given to the issue in reaching its decision.

Overall the Court regarded the NMBI's communication of its decision as deficient in that reference was not made to the mitigating factors considered, however, the Court went further and considered the various submissions made at the Board meetings considering sanction. In light of those submissions, and bearing in mind the ultimate decision communicated with associated correspondence, the Court concluded that the Board did not structure its thinking appropriately when arriving at a sanction. Instead it placed too great an emphasis on seriousness, deterrence and public protection while, at the same time, failing to discuss, consider and give sufficient weight to potential mitigating factors.

Resolution

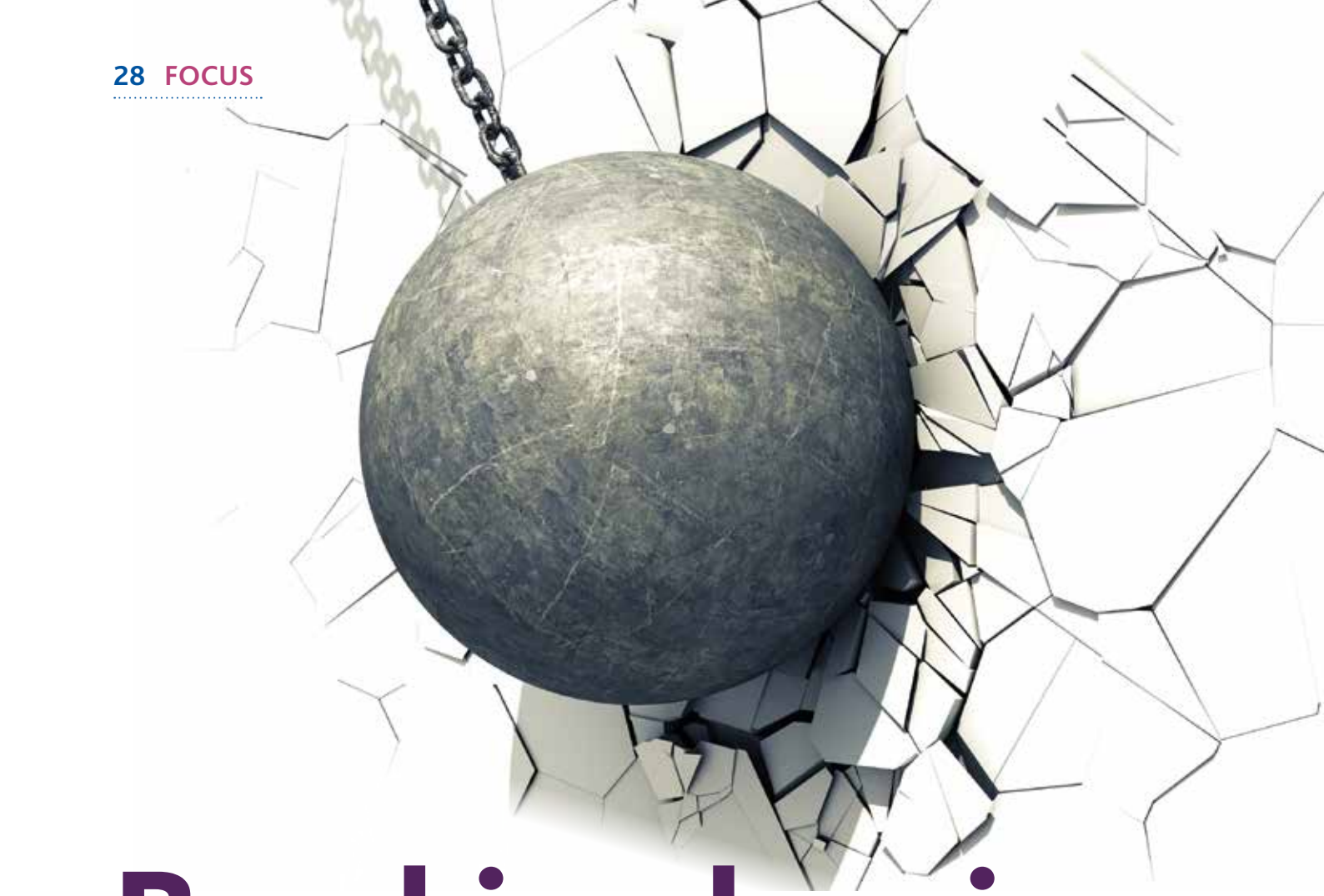
In terms of how the matter was to be resolved, the Court found itself in a quandary in that the legislation did not allow it impose an alternative sanction, and instead the decision to erase the nurses from the register was quashed, and the matter sent back to the NMBI to be considered afresh, bearing in mind the appropriate factors to be measured in deciding on sanction and the advice as to the necessity to consider sufficiently, and explain adequately, the role of mitigating factors in the ultimate decision reached.

This is a most significant judgment in many respects. First it points to the necessity for the NMBI to be aware of its duty to registrants in ensuring that unnecessary delays do not occur. This is an area where some improvements have been made, but notable examples of inexplicable delay still do arise.

Further, it is welcome as to the role of mitigating factors, the necessity for these to be given adequate weight and the requirement that sufficiently detailed reasons be given to understand the approach of the Board. The brevity of reasons provided remains a significant concern and it continues to be difficult in some cases to explain why the Board reached a particular decision.

Finally, and while not addressed in substance in this summary, there are important observations in the judgment in relation to the drafting of allegations and the way FTPCs draft their findings. The manner in which the Board presents allegations to nurses and midwives is confusing, embarrassing, unduly onerous, and is a source of waste in terms of time, resources and the stress it occasions. We have, and continue to support effective regulation of our professions, but improvements can be made without sacrifice and we will use this judgment in seeking to move the Board toward a more streamlined and effective regulatory regime.

Edward Mathews is INMO director of regulation and social policy



Breaking barriers to breastfeeding

The reasons for Ireland's low levels of breastfeeding are complex. However, there are ongoing initiatives that are helping to improve the situation, writes **Catherine Carroll**

EARLIER this year, the *Lancet* published a comprehensive review of breastfeeding. It covered, in detail, the short and long-term health consequences for infants and mothers related to not breastfeeding and the clear evidence supporting these facts.[1] Supporting mothers to initiate breastfeeding, breastfeed exclusively and breastfeed for longer durations will help reduce the rates of these illnesses and the associated economic costs. It is important for all healthcare professionals to support the HSE guidelines on breastfeeding, which recommend exclusive breastfeeding for six months, followed by the introduction of suitable complementary foods, with continued breastfeeding until two years of age or beyond.

Current breastfeeding rates

The National Perinatal Reporting System has shown that the proportion of infants experiencing any breastfeeding at discharge from Irish maternity hospitals has increased from 38% to 46% over the time period from 2000 to 2009. However, Ireland still has one of the lowest breastfeeding rates in the world with rates much lower than our nearest neighbour the UK (76%), or Sweden (over 90%).[2]

The data from the Maternal Health Behaviours and Child Growth in Infancy Report from the Growing Up in Ireland (GUI) study found that 56% of women breastfed their child to some extent.[3]

Of note, the report found that Irish women were less likely to breastfeed compared to women of all other nationalities who give birth in this country. Another interesting finding on nationality was that the male partner's nationality was related to the mothers' decision to breastfeed. The odds of breastfeeding increased by 42% where the male partner was not Irish.

Why women chose not to breastfeed

The main reason found for not breastfeeding in the GUI study was the reported belief that formula feeding was 'preferable' for 49% of women. The next two most common reasons were 'inconvenience/fatigue' at 17% and 'difficulty with breastfeeding techniques' at 8%.

Only 5.6% of mothers in this study reported 'embarrassment/social stigma' as the reason why they chose not to

breastfed. Women less than 25 years of age were more likely to report this as the reason for not breastfeeding compared to women aged 35 years or older (9.7% versus 3.4% respectively). This finding is at odds with other Irish studies which have shown much higher rates of women expressing embarrassment around breastfeeding.[4]

Why women stop breastfeeding

The most common reason for breastfeeding cessation given in the GUI study was the belief that the mother did not produce 'enough milk' or that she had a 'hungry baby' (36%). The second most common reason was that the mother planned to stop at this point (22%), followed by inconvenience/fatigue (17%).

Many mothers (25%) reported either difficulty with breastfeeding techniques or sore nipples/engorged breasts as other reasons for stopping. The woman's level of parental stress was also a significant predictor of quitting; each unit increase in stress increased the odds of quitting by 1%.

Women in the GUI study were less likely to stop breastfeeding if they made it through the first month. After this point, the likelihood of stopping falls by around 50% and remains at this level. The likelihood of stopping increases sharply again at six months of age. This change could represent the effect of reaching the end of the standard period of maternity leave. This finding would concur with other research which has found that length of maternity leave is positively associated with duration of breastfeeding and returning to full-time work outside the home is associated with reduced duration of breastfeeding.[5]

Women of older age, higher income, education and social class were also much more likely to breastfeed and tended to breastfeed for longer. A lower number of previous children was also associated with a higher probability of breastfeeding and a longer duration of breastfeeding. The effect of a number of previous children was confined only to those with three or more previous births.

Supporting breastfeeding

There is extensive evidence to show that children born in hospitals accredited under the WHO's Baby-Friendly Hospital Initiative are more likely to initiate breastfeeding and to be breastfeeding at discharge from hospital following the birth.[5] Only nine of the country's 19 maternity hospitals are fully accredited at present. The data from the GUI study demonstrated that children born in Baby-Friendly Hospital Initiative-accredited hospitals were 11% more likely to be breastfed than children born in non-accredited hospitals.

A Cochrane review published in 2012[6] found that a combination of professional and lay/peer supporters is effective in increasing the duration of any breastfeeding and the duration of exclusive breastfeeding. Recent research in Ireland has also shown that first-time mothers depend on healthcare professionals for breastfeeding support.[7]

Of the top five reasons given for stopping breastfeeding in the GUI study, four were concerns that could be easily addressed by healthcare professionals. The HSE has developed an excellent website, **www.breastfeeding.ie**, which has factsheets available to download, videos and a list of HSE publications on breastfeeding, which would help guide a breastfeeding mother should she mention any of these issues in a consultation. There is also a list of useful websites where one could direct the mother for further peer support, eg. Cuidiú, La Leche League, Friends of Breastfeeding.

Keeping women breastfeeding past the first month helped women breastfeed for longer as identified by the GUI study. Early postnatal checks may be key opportunities for healthcare professionals to offer effective support to mothers to enable them to continue to breastfeed.

The *Lancet* series describe how essential breastfeeding is for building a better world for future generations in all countries, rich and poor alike. Healthcare professionals are well placed to support the breastfeeding mother-infant dyad by offering consistent advice and support that is practical and individualised to their needs.[7] There are many resources now available for healthcare professionals to achieve this in a professional capacity or to direct breastfeeding mothers to for peer support.

Table 1: Reasons for stopping breastfeeding (ranked by frequency) given by mothers who had initiated breastfeeding

Reason	%
Not enough milk/hungry baby	36.2
Planned to stop at this time	22.2
Inconvenience/fatigue	16.9
Difficulty with breastfeeding techniques	12.7
Sore nipples/engorged breast	12.1
Formula feeding preferable	8.5
Baby weaned himself/herself	7.2
Mother's illness	6.7
Returned to work	6.4
Physician told mother to stop	2.8
Baby's illness	1.7
Embarrassment/social stigma	1.6
Wanted to drink alcohol	1.2
Other children at home	1.0
Partner/father wanted mother to stop	0.5
Lactose intolerance	0.4
Baby got teeth	0.4
On medication	0.4
Going on holidays	0.4
Mother became pregnant	0.3
No support from nurses	0.3
Twin birth	0.2
Other children not breastfed	0.2

Catherine Carroll is a senior paediatric dietitian at Our Lady's Children's Hospital, Crumlin

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Introducing Executive Council members

Anne Harney

Nurse manager/CNM2, St Hilda's Services, Athlone, Co Westmeath

I am delighted and honoured to have been elected to the Executive Council for the 2016-2018 term.

I trained as a general nurse in Jervis Street Hospital and nursed for two years post-registration in the National Renal and Transplantation Unit. I was there for the closure of Jervis Street Hospital and the opening of Beaumont Hospital. I escorted the last patient to have renal transplantation surgery performed in Jervis Street as part of an ambulance convoy to Beaumont.

I completed my midwifery training in the Rotunda Hospital. My nursing experience includes working in the paediatric/NICU in Portiuncula Hospital for five years. I worked as a practice nurse in a GP practice in the student health clinic in Athlone and also in the Athlone Institute of Technology.

I also worked in the community as a relief PHN for three months. I started nursing in the ID area in 2000 and was promoted to nurse manager in 2005.

I hold an honours degree in healthcare management, a masters in child and youth care and I also completed a certificate in nurse prescribing in the RCSI.

I am a long-term member of the INMO and of the Athlone Branch. I have been the INMO rep for St Hilda's Services since 2007. I served for three years on the Standing Orders Committee with the INMO and retired last year to join the Executive Council.

I have gained a wide range of nursing experience throughout my career and value the nursing and midwifery roles.

I am committed and dedicated to ensuring nurses and midwives are valued in their role and are given parity with all other healthcare professionals, which is long overdue.

Maria Hernandez

Staff nurse, St Columcille's Hospital, Loughlinstown, Dublin

I graduated from Unciano Colleges Manila, Philippines with a bachelor of science in nursing in 1995 and passed the Professional Regulation Commission licensure examination that same year.

I have worked as a staff nurse in St Martin de Porres Charity Hospital and The Medical City in Metro, Manila.

I came to Ireland in September 2001 and did my adaptation training in Tullamore Regional Hospital for six weeks. Immediately after, I started working in St Columcille's Hospital in Loughlinstown, Co Dublin.

I have been a member of the INMO since November 2001. I became a rep in August 2013 and have been active since. I am the chairperson of the Dublin East Coast Branch. As a rep, I have represented members in different issues in our hospital including changes made in roster, ED and ICU reconfiguration, calculation of sick leave and compassionate leave, assault at work, etc. I meet the hospital management team on a regular basis to address staffing and any of our members' issues. I am very much involved in the Taskforce on Staffing and Skill Mix Local Implementation Group in St Columcille's Hospital, where coincidentally the ward I am working on is the pilot ward.

This is my first time on the Executive Council and I will endeavour to work for better working conditions, better working hours and pay for all nurses and midwives. As a victim of bullying, I will fully support zero tolerance against bullying in the workplace. I will also be an advocate for the reps. Local reps play a big role in recruiting, leading, supporting and informing our members. Members find it helpful having someone in their own workplace to give support and advice.

Eileen Kelly

CNM2, Sacred Heart Hospital, Roscommon, Co Westmeath

I completed my general nurse training in 1994, having graduated from Beaumont Hospital School of Nursing. I work as a CNM2 in the Sacred Heart Hospital, Roscommon. Prior to this, I worked as a community RGN.

I am an active member of the INMO and have been a workplace rep since 2001. I have been secretary of the Roscommon Branch for the past number of years and this is my third term on Executive Council.

My position on Council has given me the opportunity to bring forward members' issues to a national platform. Times have been extremely challenging with difficult decisions often unfolding. But I believe that as long as nurses and midwives continue to vocalise their right to a decent wage and continue to seek suitable conditions and appropriate remuneration for education,knowledge and skills, then the future of nursing and midwifery as professions in this country will be greatly protected.

I will continue to represent members at local and national level by speaking out in the media, spending long hours travelling and going to meetings and being available for members when they need support. I will also continue to engage in dialogue and work to resolve issues, ensuring members are represented successfully and encouraging them to protect and safeguard themselves in the hostile work environments they find themselves in.

I will also continue to meet with senior INMO management officials , local and national government officials and relevant stakeholders in order to achieve the best possible outcome for nurses and midwives.

Managing acute cough in children

In the latest clinical update in this series, **Nina Thirlway** and **Gerry Morrow** examine cough with chest signs in children

ACUTE cough with chest signs in children can be caused by a number of different conditions including viral-induced wheeze, infective exacerbations of asthma, bronchiolitis and community-acquired pneumonia.

It is important to note that it can be difficult to be definite about the cause of an acute cough in children. This is because no combination of symptoms or signs has been shown to give absolute clinical certainty in diagnosing these conditions, particularly in the early stages of an illness.

Background

Studies have shown that respiratory tract infection is associated with at least one episode of wheeze in approximately 50% of children before six years of age.[1]

Ireland has the fourth highest prevalence of asthma in the world, with around 39% of 13 to 15-year-olds reporting wheezing.[2] Most acute asthma attacks are triggered by viral infection.[3]

Bronchiolitis most commonly occurs in Ireland from November to March, with most infections occurring in an epidemic lasting around six weeks, the exact timing of which varies from year to year.[4] Approximately one in every three infants will develop clinical bronchiolitis in the first year of life and 2-3% of these infants will require hospitalisation.[4] Around 29 per 10,000 children younger than five years of age require admission to hospital for community-acquired pneumonia.[5]

Viral respiratory tract infections are self-limiting conditions. On average, fever settles after three to seven days and the cough resolves within three weeks in most children.

Infective exacerbations of asthma and viral-induced wheeze are often indistinguishable in children under five years of age who present with wheeze and a respiratory tract infection. The risk of a child dying from an acute asthma exacerbation is low.[3]

Table 1: Distinguishing features of conditions causing acute cough in children

	Pneumonia	Bronchiolitis	Viral-induced wheeze	Infective exacerbation of asthma
Age	Any age	Under two years, peak incidence between three and six months of age	Under five years	Any age
Respiratory rate	Usually increased	Usually increased	May be normal or increased	May be normal or increased
Hyperinflation	Not present	Often present (but difficult to detect in infants aged < 6 months	May be present	May be present
Wheeze	Not usually present	May be present	Present	Present
Crackles	Coarse crackles, usually focal	Fine crackles present throughout lung fields	Not usually present	Not usually present

Source: Prodigy (cough – acute with chest signs in children)

Bronchiolitis affects children aged less than two years, with a peak incidence between the ages of three and six months.[4] Bronchiolitis is usually precipitated by cold symptoms which last one to three days, followed by a persistent cough. It is uncommon for bronchiolitis to cause death.[4]

Community-acquired pneumonia can be caused by bacterial or viral infection and usually presents without wheeze, but coarse crackles can be heard when listening to the chest. It is uncommon for children in developed countries to die from community-acquired pneumonia.

Diagnosis

Although it can be difficult to make a specific diagnosis in children, it is usually based on history and examination. Microbiological investigations and chest X-ray are not routinely done in these children.

The distinguishing features of conditions causing acute cough in children are provided in the *Table* above.

Assessment

It is important to determine the severity of the child's condition, bearing in mind that children who have severe or life-threatening conditions sometimes do not appear to be distressed. In particular, observe the child's degree of agitation and level of consciousness.

Agitation and behavioural changes in a child can be a sign of low oxygen levels. Look for signs of exhaustion (inability to complete sentences, for example), cyanosis (bluish lips or extremities) and use of accessory chest muscles to breathe, while the child is at rest.

Examine the child's chest and record their respiratory rate, pulse and blood pressure. Measure the child's oxygen saturation in room air using a paediatric pulse oximeter. Assess the child's hydration status by measuring capillary refill time, examining skin turgor and dryness of mucous membranes, and asking about urine output.[3,4,7,6]

Children should be admitted to hospital (usually by emergency ambulance) if there are any life-threatening features. These include: the child looking seriously unwell, if there is severe respiratory distress such as grunting, marked chest recession, or a respiratory rate of over 70 breaths/minute, if there is persistent oxygen saturation of less than 92% when breathing air, if a severe wheezing attack persists after bronchodilator treatment, or if a child with a moderate attack has worsening symptoms despite initial bronchodilator treatment.[3,4,7]

Children who were born prematurely or have significant previous medical history should have a lower threshold for admission.[4] The ability of the parent or carer to cope with the ill child should be assessed, including their level of experience and anxiety and the time they have available to care for the child.[4]

Management in primary care

Children with low blood oxygen saturation levels (hypoxia) who are awaiting transfer to hospital should be given controlled supplementary oxygen using a face mask, Venturi mask or nasal cannulae. Flow should be adjusted to maintain an oxygen saturation of 94-98%, but oxygen administration should not be delayed in the absence of pulse oximetry.[3]

Viral-induced wheeze/possible asthma

Children who are suffering life-threatening or severe wheezing/asthma attacks should be given nebulised salbutamol, while waiting admission to hospital. A 5mg dosage should be given to all children aged over five years and 2.5mg to children aged two to five years. Ideally, nebulisers should be oxygen driven (flow rate of 6L /min usually needed) to avoid worsening hypoxia.[3]

If a nebuliser is not available, or if the attack is of moderate severity, use a pressurised metered-dose inhaler with a large-volume spacer to deliver the salbutamol dose.

Children under the age of three years are likely to require a face mask connected to the mouthpiece of a spacer for successful drug delivery. A short pause between puffs may be necessary to avoid hyperventilation with puffs given one at a time and inhaled with five tidal breaths. Give a puff every 30-60 seconds, up to 10 puffs.

If the response is poor, give further doses while awaiting hospital admission and switch to a nebuliser if available. Monitor peak expiratory flow rate (if the child can comply) and oxygen saturation (if available) to assess response to treatment.[3]

If the child does not require hospital admission a short-acting beta-2 agonist (salbutamol) via a large volume spacer should be given to relieve acute symptoms. Give a puff every 30-60 seconds, up to 10 puffs. Each puff should be given one at a time and inhaled with five tidal breaths. Repeat every 10-20 minutes according to clinical response. If the child has an existing asthma diagnosis, or if asthma is suspected, a short course of oral prednisolone can also be prescribed.[3]

If there are symptoms and signs that suggest a bacterial infection oral antibiotics should be prescribed.[3] Amoxicillin is first-line treatment, with doxycycline an alternative for those aged 12 years and over, if amoxicillin is contraindicated or not tolerated. Other alternatives include cephalosporins, or a macrolide such as erythromycin, azithromycin, or clarithromycin. Duration of treatment is usually five days.

Bronchiolitis

Children with suspected bronchiolitis should be referred to hospital urgently if they are suffering from respiratory distress or appear seriously ill. If the child does not require hospital admission self-care advice can be provided and parents advised that bronchiolitis is usually a self-limiting illness with symptoms tending to peak around three to five days after onset.[4]

Community-acquired pneumonia

Children with community-acquired pneumonia who do not require hospital admission should be prescribed oral antibiotics, as bacterial and viral pneumonia cannot reliably be distinguished from each other.[7] Children younger than two years of age presenting with mild symptoms of lower respiratory tract infection do not usually have pneumonia and therefore do not need to be treated with antibiotics, but should be reviewed if symptoms persist.[7]

A history of conjugate pneumococcal vaccination gives greater confidence to this decision. Amoxicillin is recommended as first choice for oral antibiotic therapy. Alternatives are co-amoxiclav, cephalosporins or a macrolide such as erythromycin, azithromycin and clarithromycin. Macrolide antibiotics may be added at any age if there is no response to first-line empirical therapy.

In pneumonia associated with influenza, co-amoxiclav is recommended. Prescribe antibiotics for between seven and 14 days, depending on the response to treatment.[7]

Self-care advice

Advise the parents/carers to use either paracetamol or ibuprofen to treat a child who is distressed due to fever. These antipyretic medications should not be used with the sole aim of reducing body temperature and should be continued only while the child appears distressed.

Advise the parents/carers to consider changing from paracetamol to ibuprofen, or vice versa if the child's distress is not alleviated, but not to give both simultaneously. Advise the parent not to attempt to reduce fever by under-dressing the child or with use of tepid sponging. The child should be encouraged to take fluids regularly. For infants who are breastfed advise continued breastfeeding.[6]

For children managed at home, advise parents/carers to check on the child regularly, including through the night. Advise that they seek medical advice if they are unable to cope, or if the child deteriorates, particularly if breathing rate increases or there are any episodes of apnoea or signs of increased effort of breathing.

If a baby takes less than 50% of its normal feeds, or there are signs of dehydration such as dry mouth or infrequent passage of urine, it becomes difficult to rouse or has a persistent worsening of fever advise the parent to seek medical advice.[6]

Parents who smoke should be advised to stop.

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CPD Quiz

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

1. Acute cough with chest signs can be caused by:
A) Community-acquired pneumonia
B) Asthma exacerbation
C) Bronchiolitis
D) Viral-induced wheeze

2. Bronchiolitis usually:
A) Commences with cold symptoms
B) Precipitates cold symptoms
C) Presents without cold symptoms
D) Follows cold symptoms

3. The following are common features of pneumonia:
A) Presents most commonly in children under five
B) Crackles on chest sounds
C) Increased respiratory rate
D) Wheeze

4. Children with the following should have a lower threshold for admission to hospital:
A) Premature birth
B) Significant previous medical history
C) Children who do not respond to initial treatment
D) Children whose carers may not be able to cope

5. First choice antibiotic for bacterial chest infection is:
A) Doxycycline
B) Amoxicillian
C) Erythromycin
D) Azithromycin

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

Clarity informatics

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

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

Reform and recruitment

The Health Minister has proposed change in the way the HSE is structured and made a commitment to recruit nurses and midwives. **Ann Keating** reports

Harris tells Committee fewer, but better paid, HSE managers preferable was a headline over a piece in the *Industrial Relations News* (April 6). "The Minister for Health, Simon Harris, has said that he would like to see fewer managers in the health service as this would allow more attractive remuneration packages to attract international expertise to such roles. In a lengthy presentation outlining his thoughts on the health service to the Oireachtas Committee on the Future of the Health Service, including dismantling of the HSE, Minister Harris said: "There are many excellent people in the Department of Health and the HSE but it is disconcerting to note that when one advertised in the past for certain jobs, including some senior roles at various levels within the health service, there was not the level of interest one would have liked there to be." Speaking about workplace change the Minister said that "many initiatives are underway to improve staffing levels but added that the health service is operating in a highly competitive market for attracting and retaining health professionals, who are in short supply globally. Echoing the INMO's long held argument that pay is a major factor in attracting and retaining nurses, the Minister said "this (recruitment and retention) is obviously relevant in assessing both pay and tax rates."

The *Irish Independent* (April 8) ran a headline **Union vote paves way for new drive to hire nurses**. "A campaign to recruit and retain much-needed nurses across the health service will get under way as the nurses union has lifted the threat of industrial action in the short term. Members of the Irish Nurses and Midwives Organisation voted by 82pc in favour of a deal worked out in the Workplace Relations Commission. The union had served notice of a work-to-rule in protest at severe staff shortages. The union warned, however, that this deal is just a "first step" and signalled a pay battle lies ahead as part of the wider talks on a new agreement for the wider public service…INMO president, Martina Harkin-Kelly said: "Our members, in accepting these proposals, are stating quite clearly, that they represent just the first step in a three-year programme, which must see nurse/midwife employment levels increase to over 40,000 from its current level of 35,600."

The *Irish Examiner* (April 13) gave space to our press release regarding March trolley figures – **Record 9,500 patients on trolleys last month**. "A record 9,500 patients ended up on hospital trolleys last month, the highest number for the month of March in over a decade… The INMO said it was clear the measures contained in the €40m Winter Initiative Plan announced last September by Health Minister Simon Harris, were not enough to tackle the trolley problem. The plan set a maximum target of 236 for the number of patients on trolleys each morning. However, the figures were 82% over the target in March." Liam Doran said the "INMO had pointed out at the time that because the plan failed to address the difficulties in recruiting and retaining nursing staff, it "ran the risk of falling short, in terms of implementation. Additional services, either in terms of acute beds, step-down beds and/or community intervention teams are dependent on there being additional staff."

The *Sunday Times* (April 9) in a headline on page 19 posed the question – **Should Civil Servants be paid more to live here? Living in the capital is too expensive for many key workers. Is Dublin weighting the answer?** "Matthew Robson, a 24-year-old nurse, points out that "people don't go into nursing for the money." But as a recent graduate paying €650 a month in rent for a flat-share on Dublin's northside, he nevertheless finds the cost of living in the capital relative to his pay cheque "very dispiriting". Robson is on €29,500 a year, the second point on the staff nurse salary scale, and finds about half his monthly pay cheque is immediately eaten up by essential living expenses. He has an hour-long commute because he cannot afford to live near the hospital where he works, which is in an expensive suburb on Dublin's southside. "It can be a struggle for people starting out. I have a lot of friends who have gone back to their home places because Dublin is too expensive," he said. "They can go back to Wexford or Donegal and live at home. Not only are people going home but they are going abroad. It's draining staff from the big Dublin hospitals." Robson is part of a youth committee within the Irish Nurses and Midwives Organisation (INMO) that wants the trade union to push for living allowances to be paid to young nurses living in the most expensive areas of the country… Dave Hughes, deputy general secretary, recalls that in the early 2000s, as the economy began to boom and the cost of living rose, the union unsuccessfully lobbied for a Dublin living allowance to be paid to its members… It was turned down on the basis that you couldn't apply it to nurses and not to the wider public service."

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Tax needn't be taxing

INMO student and new graduate officer **Liam Conway** offers a handy guide to getting your tax affairs in order

THE mere idea of tax can put 'the fear' into many of us. People often fear the under or over payment of tax or simply don't understand it or the documentation that goes with it. I am not an accountant but as a nurse I can offer basic information to students and members on how to organise their tax. This information is available online at **revenue.ie** and **citizeninformation.ie**

Registering for online services

Thankfully, you can now manage your tax online through **revenue.ie** It is easy to register online. You will need your personal public service number (PPS number). This is a unique reference number that allows you to access social welfare benefits, public services and information in Ireland. To register you need to visit **revenue.ie** and click on 'register my account'.

Once you register online you will receive a personal identification number (PIN) to access your account. This allows temporary access and you will need to create a password thereafter. From here, you can register new employment, tax credits, upload documents and use the 'my queries service' to which revenue aspires to respond within five working days.

By clicking on 'Manage your tax 2017', you can make amendments, tax credit adjustments, register new employers and submit documentation. If you have any issues or queries using the service you can use the 'my queries service' or alternatively you can call your local tax office.

Top tip: My personal tip for students or graduates is to get in the habit of filing important documents you receive throughout the year. Keep any nursing and midwifery certificates/CPD in a portfolio, such as an A4 clear pocket folder labelled by year. Then keep all the tax forms received for the year in a folder. Then at the end of the year when you look to submit forms to receive a P21 form (to claim back tax), you will have them all at hand. Furthermore, you should also keep a separate folder for healthcare expenses for each year, as a percentage of this can be claimed back.

Nursing and midwifery tax credit

Nurses and midwives who supply or launder their uniform are entitled to a special healthcare tax credit. This is known as flat rate expenses. You can register for this by clicking on 'add new credits'. You will be instructed on which tabs to click on from there and which options are applicable to you. Every euro counts!

Registering for a new employer

It is important that just before or as you start a new employment that you register that employer with Revenue. This avoids the dreaded 'emergency tax' rate of 40% on your gross earnings. If you pay emergency tax, don't worry however. At the end of the year when you seek a balancing statement (P21), any overpayment of tax will be reimbursed. Each employer has a unique tax number and you can request this from the employer when starting a new job or position.

Relevant forms

P60: Your employer must give you a P60 within six weeks of the end of each tax year. It is a statement of your pay and of the tax, USC and PRSI deducted by your employer during the year. Your P60 is a crucial document as it is evidence of tax paid during the year, while also assisting you in seeking a tax refund. It is a summary from your employer of your earnings and tax paid during the year.

P45: This signals the end of employment. Hopefully you don't receive many of these forms during your career without you requesting them yourself! If you leave your employment, your employer must give you a P45. This is a statement of your pay and the tax, universal social charge (USC) and PRSI to date deducted by your employer. It is an important document and you need it if you are changing job – to give to your new employer in order to avoid paying emergency tax – or, if you are unemployed – to claim a tax refund and/or social welfare benefits.

P21: This form shows how much tax you have paid during the year and how your tax credits were applied. It calculates if you have overpaid or underpaid for the year. Based on this, you could receive a refund or be asked to repay under payment of tax. For students in particular, you will often find that when you work part-time and don't cross a certain level of gross earnings for the year, you can get a large sum of tax refunded. However, there are terms and conditions involved which can be viewed on **revenue.ie**

The quickest and easiest way to receive a P21 is by using PAYE Anytime or completing the eForm 12 which are accessible through 'myAccount'. For this you will need your P60 or P60s (if you have more than one employer) and/or a P45 (if you ceased employment during the year). The P60 and/or P45 must be submitted prior to requesting a P21. It is the employer's responsibility to provide you with a P60 (end of year) and P45 (if leaving a position).

If you are unsure of anything you can contact Revenue directly. You can also avail of a third-party service or 'agent', such as an accountant. As an INMO member you can avail of this service at a significantly reduced cost through our partners Cornmarket Group Financial Services. See: **www.inmo.ie/FinancialAdvice** for more information.

Contact details

If you have any general queries please contact me by email to: liam.conway@inmo.ie or Tel: 01-6640628.

Quality & Safety

A column by Maureen Flynn

Schwartz Rounds in Ireland: Who cares for the carers?

THIS month's column focuses on staff support 'care for each other'. Working in healthcare can be difficult and sometimes emotionally draining. We have a great privilege in our work yet when we help families hold it together, who holds us? Who cares for the carers? In the US, more than 425 organisations have implemented Schwartz Rounds to support staff; while around 100 trusts and hospices are running them in the UK. In 2016, Our Lady's Hospice and Care Services, Blackrock Hospice and University Hospital Galway successfully introduced Schwartz Rounds in Ireland. Preliminary feedback has been exceptionally positive. An independent evaluation of Schwartz Rounds in an Irish context is currently underway.

Schwartz Rounds

Originally developed by the Schwartz Center for Compassionate Healthcare – founded in 1995 – in Boston, US. Schwartz Rounds are monthly structured meetings. All staff working across the healthcare organisation are invited. They aim to improve staff wellbeing, resilience and support which ultimately has an impact on improved patient-centred care. The Round provides an opportunity for staff to reflect on the emotional aspects of their work. The focus is on the human dimension of care. Each round, at a maximum of one hour, is based on the story of a particular patient or a theme.

Unlike clinical supervision, after action reviews, or team debriefing sessions - Schwartz Rounds are not problem solving forums. Their purpose is to acknowledge feelings, build resilience and understand the emotional impact of work. Rounds follow a structured format: lunch is offered before the start, the mixed panel presenting talk for 10-15 minutes on a pre-planned topic, trained facilitators moderate the discussion, the audience is asked to share their thoughts, ask questions, offer similar experiences and to support each other.

Feedback on Schwartz Rounds in Galway University Hospital and Blackrock Hospice

Encourages insight

"Amazing insight into other professional's experiences"
"Felt glad that multidisciplinary from cleaner to consultant was emphasised"
"These rounds help break down barriers between all the different members of the hospital staff ..."
"Takes time out to my day to see the patients on my waiting list but is a good way to focus on caring for ourselves"

Reaffirms values

"Brings caring and kindness back into the workforce"
"Helps us remember why we are in a caring profession"

Positive feeling

"Feel-good factor - positive effect overall"
"Incredibly moving and human"
"Stunning - made me very proud to work with such compassionate, sincere and expert people"
"Well worth taking the time to attend despite a very busy schedule"

Highlighting important issues

"Highlighted other issues like open disclosure"
"Very positive and potent reinforcement of how an individual can impact on patient care through non-clinical means - smiles, compassion, greetings"
"Very thought-provoking about what we do well and when things go wrong"

The Rounds are designed to be a safe and confidential environment: patient names are changed to protect confidentiality and all participants are asked to agree that no names or information shared by colleagues are mentioned outside the one-hour Round.

Benefits

Research into the effectiveness of Schwartz Rounds shows the positive impact that they have on individuals, teams, patient outcomes and organisational culture.[1]

What are staff saying in Ireland about Schwartz Rounds?

Schwartz Rounds in Ireland offer a powerful addition to staff support interventions and one which continues to build our sense of community. The feedback from staff has been really positive – *see box on left*.

Get involved

The HSE Quality Improvement Division (QID) is working in collaboration with the Point of Care Foundation UK to introduce Schwartz Rounds to Ireland. Over the coming two years, we will train up to 30 teams who will work in their organisation to introduce Schwartz Rounds. At your next ward, team, directorate meeting why not discuss Schwartz Rounds – ask your CNM or assistant director if your organisation is one of those considering introducing this support for staff?

Further information

For more information about Schwartz Rounds or to register your organisations interest for training, you can visit our website **www.qualityimprovement.ie** or contact: Juanita Guidera, QID lead, Staff Engagement juanita.guidera@hse.ie 087 064 23 08; or Orla O'Reilly, Staff Officer orlab.oreilly@hse.ie 045 882544

Useful Resources

- **www.qualityimprovement.ie**
- **www.pointofcarefoundation.org.uk/schwartz-rounds/**

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

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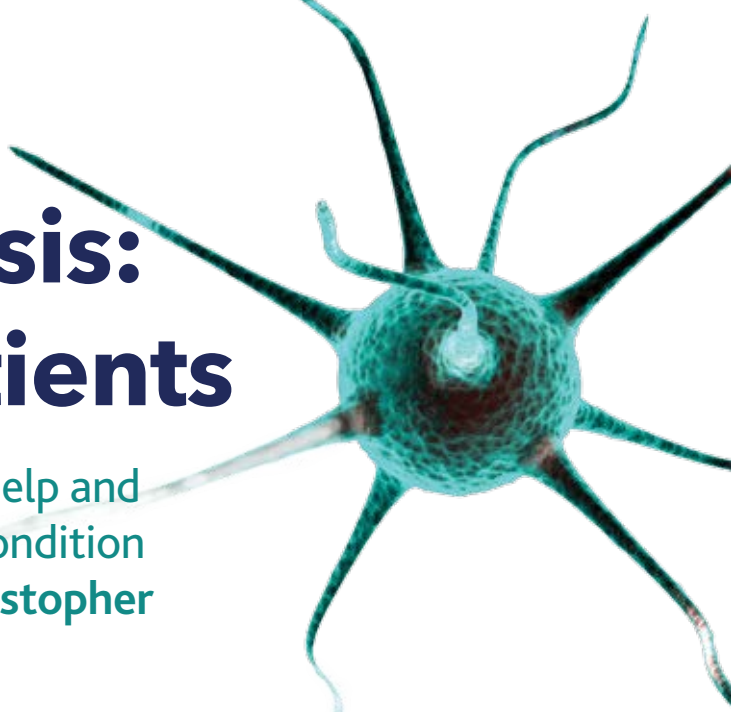

Multiple sclerosis: Supporting patients

The multidisciplinary MS team must help and encourage patients to manage their condition effectively, writes **Sinead Jordan**, **Christopher McGuigan** and **Michael Hutchinson**

MULTIPLE sclerosis (MS) is the most common cause of non-traumatic neurological disability in young adults. It is an inflammatory disease of the central nervous system, characterised by T-cell and B-cell mediated demyelination and neurodegeneration. It is typically diagnosed in people between 20 to 45 years of age and follows an unpredictable course. The prognosis can vary considerably from one person to the next.

MS typically presents with a history of acute onset of neurological symptoms or with progressive neurological impairment. The disease involves an initial relapsing-remitting course (RRMS) in 80-90% of patients, although relapses are not always followed by complete recovery. The majority of RRMS patients develop, within 10-20 years, secondary progressive MS, characterised by irreversible and relentless accumulation of disability leading not only to personal and caregiver burden but also to high societal and economic costs.

MS affects 1.1 to 2.5 million people worldwide. Environmental and genetic factors contribute to its aetiology and genetic factors contribute to MS susceptibility.

Areas with high MS prevalence include North America, Northern Europe and Australasia with a prevalence of 1:1,000 adults. Ireland has reported prevalence rates of 120-180-240 per 100,000.[1,2] MS affects women more than men, at a ratio of 2:1, and is diagnosed in Caucasians more often than in any other racial/ethnic group.[3]

Clinical courses of MS

Four clinical courses have been described:

- Clinically isolated syndrome is the first neurological episode experienced by a patient that is caused by inflammation or demyelination in the CNS. According to the MS Trust,[4] 85% of MS patients will experience an initial symptom lasting for at least 24 hours. Typical symptoms include optic neuritis, diplopia and numbness
- Relapsing-remitting multiple sclerosis (RRMS): Approximately 85% of patients who are diagnosed with MS present with RRMS. A relapse is an acute episode of neurological symptoms that gets worse over a few days and improves or subsides over time. A period of 30 days should separate the onset of two relapse events for them to be distinguished as two attacks[5]
- Primary progressive multiple sclerosis is characterised by progression of disability from the onset (usually as a progressive spastic paraparesis) without remissions or with occasional plateaus and temporary minor improvements
- Secondary progressive multiple sclerosis (SPMS) begins with an initial RRMS course, followed by remission of variable rate that may also include occasional relapses and minor remissions. The transition from RRMS to SPMS is often gradual and sometimes only detectable in retrospect.

Diagnosis

The McDonald revised criteria 2010 are generally regarded as the gold standard for the diagnosis of MS. There is no single diagnostic test for MS. The diagnosis is reliant on the patient's history and examination, the interpretation of an MRI, the presence of CSF oligoclonal bands, visual evoked potentials and neuroinflammatory bloods (ANA, ENA, ACE, Lyme serology, NMO). It is necessary to exclude other central nervous system disorders and MS-mimics such as Lyme disease (an infectious disease), neuromyelitis optica or acute disseminated encephalomyelitis.

The McDonald revised criteria 2010 have been developed and refined over the past 20 years (a recent revision is presently underway). While it is possible to diagnose MS by clinical criteria alone, all patients should have an MRI scan of the brain and spinal cord to confirm the characteristic features and to exclude MS mimics such as an Arnold-Chiari malformation. *Table 1* outlines the clinical presentation and the requirement for additional data.

An attack or relapse is defined as the recurrence of previous symptoms or the manifestation of new symptoms lasting for at least 48 hours.

Acute relapses are usually treated with a three-day course of intravenous methylprednisolone 1g daily. Steroids have been shown to reduce the time taken to recover from a relapse. Oral steroids can also be prescribed on a reducing dose over three weeks.

Symptoms and signs of MS

MS lesions plaques are found in the brain and spinal cord. Most plaques are asymptomatic. The myelin sheath that facilitates the conduction of impulses along the nerve axons becomes damaged by the autoimmune process and this causes the impulses to be delayed or completely blocked. This in turn can result in any of the numerous symptoms reported by people with MS. The symptoms are determined by where the MS lesion is located within the CNS.

Specific signs and symptoms are taken as confirmation of lesions in certain functional systems of the CNS – the following are examples of the symptoms that the patient may present with or report:

- Optic nerves : sub-acute onset of unilateral visual blurring with reduced acuity often associated with pain
- Oculomotor/brainstem: double vision, nystagmus
- Spinal cord: limb weakness and/or numbness, spasticity, sexual dysfunction, bowel and bladder dysfunction
- Brainstem: slurred speech, vertigo, facial weakness trigeminal neuralgia, difficulty swallowing (rarely)

- Cerebellar: balance disorder/ataxia and tremor
- Cerebral: mood issues/depression, cognitive impairment and fatigue
- Sensory: numbness and pain.

Symptomatic therapy

The treatments available for MS include managing symptoms with both symptom specific medications (anticholinergics for urinary urgency). Non-drug treatments include physiotherapy, occupational therapy and speech and language therapy.

Disease-modifying therapies

Perhaps the most important development in managing patients with MS was the development of consensus guidelines recommending regular, at least yearly clinical assessments, and annual MRI assessments in patients with relapsing MS.[7] These criteria emphasised the importance of classifying patients (by both clinical and MRI measures) as to having 'not active' or 'active' disease and assessing whether there was, or was not, evidence of increased neurological disability.

Disease-modifying therapies are not a cure for MS but they can reduce how many relapses someone has and how serious they are. They have been shown to reduce the risk of progressive disability. The goal of treatment should be to slow the irreparable damage to the axons and therefore delay progression of the disease to irreversible SPMS.

There has been a remarkable development in the number of disease-modifying therapies available for patients with relapsing MS in the past 20 years. Unfortunately, convincing evidence for an effect of these drugs in SPMS is not available. We are now at the stage where, with active management involving regular review, annual MRI scans and escalation of therapy, we can contemplate controlling disease activity in patients with RRMS with the aim of preventing the development of SPMS.

Given the increasing complexity of disease management in MS, patients are best managed by neurologists with a special interest in this disease. All patients with RRMS should be seen at least annually with review immediately after an annual MRI scan (even if their disease appears to be stable to them and their neurologist).

There are several factors for the clinician and patient to consider when choosing a disease-modifying therapy that best suits the patient's needs.

Firstly, consider the patient and their disease profile, age, gender, comorbidities, the level of disease activity – clinically and/or MRI – treatment history and biomarkers, ie. JCV-antibody status.

Secondly, the patient's preferences must be considered and can be determined by their lifestyle. Is the patient working? Does the patient have a busy life, young children, can this affect adherence?

The risk/benefit of the treatment to the patient must also be considered including tolerability, side-effects and the impact this may have. Frequency of treatment and mode of administration, safety and the safety monitoring that is required which may include frequent blood samples and MRI scans.

The availability and access to some disease-modifying treatments can be limited. Often, health providers have a restricted financial budget for such therapies and therefore it can be extremely difficult to get access to them.

First-line therapies are available in Ireland for people diagnosed with CIS and RRMS. They are usually well tolerated, have a good safety profile, reduce relapse by approximately one-third and may often be the only treatment necessary for many people with MS.

Second-line therapies are treatments that are licensed for use in Ireland in patients with RRMS. If they have failed a first-line treatment (their disease has continued to progress while on treatment), this can be determined by MRI changes, new symptoms or increase in previous symptoms and the expanded disability scale score (EDSS).

Table 1: Clinical presentation of MS and additional data needed[6]

Clinical presentation	Additional data needed
Two or more attacks (relapses) Two or more objective clinical lesions	None. Clinical evidence will suffice (additional MRI evidence desirable and must be consistent with MS)
Two or more attacks One objective clinical lesion	Dissemination in space demonstrated by MRI or a positive (cerebrospinal fluid) CSF and two or more lesions consistent with MS or further clinical attack involving different site
One attack Two or more objective clinical lesions	Dissemination in time demonstrated by MRI or second clinical attack
One attack One objective clinical lesion (monosymptomatic presentation)	Dissemination in space demonstrated by MRI or positive CSF and two or more MRI lesions consistent with MS Dissemination in time demonstrated by MRI or second clinical attack
Insidious neurological progression suggestive of MS (primary progressive MS)	One year of disease progression (retrospectively or prospectively determined) and two of the following: Positive brain MRI (nine T2 lesions or four or more T2 lesions with positive VEP); positive spinal cord MRI (two focal T2 lesions); or positive CSF

The EDSS is a standardised assessment tool that was developed by Kurtzke in 1983,[8] it is used by neurologists to measure disability caused by MS in eight functional systems; pyramidal, cerebellar, brainstem, sensory, bladder and bowel, visual, cerebral and other. This score allows the neurologist to determine if the patient's MS has progressed.

Second-line therapies are indicated when a patient reports new symptoms, disease is actively progressing (by clinical or MRI criteria) and treatment needs to be escalated to a more effective treatment. The decision for accelerating treatment is that of the neurologist and the patient.

Table 2 outlines the second-line disease-modifying treatments currently available, the dosage, the method of administration and very common side-effects.

Monitoring

Everyone treated with a disease-modifying treatment, regardless if it is first or second-line, should adhere to a strict monitoring regime. This may vary from centre to centre but generally involves regular blood tests to monitor LFTS and urine tests. Some therapies require the patients to have regular MRI scans performed. These are in place to ensure the safety of the patient.

Breaking bad news

It is never an easy task when you are required to confirm a diagnosis that will certainly cause the patient distress. There are however certain things that should be considered at such times. Bad news ideally should always be given in person, it may

Table 2: First-line disease-modifying treatments available

Treatment	Dosage	Administration	Side-effects
Avonex IFN beta-1a	30mcg weekly	Intramuscular injection	Flu-like symptoms, injection site reactions, liver function abnormalities
Plegridy peginterferon beta-1a	125mcg every two weeks	Subcutaneous injection	Flu-like symptoms, injection site reactions, liver function abnormalities
Betaferon: IFN beta-1b	250mcg every other day	Subcutaneous injection	Flu-like symptoms, injection site reactions, liver function abnormalities
Rebif: IFN beta-1a	22 or 44mcg three times per week	Subcutaneous injection	Flu-like symptoms, injection site reactions, liver function abnormalities
Copaxone: Glatiramer acetate	20 daily or 40mgs three times per week	Subcutaneous injection	Injection site reactions and immediate post injection reactions (rare and benign).
Aubagio: Teriflunomide	14mgs daily	Orally	Headache, alopecia, nausea, neutropaenia, raised ALT, infection
Tecfidera: Dimenthyl fumerate	240mcg twice daily	Orally	Gastrointestinal disturbances and flushing (this can be managed with aspirin)
Zinbryta: Daclizumab	150mcg once a month	Subcutaneous injection	Nasopharyngitis, injection site reactions , liver function abnormalities

Table 3: Second-line disease-modifying treatments available

Treatment	Dosage	Administration	Side-effects
Gilenya: Fingolimod	0.5mgs daily	Orally	Raised liver enzymes, bradycardia, cough, headache, sinusitis and diarrhoea
Tysabri: Natalizumab	300mgs every four weeks	Intravenous infusion	Headache, nausea, dizziness and Rigors (associated with the infusion) – UTI, opportunistic infections, PML*
Lemtrada: Alemtuzimab	12mgs daily (five days in year one and three days in year two)	Intravenous infusion	Headache, nausea, fatigue, flushing, luekopaenia, lymphopaenia, rash, UTI and URTI

** PML: Progressive multifocal leukoencephalopathy is a rare (in the general population) but serious demyelinating disease of the brain, often resulting in severe disability or death, caused by lytic infection of oligodendrocytes by the JC polyomavirus (JCV)progressive multifocal leukoencephalopathy.[9] Currently there is an anti-JCV antibody test/assay (ELISA) this permits the neurologist to stratify the risk of PML associated with the treatment of Tysabri. Patients that test positive are at an increased risk compared to those who test negative*

help if you ask the patient to bring a relative with them for the consultation as it forewarns a patient that a serious conversation is about to take place.

It is essential that you use language that the patient will understand and have in-depth knowledge of the clinical course the patient has been diagnosed with. It helps to establish what the patient already knows about MS and allow time for the patient to confirm they understand what you are talking about and to ask questions if they wish.

At this initial consultation, it is important to try and gauge how much information the person would like to know as it will vary significantly from one person to the next. Stay mindful of how the patient is coping with the information.

Finally, a plan should be put in place, including a follow-up appointment with the consultant neurologist or the MS nurse specialist. Written information should be provided including contact details of the MS Ireland.

MS management and support networks

People living with MS will acquire coping strategies to deal with their diagnosis. How useful these strategies are will depend on the patient's outlook, their personality and the support network they have in place.

The multi-disciplinary team (MS nurse, neurologist and GP) should try to help and encourage the patient to manage their disease effectively, allowing them to live their life as normally as possible.

There are very useful supports available to people with MS in the community.

Patients on disease-modifying treatments may have access to homecare nurses who are specially trained in the administration of specific treatments. They have a huge knowledge base with regards to the expected side-effects and management of these.

MS Ireland is another excellent resource for patients and their families. It is a national organisation that provides information, support and advocacy services to the entire MS community. It provides a wide range of MS programmes (including physiotherapy, symptom management and information forums). MS Ireland runs workshops and activities throughout the country that are aimed at different groups such as newly diagnosed people, carers, children of parents with MS and health professionals.

The positive factor for people diagnosed with MS at the moment is that there are so many treatments available to them compared to 20 years ago. The volume of research being done for MS is huge, research shows that early treatment with a disease-modifying treatment is essential. There are many exciting therapies currently in clinical trials that hopefully will be available in the next few years.

Sinead Jordan is clinical nurse specialist in MS, Christopher McGuigan is a consultant neurologist and Michael Hutchinson is a consultant neurologist at St Vincent's University Hospital, Dublin

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HPV vaccine: a key cervical cancer prevention strategy

Primary HPV vaccination and secondary cervical screening are effective prevention strategies to reduce the incidence and mortality of cervical cancer in Ireland, writes **Carrie Powles**

THE world has a population of nearly three billion women aged 15 years and older who are at risk of developing cervical cancer. Worldwide cervical cancer ranks the fourth most common cancer among women and the second most common cancer deaths in women aged 15-44 years. In Ireland there are 295 cases of invasive cancer each year and 3,213 cases of cervical cancer in situ.[1] Yearly, more than 6,500 women are diagnosed with high grade cervical intraepithelial neoplasia (CIN) and require treatment at one of the 15 national CervicalCheck colposcopy clinics.[2]

Human papillomavirus (HPV) is understood to play a definite role in the development of cervical cancer. It is a necessary but not a sole causative agent. Some 99.7 % of cervical cancers contain high risk HPV DNA.[3]

HPV is a large family of double stranded DNA viruses. Approximately 40 of these can infect the genital tract and 14 are recognised as high risk oncogenic HPV. HPV 16 and 18 are associated with 70% of cervical cancers worldwide. HPV is an extremely common infection. It is estimated that 80% of women will become infected within 18 months of becoming sexually active. The vast majority of infected individuals mount an effective immune response becoming HPV negative within a further 18 months with subsequent sustained clinical remission from disease. In a minority of women the infection can persist. Contributing factors for the development of cervical cancer include cigarette smoking, which lowers the immune response, and immune suppression.

Screening

The two main preventative strategies for cervical cancer in Ireland are screening and vaccination. CervicalCheck is an organised, population-based and quality-assured screening programme. CervicalCheck is designed to detect signs that disease may develop in women who are within the at risk population. Approximately 1.2 million women who are resident in Ireland aged 25 to 60 are eligible for screening. For women aged 25 to 44, tests are offered at three-yearly intervals. For women aged 45 to 60, the interval changes to five yearly following two consecutive negative results. A call/recall system is in place and the result of the screening test or treatment at colposcopy discharge recommendation determines when women will be recalled.

The levels of engagement with CervicalCheck needs to remain high, (greater than 80% coverage of the target population) in order to achieve the goal of impacting on cervical cancer. To date the overall number of women screened by CervicalCheck is high (79.6%) we are aware that currently one in five women are not attending for screening. We would like to increase uptake further especially in counties where uptake is lower. Women in Clare Laois, Kilkenny, Monaghan, Offaly and Roscommon are less likely to attend as are women over the age of 50 years.[4] Health professionals are challenged to promote and facilitate continued participation of all eligible women.

GP Practices rank the highest (76%) for women sourcing information about their screening needs and health. Therefore doctors and nurses should continue to use every opportunity to provide women with appropriate information about their screening needs.[5] Healthcare professionals should remember to check a woman's cervical screening status; ask if they are up to date with cervical screening, remind and encourage women to attend and facilitate women's engagement with screening.

Evidence shows that women who have a positive experience when attending for a cervical screening test are more likely to continue to participate in the programme.[6] A screening test is not a test for cancer; currently the test involves cytology as the primary screening tool, and may involve a HPV type assessment. Remember a screening test is not a diagnostic test. A screening test is not recommended on a woman who is symptomatic, further investigation and a gynaecology referral should be considered.

The Health information and Quality Authority (HIQA) is currently conducting a Health Technology Assessment (HTA) on HPV technologies before the introduction of HPV testing as the Primary screening strategy for CervicalCheck. The HTA will address and inform on screening strategies, tools, age range and screening intervals; changing the landscape of Ireland's cervical screening programme significantly in the future. This will impact the CervicalCheck programme, contracted laboratories, colposcopy clinics, nurses and doctors who perform cervical screening and eligible women.

Vaccine

Recognition of the role of oncogenic HPV in the genesis of cancer of the cervix prompted the development of a vaccine against the most commonly recognised oncogenic types. There is evidence that HPV vaccines prevent cervical cancer.[7]

The HPV vaccine is recommended by the WHO, the American Society for Clinical Oncology, the International Federation of Obstetricians and Gynaecologists and the expert Immunisation body in Ireland to reduce the burden of cervical cancer in women.[8]

There are three licensed HPV vaccines:

- HPV 2 Cervarix vaccinates against types 16,18, causing 70% of cervical cancers

- HPV4 Gardasil vaccinates against HPV types 6, 11, 16, 18, two of which cause 70% cervical cancers and 6 and 11 causing warts
- HPV9 vaccinates against HPV types 6, 11, 16, 18, 31, 33, 45, 52, 59, seven of which cause 90% cervical cancers.

Since 2006, countries that have started HPV vaccination programmes with high uptake rates have revealed a reduction in high grade cervical intraepithelial neoplasia (CIN), with Scotland and Denmark showing a reduction of more than 50%.[9,10] There was also a fall in incidence of anogenital warts in vaccinated girls under 21 in Australia from 18% to 1.1 %.[11]

HPV4 vaccine (Gardasil) is used in the HSE HPV school vaccination programme in Ireland since 2010.

- It is licensed to prevent premalignant genital lesions and cervical cancer related to HPV types 16 and 18
- All girls less than 15 years of age require two doses of HPV vaccine given at zero and six months
- All girls aged 15 years and up to the age of 26 and people with weakened immune systems require three doses of HPV vaccine given at zero, two and six months
- The duration of efficacy of the HPV vaccines is likely to give long-term protection. Delere et Al's meta-analysis of vaccine protection against Human Papilloma virus showed 84% efficacy and duration >6 years and is likely to predict long-term efficacy duration.[12]

Remember cervical screening should continue in the vaccinated cohort as to date the vaccines only protect against 70% of oncogenic HPV types.

Boys are currently not vaccinated but it's worth noting that HPV is also responsible for more than 90% of anal cancers, more than 40% of penile cancers and more than 35% of oropharyngeal cancer.[13] There is a case for vaccinating boys as herd immunity would confer protection from vaccinated to unvaccinated people.

Schools

The HSE HPV school vaccination programme is recommended for all girls aged 12-13 years and ideally the HPV4 Gardisil vaccine should be given before exposure to HPV virus at sexual contact. The HSE HPV schools programme distributes information leaflets, consent forms and contacts to parents in advance of administering the vaccination.[14] Factsheets are also available from the National Immunisation office on 'HPV Vaccine Key Facts' for GPs and 'HPV Vaccines and Cervical Cancer' for school principals.[15]

More than 220 million doses of HPV4 (Gardasil) have been distributed in more than 29 countries worldwide. In Ireland in excess of 220,000 girls have been fully vaccinated by HPV school vaccination teams. The vaccination programme in Ireland aims to achieve a high uptake of over 80% for a completed vaccine course. Until 2015, the uptake rate was high; 2014/15 saw an 87% uptake following two doses with an impressive cohort retention record of over 97%.[15]

Concern

However parents started to raise concerns about vaccine safety in 2015 following local and national media coverage alleging that the HPV vaccine was unsafe. The safety profile of the HPV vaccine has been monitored since 2006 by the WHO Global Advisory Committee on Vaccine Safety (GACVS), the European medicines agency (EMA) and other international bodies.

The World Health Organization GACVS has reviewed the evidence on the safety of Gardasil vaccine and concluded in December 2015 that Gardasil continues to have an excellent safety profile.[16] In November 2015 the EMA reported following a review of HPV vaccines found no evidence there was any causal relationship between the HPV vaccine and chronic-fatigue-like conditions.

In January 2016 the EMA issued a final report on this review of HPV vaccines: "EMA confirms evidence does not support that they cause complex regional pain syndrome or postural orthostatic tachycardia syndrome."[17] No scientific evidence of an increased link in incidence of long-term medical conditions and the vaccine has been established to date.

Alarm

In Ireland and other jurisdictions the anti HPV vaccine narrative has led to a drop in public confidence and negatively influenced the decision making of parents. The eroded confidence in the HPV vaccine and authorities delivering them has led not only to vaccine hesitancy but has dramatically impacted on the HPV vaccination uptake rate in Ireland. The 2015/16 uptake rates were reduced to 72% and 2016/17 rates is estimated by the National Immunisation office, at 50% following first dose of vaccine, down in all areas nationally. The reduced rates are believed to be directly related to the vaccine safety scare. It would be a shame if avoiding the risks associated with the HPV vaccine were to become more important than benefiting from the protection the vaccine has to offer. This is an alarming concern for health care professionals in cervical cancer prevention.

Healthcare professionals will be asked questions by concerned parents and the public such as: does HPV cause cervical cancer; does HPV vaccination prevent HPV infection and cervical cancer; and is it safe? The evidence to date suggests yes to all three questions. There is no doubt HPV vaccination is both safe and effective.

HPV vaccination coupled with the cervical screening programme has the potential to prevent women from developing cervical cancer. All healthcare professionals play a vital role in the promotion of the HPV vaccine and cervical screening. The recommendation of a trusted health professional leads to increased vaccine and screening uptake. Resources are available from CervicalCheck and the National Immunisation office to support informed consent in a way the public can understand about the safety and effectiveness of the HPV vaccine and cervical screening.

Carrie Powles is screening training co-ordinator for CervicalCheck and an honorary clinical lecturer of the RCSI

The author challenges health professionals to become advocates for cervical screening and HPV vaccination. Combined screening and vaccination has the potential to save young women's lives.

The author would like to acknowledge the kind assistance of Criona Burns, GP advisor, CervicalCheck (NSS) in compiling this article.

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Where there is breath...

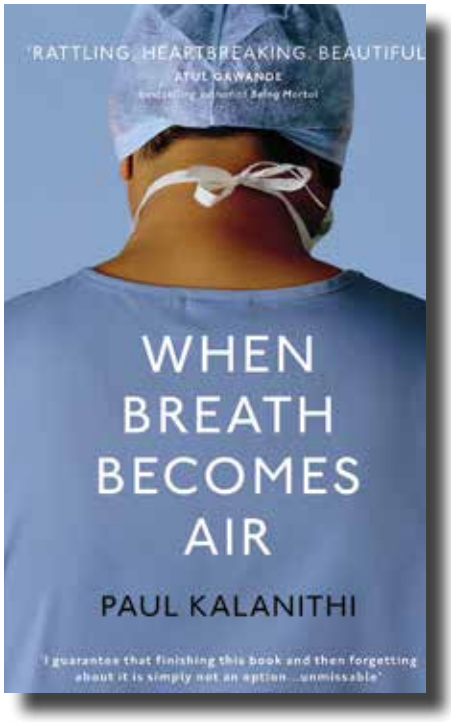
"I FLIPPED through the CT scan images, the diagnosis obvious: the lungs were matted with innumerable tumours, the spine deformed, a full lobe of the liver obliterated. Cancer, widely disseminated."

Paul Kalanithi, an American trainee neurosurgeon, had examined hundreds of scans before but this one was his own. He had developed inoperable lung cancer at the age of 36. A talented medic with a rewarding career ahead of him, Paul was now living on borrowed time. One day he was a doctor treating the dying, the next he was a patient struggling to live.

Yet there was far more to Paul than just being a doctor with cancer. In the time he had left, he wrote this detailed and lucid account of his experience of illness and of life – a remarkable literary effort that stretches right up to the final furlong of his life, when the drugs finally stopped working.

He packed quite a lot into the short time left to him – he died less than two years following the day he examined his CT scan – continuing to work as a surgeon for a while and trying to enjoy to the full life with his family and friends.

He spent much of this time writing; his



account covering his life before and after the fateful diagnosis sparing the reader none of the often cruel details of his cancer journey. To his great joy, he became a father eight months before his death. He was present at his daughter's birth, having been pushed to the delivery room in a wheelchair by his father.

Paul Kalanithi was more than a surgeon; his was certainly not 'the life unexamined'; he had a rich hinterland beyond the world of medicine. He had studied English as well as medicine, and gained solace from literature and philosophy. He admired TS Eliot and Samuel Becket, as well as the writings of William Osler, a pioneer of modern medicine. Paul's final journey could well be summed up by the line from Waiting for Godot: "I can't go on. I'll go on."

His wife Lucy, who provides the poignant epilogue to the book, says her husband spent much of his life wrestling with the question of how to live a meaningful life.

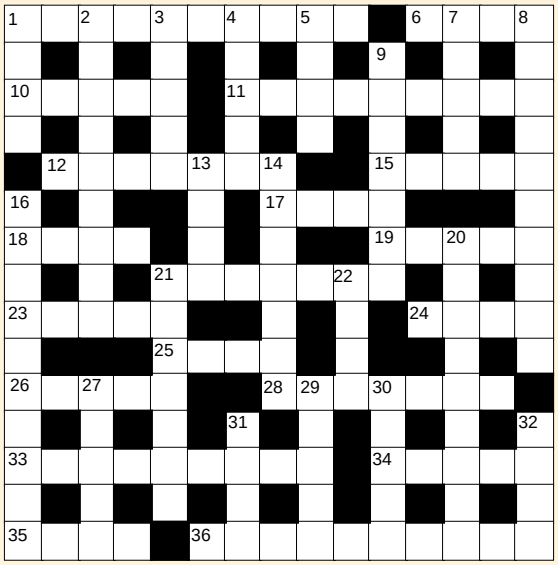
Paul Kalanithi's lyrical testament, which tells the story of his transformation from a medical student, seeking to find what makes a virtuous and meaningful life, into a neurosurgeon working on the brain, the very core of human identity, and then into a patient and a new father – shows this remarkable young man lived as meaningful a life as anyone could wish for.

– Niall Hunter

When Breath Becomes Air by Paul Kalanithi, is published by Vintage. ISBN-13: 978-1847923677 RRP €10.99

Crossword Competition

WIN A €30 BOOK TOKEN



Across
1 Slander (10)
6 Profit (4)
10 Grouting is part of this person's trade (5)
11 In control of one's movements – from Europe, for example (9)
12 Completely ineffective (7)
15 & 34A It could be happily ever after, but there's nothing more to add! (3), (2), (5)
17 It is called out to make a horse stop (4)
18 Natural coral formation (4)
19 The capital of Bulgaria (5)
21 Midlands town, a source of ethanol (7)
23 A person, not an animal (5)
24 She accompanied Jack in a nursery rhyme (4)
25 River which flows through Florence (4)
26 Fishy way to make a living (5)
28 That strange wee ally may have a form of strabismus (4), (3)
33 Iconic item of fashion accredited to Mary Quant (4), (5)
35 The last word of a prayer (4)
36 Dance that makes a British prince put on weight (10)

Down
1 Information (4)
2 & 7D Nautical command for maximum speed (4), (5), (5)
3 Ms Streep won her first Oscar for *Kramer vs Kramer*
4 Filled tortillas (5)
5 Possesses scattered snow (4)
7 See 2 down
8 & 9 Rubella, for example, solidifies a beaten mixture (10), (7)
13 Way out (4)
14 Bird with a forked tail (7)
16 The heart condition might make Harry ham it up (10)
20 Rath (5), (4)
21 Examine any seal dissection (7)
22 Cuticle (4)
27 Musical named for an orphaned heroine (5)
29 Change (5)
30 Gloves etc. produced from a hard-twisted material (5)
31. Loud exhalation, showing tiredness or disappointment (4)
32 Religious song

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

The prize will go to the first all correct entry opened.
Closing date: Tuesday, May 23, 2017
Post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin

Solutions to April crossword:

Across:
1. Acknowledges 7. Him 9. Bell 10. Stormy 11. Ants 14. Lemon 15. Gecko 16. Stye 18. Copes 21. Rouge 22. Tramp 23. Nadir 24. Over 25. Flirt 26. Price 29. Eden 33. Offend 34. Mayo 36. Ash 37. Osteoporosis

Down
1. Ale 2. Kilt 3. Oust 4. Loose 5. Dumbo 6. Shun 8. Mashed potato 9. Beggar's Opera 12. Accuse 13. Dozen 14. Laced 17. Tragic 19. Purse 20. Stiff 27. Rifle 28. Cheap 30. Echo 31. Oder 32. Imps 35. Yes

The winner of the April crossword is: Graham Knight Blackrock Co Dublin

MONEY MATTERS

Knowing your AVCs

Ivan Ahern advises on last-minute AVCs for public sector employees approaching retirement

ARE you a public sector employee and are you approaching retirement? If you answered yes to both questions then it is worth your while investigating if the tax-free lump sum you will receive at retirement is the maximum amount you are entitled to.

This tax-free lump sum may be less than the maximum amount you are entitled to for many reasons. It simply boils down to your own individual circumstances.

- Have you less than full service?
- Have you received a reduction in pay in the last number of years?
- Have you more than 40 years' service and are you over the age of 60 having worked beyond your normal retirement age?
- Have you non-pensionable earnings?

If you fall into any of the four categories above and have not yet retired, then there is still time to maximise your tax-free lump sum using a last-minute AVC.

How does a last-minute AVC work?

In simple terms, you invest a single investment into a low-risk pension fund prior to your retirement and avail of the tax relief available on your investment. The reason you can claim tax relief on your investment is because AVC contributions made while working are eligible for tax-relief at your marginal rate of tax (subject to Revenue limits). Typically for the average employee paying into a last-minute AVC, this is 40%. After you retire, you can then draw down your total investment as a tax-free lump sum, less charges.

Example

Susan is retiring this year and it has been identified that her tax free lump sum will be short €12,000 as she has not worked for 40 years and she also has had a number of pay cuts over the last few years.

In order for Susan to maximise her lump sum she invests €12,000 plus charges into a last-minute AVC before she retires.

The charges associated with a last-minute AVC include a consultancy charge of €450, a contribution charge of typically 4% and an annual management charge of typically 1%.

After Susan invests her €12,950 (including charges), she can claim back €5,180 of her investment from Revenue as she is paying 40% income tax.

When Susan retires she will receive her shortfall of €12,000.

Not retiring in the near future and not yet saving for your retirement fund?

If you fall into this category then it is important that you get financial advice about your retirement entitlements.

Over recent years there have been many changes to public sector pension schemes (superannuation) as well as the state pension. The pension pot that you thought you would receive may be a lot smaller in reality.

People, in general, can no longer rely on the state pension and for younger people it will not be anything like the current pension we know today.

When it comes to saving for your retirement there are many options to choose from. Such options include AVCs, purchase of notional service, retirement savings plans or sometimes, a combination of them all.

What works for one person may not work for another. It all comes down to your individual circumstances and needs.

You can only do a last-minute AVC before retirement.

Ivan Ahern is a director of Cornmarket Group Financial Services Ltd

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For an appointment with a retirement planning consultant see www.cornmarket.ie or contact Cornmarket at Tel: 01 4200986

Guiding nursing and midwifery practice

Statement of Strategy 2017-2019 launched by NMBI

THE NMBI *Statement of Strategy 2017-2019*, which aims to support registrants and protect the public by establishing standards and requirements that guide nursing and midwifery practice in Ireland, was launched earlier this month by Minister for Health Simon Harris.

The Strategy outlines three strategic priorities:

- Strengthening the NMBI's reputation with registrants, the public and key stakeholders
- Building stakeholder understanding of how the NMBI works and making it more consistent, efficient and effective to deal with
- Ensuring NMBI is equipped to meet the needs of registrants, the public and other stakeholders and is able to deliver on its new strategy.

The NMBI *Statement of Strategy 2017-2019* was completed following a process that included developing a draft document based on NMBI's statutory responsibilities and organisational objectives, and then a public consultation on this draft in October 2016.

Pictured at the launch of the *NMBI Statement of Strategy 2017-2019* were (l-r): *Mary Griffin, NMBI CEO; Minister for Health, Simon Harris; and Essene Cassidy, NMBI president. The Strategy aims to support registrants and protect the public by establishing standards and requirements that guide nursing and midwifery practice in Ireland*

This consultation garnered feedback from registrants, former Board members, staff organisations, employers, patient advocate groups and other key stakeholders via an online survey, email responses and workshop meetings. This feedback was then incorporated into the final Strategy.

Speaking on the Strategy, president of the NMBI, Essene Cassidy, said: "This new strategy reflects our drive now to strengthen our relationship with our registrants, to make our work more transparent and to make sure we are equipped to meet the needs of our registrants, the public and other stakeholders going forward."

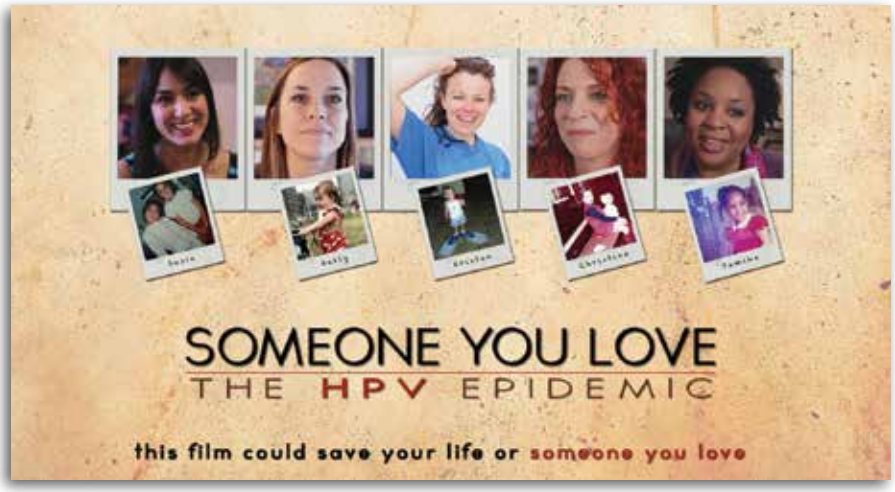
Raising awareness of HPV epidemic

New documentary highlights real life impact of HPV-related cancer

SOMEONE You Love: The HPV Epidemic, a documentary which aims to highlight the real life impact of HPV-related cancer and raise awareness of the widely misunderstood disease, was screened for the first time in Dublin recently.

The documentary follows the stories of five women who have been afflicted by HPV, outlining their battle with cervical cancer, and includes interviews with some of the world's leading experts on HPV.

Someone You Love: The HPV Epidemic is supported by MSD Ireland, Cerviva, Marie Keating Foundation, Irish Cancer Society, Irish Family Planning Association and the Well Woman Centre.



This year in Ireland, more than 280 women will be diagnosed with cervical cancer and 90 women will succumb to it, despite the modern treatments provided in Ireland. In addition, more than 6,500 women in Ireland receive invasive treatment to remove HPV-caused pre-cancers each year, and one in 10 women will need treatment in their lifetime because of HPV infection.

Cervical cancer survivor and patient advocate, Christine Baze, who took part in the documentary, said: "For me, making *Someone You Love* gave me the opportunity to show the world my story of survival, while helping others to understand HPV and the misconceptions, stigma and pain associated with this terrible affliction on our bodies. I hope it evokes an emotional impact from the audience and gives people an insight into the struggle, heartbreak and triumph we experienced during the making of the movie."

There are approximately 170 different types of HPV, of which around 40 HPV types affect the genital areas, mouths and throats of men and women. A number of these strains have a strong risk of causing cancer but often do not present with symptoms. As a result, those affected will be unaware that they have HPV but may still pass on the infection.

A panel discussion, moderated by writer and HPV-cancer survivor Emily Hourican, was held following the documentary to discuss the impact and burden of HPV on Irish society. Panel members included Irish cervical cancer survivor Heather Keating, Dr Matt Hewitt, Dr Robert O'Connor and Christine Baze.

For more information on HPV visit **www.hpv.ie**

Cinema offer for INMO members

AS AN INMO member, you have access to the exclusive savings and discounts programme 'INMO Groupscheme'. Groupscheme members can save money on hundreds of well-known brands and retailers in Ireland and take part in a number of competitions each year.

The 'cinema plus' offer on INMO Groupscheme launched at the beginning of April, with Omniplex and Cineworld being the first two chains to launch and other major chains to follow. Discounts of up to 40% will apply.

To register go to **www.inmo.ie/inmogroupscheme** and click on 'register now'. We will email members twice a week to promote new offers and remind users about existing offers.

Improving the standard of end of life care in hospitals across Ireland

THE Health Service Executive and Irish Hospice Foundation have announced the new Joint Oversight Group of the Hospice Friendly Hospitals Programme, which aims to improve the standard of end-of-life care in all Irish adult, child and maternity hospitals.

The new group is being formed to further support the embedding of the programme within HSE structures. It will also examine ways to expand and develop the programme across the hospital system where possible.

The Joint Oversight Group is chaired by Prof Cillian Twomey and includes experts from clinical programmes in palliative care, older persons, emergency department and paediatric care, and will meet three times a year.

The programme co-ordinates three networks for hospital staff to promote improvements in end-of-life care from the perspective of patients, families and hospital staff and advocates for investment in palliative, end-of-life and bereavement care services at the hospital, hospital group and national levels. It develops and promotes the use of ceremonial resources such as the end of life symbol, family handover bags, drapes and ward altars.

It also develops promotional and educational supports for all hospital staff and co-ordinates the Design and Dignity Project which aims to transform the way hospital spaces are designed for people at end of life. It provides expert advice and guidance directly to hospital staff to support the implementation of the Hospice Friendly Hospitals Programme in their hospitals.

May

Wednesday 10
OHN Section conference. Cork. Log on to **www.inmoprofessional.ie** or contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 13
School Nurses Section meeting. Portlaoise Heritage Hotel, Town Centre, Portlaoise. 10.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Tuesday 16
Student Allocations Liaisons Group meeting. INMO HQ. From 12.30pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 27
CNM/CMM Section meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Tuesday 30
Telephone Triage Section meeting. Limerick. Session on pregnancy complications and mindfulness. 10am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

June

Wednesday 7
ED Nurses Section meeting. INMO Cork Office. 10am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 10
PHN Section meeting. INMO HQ. From 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 10
Community RGN Section meeting. INMO HQ. 11am-1pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 10
CNM/CMM Section meeting. Limerick. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Thursday 15
ODN Section meeting. INMO HQ. 6pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Wednesday 28
CPC Section meeting. INMO HQ. From 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Thursday 29
Orthopaedic Nurses Section meeting. Cappagh Hospital, Dublin. From 11am-1pm. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Upcoming events

- The Irish Nurses and Midwives Golf Society outing will take place on May 19, 2017 in Portumna Golf Club. Cost €50. Booking from April 3, 2017, email: portumnagc@eircom.net. Bookings will only be confirmed on receipt of payment within five days to Bernie Kilmartin or Marie Kelly, Portumna Golf Club, Ennis Road, Portumna, Co Galway. For further details contact Bernie Kilmartin at Tel: 087 6787395 or Michael Ryan at Tel: 090 9741059
- The second National Paediatric Children's Nurse Specialist Seminar, entitled 'Paediatric specialist nursing – a changing landscape' will take place in AMNCH Auditorium, Tallaght Hospital on Thursday, May 25, 2017 from 8.30am to 4.30pm. Admission is free. Tel: 01 4142846, Bleep: 7186, email: patricia.gaule@amnch.ie

INMO Membership Fees 2017

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

Condolences

- The INMO extends its sincere condolences to Mary Leahy, INMO member, on the sudden passing of her husband, Andrew Leahy. RIP
- The INMO sends its deepest sympathies to the family and friends of Eithne Hallinan, of the Mater Misericordiae Hospital, who passed away recently. May she rest in peace

Important message from the INMO

Is your INMO membership up to date?

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

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

Please advise the INMO directly if you have changed employer or work location

Contact the membership office with any updates through the main INMO switchboard at Tel: 01 6640600 or email: membership@inmo.ie

INMO