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Fair pay – an issue for all nurses and midwives

IN RECENT weeks there has been an increased focus on the issue of public service pay, with particular attention on the flawed and damaging strategy of offering lower pay to new entrants, ie. nurses, midwives, teachers and the Gardaí.

The situation was further highlighted through comments by the chief executive officer of the Workplace Relations Commission, Kieran Mulvey, who said new entrant pay would have to be examined in the context of the wider labour market. This was followed by the immediate rebuttal of this stance by the secretary general of the Department of Public Expenditure and Reform, Robert Watt, who said the Lansdowne Road Agreement must stand and was not subject to review or renegotiation at this time.

In the context of this recent debate, very little reference was made to the fact that between 2009 and 2014 all public servants suffered a minimum pay reduction of 14% with many suffering reductions of 16% plus. In the case of nursing and midwifery, this pay reduction was accompanied by the unmitigated disaster of the recruitment ban, which resulted in the loss of 5,200 nursing and midwifery posts or almost 13% of nurses and midwives working in the public health service. In addition, members had to endure an increase in working hours.

As part of the Lansdowne Road Agreement, small steps were taken with regard to restoring pay, in the form of €1,000 in each of the next two years or, broadly, 2% per annum. However, and this is now quite clear, this slow pace of restoration is neither fair, reasonable or sustainable in the context of an economy which is growing at up to 7% per annum. It is completely fair for nurses and midwives and other public servants, through their unions, to demand a significant acceleration with regard to pay restoration.

This wholly legitimate perspective was further reinforced during the recent general election campaign when outgoing ministers, including the Minister for Finance, repeatedly stated that the 'Emergency' was over and economic recovery was underway.

In the context of nursing and midwifery, it must be noted that, unlike other areas of the economy, the need for early, positive movement on pay is vital due to the severe recruitment and retention problems facing the professions. It is not just that we cannot attract and retain new graduates; the reality is that we continue to haemorrhage colleagues, with nurses and midwives with three, five, seven and greater years' experience growing tired of pay cuts, long hours, excessive workloads and a general approach from management which ignores these realities.

In addition, and this is key, we have an urgent need to reflect on the pay of all nurses and midwives, the expansion of roles, the increased responsibility and the higher levels of autonomy that are now an everyday reality for every nurse and midwife. It is against this background of pay (and hours) being an issue for all nurses and midwives that the Organisation gathers for its annual conference from May 4 to May 6. At this conference, we must have this discussion, acknowledge and embrace the new evolving role of every nurse and midwife and demand, without fear or favour, an immediate examination of the pay of all nurses and midwives.

It is still true that nurses and midwives are underpaid, undervalued and overworked, however, beginning at this conference and in the context of a growing economy, we must 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 in other countries so that we can attract, retain and reward nurses and midwives. This journey may be difficult but we must take our first steps at this year's annual conference.

Liam Doran
General Secretary, INMO

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

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- **Karen McGowan,** ANP, Beaumont Hospital, Dublin 9

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Ex-Officio

- **Claire Mahon**

Executive Council 2016-2018 elected

Candidates declared for officer elections

FOLLOWING the recent election process, the INMO Executive Council for the period 2016-2018 has been elected *(see opposite)*.

The new Executive Council will officially take up office on May 6, following the close of business at the annual delegate conference in Killarney. The newly elected Executive Council will meet for the first time in June.

The election for the offices of president, first vice president/ honorary treasurer and second vice president will take place on Friday, May 6 at 2.15pm and all official delegates to annual conference will have a vote. Those standing for each position are as follows:

Office of president

- Margaret Frahill, CNM3, Theatre Department, Mercy University Hospital Cork
- Martina Harkin-Kelly, specialist co-ordinator/nurse educator, CN/ME, Sligo/ Leitrim and West Cavan, Cregg House Campus, Co Sligo.

Office of first vice president/ honorary treasurer

- Margaret Frahill, CNM3, Theatre Department, Mercy University Hospital Cork
- Eileen Kelly, staff nurse, Sacred Heart Hospital, Roscommon
- Mary Leahy, public health nurse, Doughiska Primary Care, Galway.

Office of second vice president

- Margaret Frahill, CNM3, Theatre Department, Mercy University Hospital Cork
- Eileen Kelly, staff nurse, Sacred Heart Hospital, Roscommon.

INMO general secretary, Liam Doran said: "The Organisation would like to thank and congratulate all those who put their names forward for the new Executive Council and we look forward to working with all the new officers, once elected, in the months and years ahead."

Restoration of pay a key issue at ADC 2016

THE INMO is holding its 97th annual delegate conference in the INEC Convention Centre in Killarney from May 4-6.

The conference will once again see more than 350 delegates from the Organisation's branches and sections gather to discuss and debate nearly 70 motions on issues such as pay restoration, 37 hour week, recruitment and retention and staffing levels in all areas. The full text of the motions for debate can be viewed on the INMO website **www.inmo.ie**, together with full details of the conference agenda.

The theme for this year's ADC is *'Registered nurses and midwives: professionals in action – making the difference'.*

Wednesday agenda

The conference will commence with a press conference on Wednesday, May 4 at 12.15pm. Registration commences at 2pm and the conference itself will start at 3pm, with a debate on Organisational motions in private session.

There will be a debate on education and social policy motions from 5.30-6.45pm, followed by the adoption of a position statement regarding HCA grade. Dinner will be at 8pm, after which there will be a table quiz/raffle in aid of a local charity.

Thursday agenda

Thursday's proceedings will commence at 9am with a debate on professional and industrial motions until 11.15am. At 11.45am there will be a discussion/adoption of the INMO *Health Policy – Excellence in Healthcare,* after which the debate on motions will continue.

There will be a review of the year at 12.45pm by David Hughes, deputy general secretary. INMO president Claire Mahon will address delegates at 1pm. At 2.30pm, Mark Loughrey will give a presentation on nurses and midwives in the 1916 Rising.

Motions will continue to be debated until 6pm, followed by a keynote address from motivational speaker Gerard Moran.

Dinner is at 8pm, after which the Gobnait O'Connell Award, the Coleman Research Award and the Preceptor of the Year Award will be presented. This will be followed by entertainment.

Friday agenda

Debate on remaining motions will continue on Friday morning from 9am to 12pm, at which time the Minister for Health is expected to address delegates, subject to the ongoing discussions to form a new government.

At 2.15pm the result of the Executive Council elections will be announced and the president, first vice president/ honorary treasurer and second vice president for 2016-2018 will be elected. The conference will close at 5pm. A drinks reception will be held at 7.30pm before the annual gala dinner.

INMO general secretary, Liam Doran said: "This conference is taking place against the background of pay (and hours) being an issue for all nurses and midwives. Nurses and midwives are underpaid, undervalued and overworked.

"However, beginning at this conference and, in the context of a growing economy, we must unite, as we have done before, in pursuit of the legitimate 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 once and for all. This journey may well be difficult but we must take our first steps at this year's annual conference."

March trolley figures at all-time high

Actions agreed under ED taskforce have not been implemented

A TOTAL of 9,381 patients were on trolleys in March this year awaiting admission for inpatient treatment, representing a 5% increase compared to March 2015 and the highest trolley figures recorded for March to date.

The figures *(see Table 1)* also show that March 2016 saw a 100% increase in overcrowding compared to March 2008 when 4,701 patients were on trolleys, confirming that despite the initiatives to date, the service continues to face intolerable levels of overcrowding. This is due to a lack of beds and staff across the system.

The figures also confirm that all of the actions required, and agreed under the ED Taskforce, have not been implemented, with patient care continuing to be compromised and nursing staff continually overworked.

The hospitals that suffered the greatest deterioration were:

- Midland Regional Hospital, Tullamore up from 204 to 568 (+364)
- South Tipperary General Hospital up from 233 to 552 (+319)
- University Hospital Limerick up from 558 to 710 (+152)
- Cork University Hospital up from 412 to 550 (+138)
- Bantry General Hospital up from 39 to 146 (+107).

INMO general secretary Liam Doran said: "In view of these figures the INMO, and myself as joint chair of the ED Implementation Group, will seek an immediate meeting of the Group to assess the situation and determine what additional measures can be taken to alleviate the suffering of patients. Nothing must get in the way of whatever special measures are necessary to lessen the current environment facing patients and frontline staff."

Table 1. INMO trolley and ward watch analysis March 2006 – March 2016

Hospital	March 2006	March 2007	March 2008	March 2009	March 2010	March 2011	March 2012	March 2013	March 2014	March 2015	March 2016
Beaumont Hospital	514	598	615	744	937	610	655	581	342	643	721
Connolly Hospital, Blanchardstown	244	288	176	288	170	375	257	573	364	452	300
Mater Misericordiae University Hospital	598	416	422	375	496	311	380	262	264	541	356
Naas General Hospital	478	286	225	384	234	778	240	227	234	389	426
St Colmcille's Hospital	216	32	34	155	219	210	189	150	n/a	n/a	n/a
St James's Hospital	670	95	257	234	136	210	75	216	152	335	162
St Vincent's University Hospital	413	464	429	515	594	560	456	404	178	599	672
Tallaght Hospital	734	339	381	686	509	643	211	389	392	409	506
Eastern	**3,867**	**2,518**	**2,539**	**3,381**	**3,295**	**3,697**	**2,463**	**2,802**	**1,926**	**3,368**	**3,143**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	42	39	146
Cavan General Hospital	355	238	121	113	312	489	249	125	36	65	117
Cork University Hospital	467	341	373	331	586	843	596	308	304	412	550
Kerry General Hospital	159	30	148	12	69	81	34	118	76	125	89
Letterkenny General Hospital	228	275	42	11	86	51	43	180	227	281	191
Louth County Hospital	12	12	26	1	2	n/a	n/a	n/a	n/a	n/a	n/a
Mayo General Hospital	281	163	148	48	216	68	220	203	186	247	325
Mercy University Hospital, Cork	200	145	98	163	135	186	172	292	222	251	194
Mid Western Regional Hospital, Ennis	71	128	38	38	27	81	27	58	n/a	14	36
Midland Regional Hospital, Mullingar	6	11	11	28	230	331	288	403	250	562	468
Midland Regional Hospital, Portlaoise	56	39	78	63	24	90	55	60	166	217	260
Midland Regional Hospital, Tullamore	4	0	0	5	68	224	158	199	396	204	568
Monaghan General Hospital	3	45	37	35	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
Our Lady of Lourdes Hospital, Drogheda	405	386	194	398	356	541	660	333	474	533	474
Our Lady's Hospital, Navan	41	100	55	105	66	249	117	175	60	75	46
Portiuncula Hospital	78	23	38	16	74	71	105	162	45	99	86
Roscommon County Hospital	108	36	95	91	55	121	n/a	n/a	n/a	n/a	n/a
Sligo Regional Hospital	161	46	77	96	153	156	104	242	238	235	213
South Tipperary General Hospital	111	88	55	53	89	104	150	158	250	233	552
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	n/a	48	49	214	265	284	357
University Hospital Galway	258	189	209	305	443	626	409	401	387	634	539
University Hospital Limerick	223	42	188	199	237	269	319	924	499	558	710
University Hospital Waterford	n/a	n/a	19	69	64	148	110	102	352	289	306
Wexford General Hospital	294	86	112	159	34	348	127	273	42	194	94
Country total	**3,521**	**2,423**	**2,162**	**2,339**	**3,326**	**5,125**	**3,992**	**4,930**	**4,567**	**5,566**	**6,238**
NATIONAL TOTAL	**7,388**	**4,941**	**4,701**	**5,720**	**6,621**	**8,822**	**6,455**	**7,732**	**6,493**	**8,934**	**9,381**

Comparison with total figure only:

Increase between 2015 and 2016: 5%
Increase between 2014 and 2016: 45%
Increase between 2013 and 2016: 21%

Increase between 2012 and 2016: 45%
Increase between 2011 and 2016: 6%
Increase between 2010 and 2016: 42%

Increase between 2009 and 2016: 64%
Increase between 2008 and 2016: 100%
Increase between 2007 and 2016: 90%
Increase between 2006 and 2016: 27%

Second WRC review considers implementation of ED Agreement

THE Workplace Relations Commission (WRC) held its second review of the ED agreement, between the INMO/HSE/Department of Health on Friday, April 15, 2016.

The review enabled the WRC to receive reports, from both management and the INMO, on the implementation of all aspects of the agreement, and to deal with any difficulties and obstacles. The following is a summary of the issues reviewed in the process.

Taskforce on Nurse Staffing in Emergency Departments

A critical part of the agreement is the establishment of a Taskforce on Nurse Staffing in EDs to review and recommend standard staffing levels for all EDs in the country.

Ahead of this second review, the INMO had made it plain, to the management side, particularly the Department of Health, that the failure to progress this part of the agreement was a major breach and completely unacceptable. Arising from this, at the recent review, a proposal was made providing for a process, to report within three months, to examine previous staffing reviews undertaken in Ireland, together with international research. Further discussions on this were ongoing at the time of going to press, with a view to finalising this critical aspect of the overall agreement.

Current staffing issues

It was reaffirmed at the review that all vacant posts in EDs (currently 140 approximately) will be filled. The HSE/Department of Health acknowledge that, despite the tightened financial controls now in place, the commitment to fill all vacant ED nursing posts is absolutely steadfast and all local employers are being advised of same. This issue will be monitored via the weekly group/hospital level meetings, established under the agreement between INMO and management.

Additional staff – admitted patients

At the review the INMO also reaffirmed its demand for the need for additional nursing staff to look after the increased volume of attendances at EDs and, in addition, admitted patients in the ED. This issue was also raised at the most recent meeting of the ED Taskforce Implementation Group, at which the INMO stated that, in the absence of additional staff, the Organisation would be seeking the closure of beds in many hospitals across the country. These bed closures would be necessary to ensure safe care and safe practice in a situation where nursing staff are completely overwhelmed both in EDs and inpatient wards/units.

Additional posts/regradings

The management side confirmed that the circular sanctioning the additional posts provided for in the agreement, had been issued. This circular provides for:

- Assistant director of nursing posts in all 26 EDs, with sole focus on patient flow
- CNM2 posts in 15 hospitals to look after admitted patients
- Seven CNM1 posts (conversion) to be established via internal competition in all EDs (St James's ED already has these seven CNM1 posts).

The review also confirmed that the new ADON post for patient flow in ED is completely separate from existing senior nurse management structures in hospitals. The priority for this post is patient flow to assist the functioning of EDs.

Miscellaneous matters

During the review, the INMO raised issues that members had reported were creating difficulties at local level in some locations, including:

- The necessity to remind some hospital managements that there is one national Escalation Policy, which is not subject to amendments/additions in any way, shape or form by local management
- The need for some managements to identify the senior clinical decision makers who will be available outside of core hours to assist with patient flow and admissions/discharge decisions
- The need for hospital managements to accommodate requests from nursing staff for flexible working opportunities across the hospital environment
- The need to engage with the National Ambulance Service, together with Group CEOs, leading to the provision of ambulance protection to individual hospitals enduring high volumes of overcrowding
- Swifter action on the introduction of the No Faults Compensation Scheme, the Hygiene and Health and Safety Audits, in full conjunction with the INMO, as provided for under the agreement.

It was acknowledged at the review that the level of ED overcrowding and the number of admitted patients on trolleys continues at record high levels. It was also agreed that this requires the system-wide measures to be applied with even greater priority.

Further WRC review

At the conclusion of this second review the WRC indicated it would convene the parties, for a third review of the implementation of the agreement, on May 23, 2016.

Special Delivery Unit (SDU) reports

Subsequent to the review, the SDU issued its first 12 reports to the hospitals/groups involved, which are to be discussed at the next round of meetings provided for under the ED agreement.

These reports show that all 12 hospitals have been in breach, on several occasions, of the Directive issued by the Minister/HSE on the nine hour target and other measures. These hospitals have now been given a defined period to demonstrate improvements under stated headings before fines are levied. The 12 hospitals will be subject to ongoing, unannounced visits from the SDU to assess the implementation of the improvement measures required.

INMO general secretary Liam Doran said: "All parties acknowledge that the level of ED overcrowding continues at record levels, resulting in unacceptable care environments and excessive workloads on staff. This is compounded by the continuing failure of some managements to implement this system-wide agreement on a 24/7 basis. It is clear that in such situations our members may need to initiate action, at local level, to highlight local problems, breaches of the agreement and resulting compromising of patient care.

"The INMO reaffirms its commitment to the agreement and we will continue to work with managements, at all levels, who are committed to addressing this crisis through the agreement measures. However, where management ignore the extent of the problem, our members will be supported in taking necessary actions to ensure the agreement is fully implemented".

ED Taskforce Implementation Group reviews progress

THE latest meeting of the ED Taskforce Implementation Group took place on Monday, April 18, 2016. The INMO was represented at this meeting by general secretary Liam Doran, in his capacity as joint chair of the group.

The purpose of the implementation group is to monitor, on an ongoing basis, the implementation of the 80 or so recommendations from the ED Taskforce report which issued in April last year.

At the latest meeting a number of issues were discussed including:

- Confirmation that the latest attendance figures, for all emergency departments, indicate there has been an increase, in the year to date, of 7.9% as compared to 2015
- This significant increase, in terms of numbers of attendances/admissions, marks a step change in the challenge facing the ED and hospital wide system to cater for, in a safe and appropriate fashion, this increase in demand
- In the area of social care it was confirmed that there is no funding for any additional homecare packages above those currently in operation, and any new package can only be granted when a current recipient no longer requires same.

Obviously the above point will negatively impact on the ability of people, usually frail elderly, to remain at home, with receipt of appropriate supports, thus leading to their attendance, to the hospital system, sooner rather than later.

It was also confirmed that no additional long-term care beds are expected to become available in the short term, either through the public or private pathway. In this regard it was acknowledged that nurse recruitment in long-term care facilities remains hugely problematic, resulting in many private nursing homes being unable to take on additional patients at this time.

In relation to the acute hospital division significant attention was paid to:

- The growing difficulties in increasing bed numbers, due to staff shortages
- The real potential for beds having to be closed, on the grounds of risk, health and safety, due to staff shortages
- The lack of clarity, within the system, with regard to recruitment, at this time, due to the overall budgetary situation of the HSE.

In response to this it was agreed, at this meeting, that the issue of recruiting/retaining nursing staff would be regarded as a 'red flag' issue by the Taskforce, and a priority issue to be discussed when a new Minister for Health is appointed on the formation of a new government.

However, no new initiative was agreed at the meeting as this is a 'policy' issue which requires ministerial/government approval.

Special Delivery Unit

The Taskforce also heard that the Special Delivery Unit (SDU) had issued its first 12 reports, to the hospital/group system, arising from its first set of reviews under the ED agreement between the INMO, the HSE and the Department of Health.

In these reports it was confirmed that a timeframe for improvements, under each of the areas/regions identified, had been specified, usually the end of May. It was stated that fines will apply, thereafter, if improvements are not demonstrated.

In relation to this it was also confirmed that the SDU will undertake unannounced visits to these 12 hospitals over the next four to five weeks to assess progress on implementing the required measures. In addition, the SDU will have a cross divisional responsibility seeking to link the work of the acute/social care/primary care divisions, leading to more integrated decision making.

Summary

In summary, the latest Taskforce meeting noted:

- The HSE clearly stating that the service is under severe pressure and that, as a result, patient need, either in the hospital or at home, is not being fully met
- In the absence of a functioning Minister (instead of a caretaker Minister) no new/required initiatives will be forthcoming. It was acknowledged, particularly taking into account renewed UK recruitment initiatives targeted at Irish nurses, that there is a likelihood that there may be a contraction of bed numbers, during the second and third quarters, to reflect available staffing
- Notwithstanding the difficulties itemised above, there was confirmation that both the Department of Health and the HSE remain fully committed to all elements of the ED agreement including the filling of posts. It was also acknowledged that the pace of implementation would have to be increased.

INMO general secretary Liam Doran said: "It is quite apparent that the pace of implementation, of the 80 recommendations, continues to be less than optimal resulting in avoidable difficulties within the system. It was equally apparent that the health service, due entirely to increased demand, has been given a wholly inadequate budget, for 2016, which will, if not addressed, materially affect service provision in the second half of the year.

"It is imperative, in the interests of addressing the problems facing the health service, that a new government is formed as the current vacuum is, undoubtedly, leading to avoidable difficulties".

The Taskforce Implementation Group will meet again after approximately eight weeks.

NMBI registration fees 2016

The Nursing and Midwifery Board of Ireland (NMBI) has notified the INMO that the Board of NMBI will be considering the removal of names of nurses/midwives, from the register, who have not paid their annual retention fee for 2016 as of May 24, 2016. If the Board decides to proceed with this removal of names from non-payers, this will take place with effect from that date.

Against this background, the INMO reminds all members who have not already done so, to move, immediately, to pay the annual retention fee (€100) for 2016 to avoid any difficulties or significant costs.

For further information see: **www.nmbi.ie/News-Events/News/Removal-from-Register**

INMO calls for urgent reform of public health and primary care services

A REPORT on 'Missed Care – Community Nursing in Ireland' indicating that community nursing in Ireland is under severe strain was recently launched at INMO HQ.

Commissioned by the INMO as part of the professional programme and strategy to develop community services in Ireland, the report was written by Dr Amanda Phelan and Sandra McCarthy of the School of Nursing, Midwifery and Health Sciences at UCD.

Following extensive research, lead author, Dr Phelan, points to the lack of necessary reform in community nursing which has led to a service that is struggling to meet the demands from challenges, including a changing national demographic, earlier acute care discharges, more complex case management and consequences of the staffing moratorium.

The report focuses on the concept of missed care which is where care that should have been done has been omitted, delayed or rationed either in part or wholly. The study findings are based on surveys with 283 public health nurses and community RGNs, interviews with stakeholders and a health economics review. The findings include:

- Over 50% of respondents indicated missed care in their previous working week
- 17% indicated they had a caseload over a geographic population of 10,000
- The main area of missed care was in health promotion, particularly in relation to older people and chronic disease management
- Care of older people on the risk register was identified as a particular challenge; > 70% said they were unable to address this in the previous week
- There was a high degree of missed care where caseloads included disadvantaged groups (asylum seekers, homeless, migrants and Traveller populations)
- 79% indicated they were unable to update case notes as required in the previous week
- Lack of administrative support and inadequate staffing levels had a significant impact on missed care
- Increased caseload and case complexity also contributed to missed care
- It estimated that missed care in health promotion of an older person could have an individual cost of €18,527.

Pictured at the INMO launch of the UCD Report on Missed Care in the Community last month were (l-r): Claire Mahon, INMO president, Dr Amanda Phelan, UCD and Madeline Spiers, former INMO president and nominee in Seanad elections

Speaking at the launch Dr Phelan said: "This study examines the context of community nursing in Ireland. Despite many reports pointing to the need for service reform since 1975, community nursing in Ireland has remained static in terms of demographic change, policy change and structural change within health services delivery.

"The experiences of community nurses demonstrate that they are prioritising clinical work (injections, dressings) and legislation obligations (child notifications and child protection), and although missed care was identified at lower rates in these domains, this was at the expense of health promotion and disease prevention. However, in applying case scenarios based on cost benefit analysis of addressing health promotion areas in a comprehensive way, clear potential economic savings can be made."

According to the report the consequences of missed care are multifold:

- A lack of human capital to meet community population need
- Reduced ability to alleviate the pressure on acute care
- A lack of ability to provide choice in care in community
- An inability to meet statutory and regulatory expectations
- A potential increase in health costs due to missed care
- Staff burnout and missed care has been identified with a higher level of intention to leave.

One of the main recommendations emanating from the study is that a Commission be established, to report within one year, to determine the roles that nursing/midwifery will play as a central component of any developed primary care system.

A prominent reason for missed care identified in the study was in relation to a lack of administrative support which reduced the time available to deliver direct nursing care. Another issue related to inadequate staffing and general cross covering caseloads, particularly in relation to filling service gaps, long-term cover for retirement, maternity leave or long-term sick leave.

The study makes 16 recommendations that call for the establishment of a commission to examine the role of community nursing and midwifery and consider issues such as structures, governance, skill mix, career advancement pathways for community nurses, as well as the demand for service expansion.

INMO general secretary Liam Doran said: "The results of this study again reinforce the need for sustained investment in our public health service. The lack of proper funding has severely hindered nurses and midwives in the delivery of care as is evidenced in the study. A fit for purpose primary care service is an essential component of any health service. It is vital that investment is made now and into the future to ensure that a world class service can be delivered to all those who need it."

Dr Phelan said: "Urgent reform is required in terms of ensuring comprehensive care is delivered by a community nursing workforce that can adequately contribute to contemporary health demands at primary, secondary and tertiary care levels for individuals, families and communities."

See also page 26

Wage restraint totally unsustainable

With property prices rising the figures don't add up, writes Dave Hughes

IT IS probably still the main ambition of young people entering the workforce that they will have a secure, reasonably well paid job and a roof over their heads, which they can afford without stifling their entire social life and, if necessary, their ability to provide for a family.

The key equation in making this happen for the majority of the workforce is the cost of housing versus their gross income. The Central Bank, wearing its new cloak of responsibility, has now set the rules for that equation, by capping the amount which new buyers can borrow with a loan to income ratio of 3.5 times annual gross salary and a maximum loan to value of the house being purchased of 90%, up to a ceiling of €220,000 and 80% if the house is valued more than that.

When one does the maths on these valuations, for example in relation to the staff nurse salary scale, it is clear that modest incomes are not sufficient to buy a house in Ireland today. LUAS tram drivers are currently partaking in a bitter industrial dispute with their employers in which their demands have been variously described as excessive or even outrageous. It might be suggested that, in fact, the workers in this case have a more realistic understanding of what it costs to provide a roof over your head, as a PAYE worker. It demands a lot more than the average industrial wage, which is currently just under €37,000 per annum, to secure a mortgage large enough to buy a home.

According to myhome.ie, 75% of house purchases by first time buyers in the Leinster area paid €220,000 for their house this year. There is clearly a relationship between the loan to value set by the Central Bank and this figure. The current staff nurse salary scale runs from €27,483 to a maximum of €42,469 at point 12, with a long service increment of €43,800 after 15 years of service.

Let us take a staff nurse on point eight of that scale, which is marginally above the average industrial wage at €37,408 per annum, the maximum loan to income which can be borrowed on that salary is €130,928. This would leave the staff nurse in question almost €90,000 short of the mixed adjusted asking price for a house in Dublin in 2016 (according to myhome.ie). In fact, in order to avail of a loan of €220,000 an employee would have to have a gross income of €62,857 per annum. The same myhome.ie survey indicates the average price for a four-bedroomed house in Dublin is €399,000.

INMO deputy general secretary Dave Hughes: *"The new government, when and if it is formed, will face a massive level of discontent vented through strike actions and public protests in demand of higher wages and lower house prices"*

The figures simply do not add up. The current wage level in Ireland is too low to meet the cost of housing. It will take two annual salaries of over €30k per annum to receive a loan sufficient to purchase an average house in Leinster and it is not much better for the rest of the country. Banks will insist on confirmation from the employer of the gross salary paid and that tenure of office is permanent in order to give that loan and, having achieved it, the borrowers face a lifetime of significant mortgage repayments.

Something has to give. Either wages need to significantly increase or house prices to drop. Already the construction industry has featured in the media suggesting government subsidies or lower tax take from construction costs to make houses more affordable.

Either of these solutions means that the taxpayer, the majority of whom are PAYE workers, will foot the bill. Colm McCarthy, the often quoted economist, has stated that house prices in Ireland are unrealistic and he has estimated that the selling price is roughly double the actual cost of construction. Government simply wrings its hands as if there is nothing it can do. Meanwhile, the elephant in the room is that we already have a severe housing crisis, with mounting homelessness which is merely the tip of the iceberg if this unsustainable low income versus high property or house value continues.

The new government, when and if it is formed, will face a massive level of discontent vented through strike actions and public protests in demand of higher wages and lower house prices.

The INMO has already called for a renegotiation of the Lansdowne Road Agreement and the immediate full restoration of pay to all public servants, including the abolition of the pension levy.

– Dave Hughes, INMO deputy general secretary

Trust in Care is the sole policy agreed for use in allegations of abuse

TRUST in Care is the agreed policy for Health Service employers to use when investigating allegations of abuse against staff members.

For the purpose of this policy, abuse is defined[1] as "any form of behaviour that violates the dignity of patients/clients. Abuse may consist of a single act or repeated acts. It may be physical, sexual or psychological/emotional. It may constitute neglect and poor professional practice.

It may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. Repeated instances of poor care may be an indication of more serious problems within the organisation for which the individual employee cannot be held accountable.

"There are four broad definitions of abuse which can be used to illustrate the type of behaviour which may constitute abuse: physical, sexual, psychological/emotional or neglect."

A great deal of confusion has been caused by the introduction, without consultation, of another policy entitled *Safeguarding Vulnerable Persons at Risk of Abuse* by the HSE Social Policy Division. The INMO and other health service unions objected to the introduction of this policy without consultation, on the basis that many managers were substituting it for the agreed *Trust in Care* policy.

Therefore, the trade unions raised this as a matter of dispute and correspondence was exchanged. A meeting was held at which the HSE confirmed that the *Trust in Care* policy remains the only policy to be used in allegations of abuse against staff as defined in the *Trust in Care* policy document.

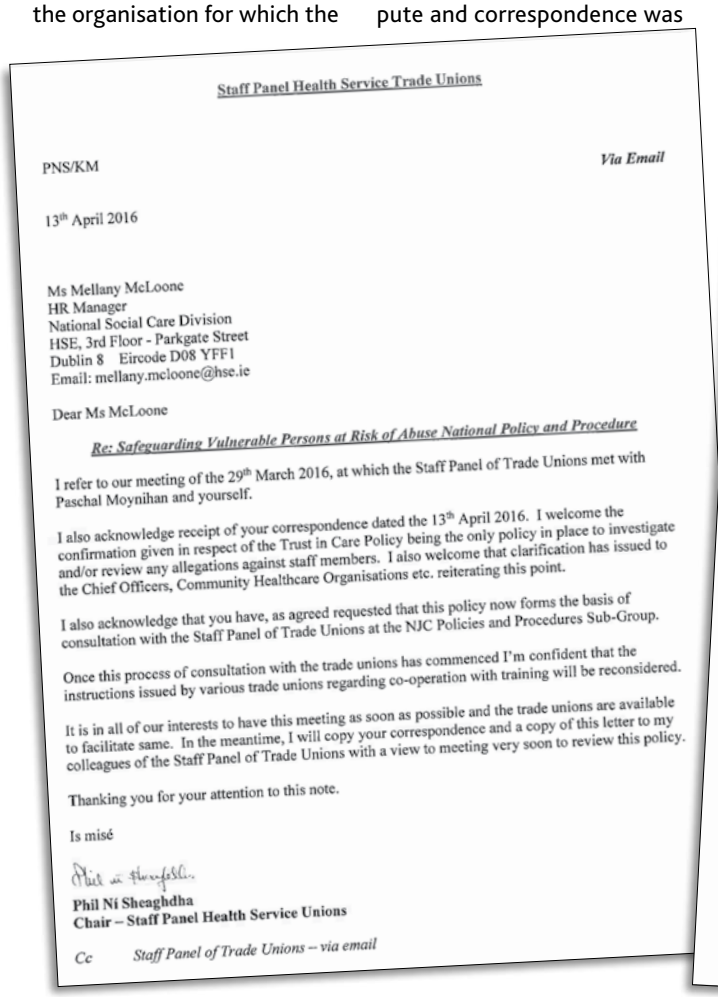
The letters which are illustrated here contain the full contents of management's letter and the trade union response. A further meeting is to be held in order to consider aspects of this policy. Following this further information will be issued to members.

If you have any queries regarding this, please contact your industrial relations officer and remember if you are asked for a statement or to attend a meeting regarding any form of an allegation, do not do this without first consulting the INMO for advice or assistance.

– Phil Ni Sheaghdha, INMO director of industrial relations

Reference

1. Trust in Care: Policy for Health Service employers on upholding the dignity and welfare of patient/clients and the procedure for managing allegations of abuse against staff members, HSE – Employer Representative Division, May 2005, page 7



Staff Panel Health Service Trade Unions

PNS/KM — *Via Email*

13th April 2016

Ms Mellany McLoone
HR Manager
National Social Care Division
HSE, 3rd Floor - Parkgate Street
Dublin 8 Eircode D08 YFF1
Email: mellany.mcloone@hse.ie

Dear Ms McLoone

Re: Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedure

I refer to our meeting of the 29th March 2016, at which the Staff Panel of Trade Unions met with Paschal Moynihan and yourself.

I also acknowledge receipt of your correspondence dated the 13th April 2016. I welcome the confirmation given in respect of the Trust in Care Policy being the only policy in place to investigate and/or review any allegations against staff members. I also welcome that clarification has issued to the Chief Officers, Community Healthcare Organisations etc. reiterating this point.

I also acknowledge that you have, as agreed requested that this policy now forms the basis of consultation with the Staff Panel of Trade Unions at the NJC Policies and Procedures Sub-Group.

Once this process of consultation with the trade unions has commenced I'm confident that the instructions issued by various trade unions regarding co-operation with training will be reconsidered.

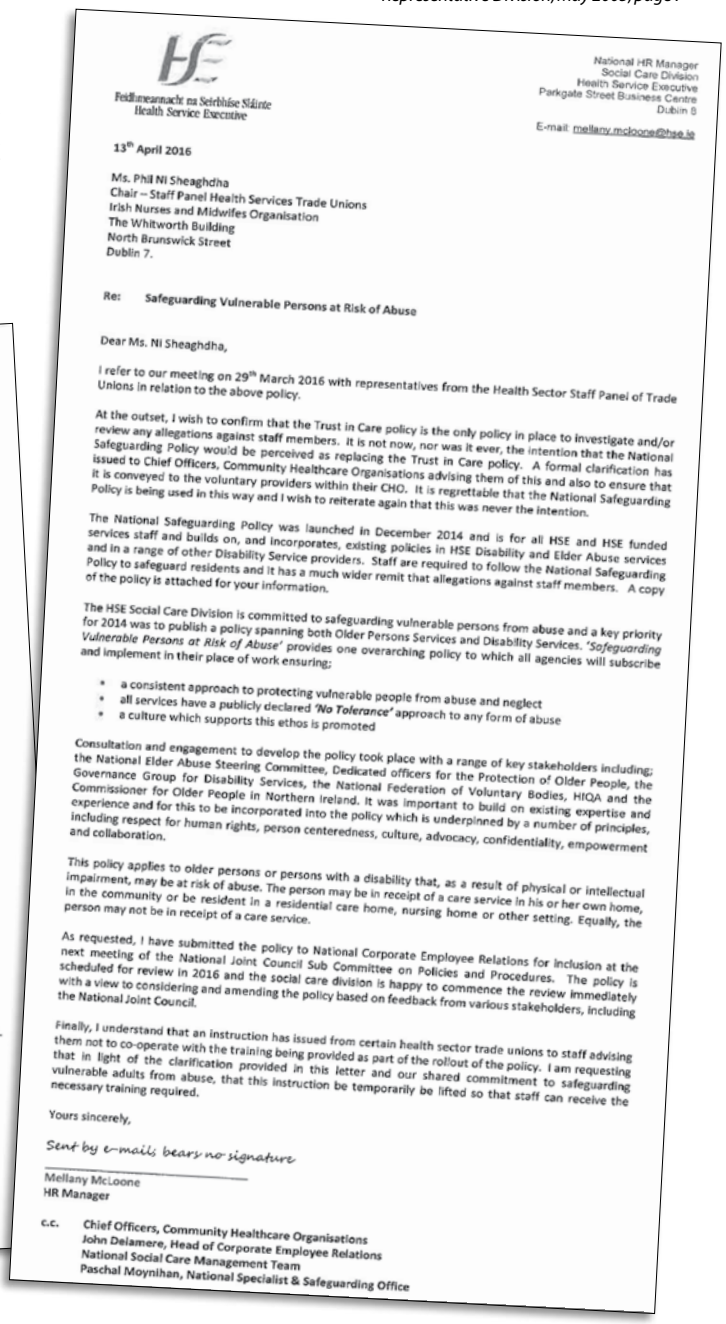
It is in all of our interests to have this meeting as soon as possible and the trade unions are available to facilitate same. In the meantime, I will copy your correspondence and a copy of this letter to my colleagues of the Staff Panel of Trade Unions with a view to meeting very soon to review this policy.

Thanking you for your attention to this note.

Is misé

Phil Ni Sheaghdha
Chair – Staff Panel Health Service Unions

Cc *Staff Panel of Trade Unions – via email*



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

National HR Manager
Social Care Division
Health Service Executive
Parkgate Street Business Centre
Dublin 8
E-mail: mellany.mcloone@hse.ie

13th April 2016

Ms. Phil Ni Sheaghdha
Chair – Staff Panel Health Services Trade Unions
Irish Nurses and Midwifes Organisation
The Whitworth Building
North Brunswick Street
Dublin 7.

Re: **Safeguarding Vulnerable Persons at Risk of Abuse**

Dear Ms. Ni Sheaghdha,

I refer to our meeting on 29th March 2016 with representatives from the Health Sector Staff Panel of Trade Unions in relation to the above policy.

At the outset, I wish to confirm that the Trust in Care policy is the only policy in place to investigate and/or review any allegations against staff members. It is not now, nor was it ever, the intention that the National Safeguarding Policy would be perceived as replacing the Trust in Care policy. A formal clarification has issued to Chief Officers, Community Healthcare Organisations advising them of this and also to ensure that it is conveyed to the voluntary providers within their CHO. It is regrettable that the National Safeguarding Policy is being used in this way and I wish to reiterate again that this was never the intention.

The National Safeguarding Policy was launched in December 2014 and is for all HSE and HSE funded services staff and builds on, and incorporates, existing policies in HSE Disability and Elder Abuse services and in a range of other Disability Service providers. Staff are required to follow the National Safeguarding Policy to safeguard residents and it has a much wider remit that allegations against staff members. A copy of the policy is attached for your information.

The HSE Social Care Division is committed to safeguarding vulnerable persons from abuse and a key priority for 2014 was to publish a policy spanning both Older Persons Services and Disability Services. *'Safeguarding Vulnerable Persons at Risk of Abuse'* provides one overarching policy to which all agencies will subscribe and implement in their place of work ensuring;

- a consistent approach to protecting vulnerable people from abuse and neglect
- all services have a publicly declared ***'No Tolerance'*** approach to any form of abuse
- a culture which supports this ethos is promoted

Consultation and engagement to develop the policy took place with a range of key stakeholders including; the National Elder Abuse Steering Committee, Dedicated officers for the Protection of Older People, the Governance Group for Disability Services, the National Federation of Voluntary Bodies, HIQA and the Commissioner for Older People in Northern Ireland. It was important to build on existing expertise and experience and for this to be incorporated into the policy which is underpinned by a number of principles, including respect for human rights, person centeredness, culture, advocacy, confidentiality, empowerment and collaboration.

This policy applies to older persons or persons with a disability that, as a result of physical or intellectual impairment, may be at risk of abuse. The person may be in receipt of a care service in his or her own home, in the community or be resident in a residential care home, nursing home or other setting. Equally, the person may not be in receipt of a care service.

As requested, I have submitted the policy to National Corporate Employee Relations for inclusion at the next meeting of the National Joint Council Sub Committee on Policies and Procedures. The policy is scheduled for review in 2016 and the social care division is happy to commence the review immediately with a view to considering and amending the policy based on feedback from various stakeholders, including the National Joint Council.

Finally, I understand that an instruction has issued from certain health sector trade unions to staff advising them not to co-operate with the training being provided as part of the rollout of the policy. I am requesting that in light of the clarification provided in this letter and our shared commitment to safeguarding vulnerable adults from abuse, that this instruction be temporarily be lifted so that staff can receive the necessary training required.

Yours sincerely,

Sent by e-mails bears no signature

Mellany McLoone
HR Manager

c.c. Chief Officers, Community Healthcare Organisations
John Delamere, Head of Corporate Employee Relations
National Social Care Management Team
Paschal Moynihan, National Specialist & Safeguarding Office

INMO calls for national health summit

WITH 390 admitted patients being cared for on trolleys on the morning of International World Health Day, the INMO renewed its call for a national health summit and called on elected politicians to demonstrate new politics by showing cross party and independent support for the voice of nurses and midwives in Seanad Éireann.

Thursday, April 7 was designated as International World Health Day 2016. It provides the focus for governments, policy makers and society to reflect on the health issues of the day and the challenges to deliver effective health services.

This took place in the week that the INMO, in conjunction with UCD, published the first ever report on missed care in respect of community health services in Ireland. The report gives evidence of an under-resourced community nursing service, which barely manages to meet the statutory obligations for eligible clients. It also highlights that cutbacks in health services have impacted greatest in terms of missed care on the most vulnerable groups in society.

There was a high degree of missed care where caseloads included disadvantaged groups such as Travellers, asylum seekers, homeless and migrants. A staggering 72% of respondents to the missed care survey reported that nursing care of their homeless population caseload, was missed during the previous week.

Similarly, the survey indicated that 70.7% of respondents reported their work on maintaining the at-risk register for older people was missed in the previous week,

and a further 62.6% said that follow-up visits with older people were also missed *(see also page 26-27)*.

The INMO fully supports the call by the World Health Organization on World Health Day for action to halt the rise in diabetes. This is a global problem and a particular problem facing the Irish health service.

"These issues are the tip of the iceberg in terms of the health challenges facing Ireland and the globe," said Dave Hughes, INMO deputy general secretary. "This is why our nurse and midwife members are adamant that now or in the future the professions need a direct voice in the Seanad to put the focus on health as opposed to such debates always being qualified by cost."

Madeline Spiers, former INMO president, was nominated for the Labour panel of Seanad Éireann in 2016 through the ICTU.

Mr Hughes continued: "Graduate nurse and midwife members now have an entitlement to register for their vote in future Seanad elections. It is important that they are on the register which will be published in June this year. The provision of safe public health services on a global basis is a political issue and the INMO must advocate for safe, accessible public health services in every forum available for the benefit of patients, nurses and midwives."

Cork radiotherapy members ballot for action

AS WE were going to press, INMO members were balloting for industrial action, in the form of a work to rule, in the GB radiotherapy ward at Cork University Hospital due to ongoing inadequate and unsafe nurse staffing levels on the ward.

At a Workplace Relations Commission hearing in May 2015, management agreed to review the following:

- Bed capacity on the ward
- Current staffing numbers
- Acuity and dependency levels and nursing metrics oncology
- Early warning score notifications
- Skill mix, including nurse management grades on the ward
- Rosters.

To date management has failed to produce a report on the review. In addition, six additional beds have been opened on the ward without any commensurate increase in staffing levels.

INMO IRO Mary Rose Carroll: *"Members are disappointed that their legitimate concerns are being ignored and have been further compromised by additional beds on the wards"*

On behalf of its members, the INMO formally outlined its concerns for patient safety in writing to hospital management on December 14 and 22, 2015. A meeting was held on December 17, 2015, where the concerns were further elaborated on but no progress has been made as management has not responded to the issues raised, nor has any meaningful effort been made to remedy the situation.

The INMO again wrote to management requesting further meetings and a response to members' concerns on January 15 and 28, February 29, March 11 and 18, and April 1 and 6, 2016. However, no meeting has taken place to date.

INMO IRO Mary Rose Carroll said: "It is regrettable that INMO members have to consider engaging in industrial action given that management is aware of the needs of the service and has failed in its commitment to honour the terms of the WRC agreement brokered in May 2015. In addition, management has increased bed numbers without any corresponding increase in staffing levels. Members are extremely frustrated at management's lack of acknowledgement and engagement on this issue. They are disappointed that their legitimate concerns regarding their ability to provide safe care are being ignored and have been further compromised by the placing of six additional beds on the ward.

"Moreover, management has not recognised, nor acknowledged, our members' concerns with regard to patient safety, their professional registration and their wellbeing, which is compromised as a result of working in this environment."

The work to rule would allow available nurses to prioritise all care by ceasing non-urgent clerical and administrative work. The INMO remains available to meet with management in an effort to resolve this issue.

St Camillus work to rule suspended

INMO members in St Camillus Hospital, Limerick suspended the work to rule action that commenced in early April at the hospital following an interim agreement reached at the Workplace Relations Commission (WRC).

This follows the HSE agreeing interim rosters, with the INMO and SIPTU, which acknowledge the staffing requirements. Intensive efforts are now being made to recruit the additional nurses required. Other measures related to the permanent filling of nurse manager posts and professional development will be progressed.

The HSE has committed to monitoring, on a daily basis, the admission of patients in tandem with the availability of staff. The WRC agreed to reconvene the parties on Monday, May 9, to review progress.

***INMO IRO Mary Fogarty:** "It is a poor reflection of our health service providers that nurses are driven to take industrial action to protect vulnerable residents in the care of the HSE"*

The planned industrial action at the hospital came some seven months on from notification by nurses to senior HSE managers that the clinical care of patients at the hospital was compromised due to ongoing unfilled nursing posts (approximately 15).

The INMO, at the request of its members, has engaged with the HSE since last November in efforts to fast-track recruitment of nurses. However, this has not yet yielded sufficient numbers of nurses and has left residents at ongoing risk.

Calls by members for the HSE to curtail admissions to the 100 bed facility until such time as the nursing levels improve were also rejected. INMO members then felt they were left with no other option but to commence the industrial action, which was suspended once the HSE agreed to interim roster arrangements.

INMO IRO Mary Fogarty said: "Nurses are the lead clinicians in older persons residential services. Their expertise and knowledge of the needs of their patients, and their concerns about the ability of their employer, the HSE, to deliver safe care should not go unheeded. Equally, our members are accountable to patients, families and regulatory agencies to ensure that standards of care are met. It is a poor reflection of our health service providers that nurses are driven to take industrial action to protect vulnerable residents in the care of the HSE."

Limerick ID service issues with WRC

THE INMO has raised with the Brothers of Charity Services, Limerick unilateral changes in the terms and conditions of employment for both pregnant new employees and permanent employees who become ill and have less that one year's service.

The Organisation has written twice to management of this service for people with intellectual disability, and has yet to receive a formal response. In addition, there appears that there is a roster anomaly for some nurses who work 39 hours per week. This is an historical roster issue that was approved by management many years ago, however present management has not approached the INMO to rectify the anomaly by revising the roster.

The INMO has referred these issues to the Workplace Relations Commission.

– Mary Fogarty, INMO IRO

Award for PHN over sick leave pay

A RIGHTS Commissioner recently awarded a public health nurse €5,000 due to the manner in which the HSE handled her case while on sick leave. In its recommendation the Rights Commissioner stated: "This matter was not well handled by the employer and indeed their handling of it leaves a lot to be desired."

During the INMO member's absence on sick leave, the employer stopped her pay without informing her, denied her access to extended sick leave which she was entitled to, and provided her with information and documents that were difficult to understand in relation to pay roll matters and advice regarding her status while on sick leave.

The member complied fully with her obligations under the Sick Leave Policy, however the actions of management on this matter caused her unnecessary financial hardship and stress. The Rights Commission concluded by stating: "The way the matter was handled by the employer was not fair to the claimant and unnecessarily caused her significant problems and hardship."

INMO IRO Joe Hoolan said: "This was a very important win at the Rights Commissioner Service as there are an increasing number of examples where employers are ignoring their responsibilities to their employees in relation to sick leave, and treating them at times in an appalling manner. It is hoped by this award that it will focus management's attention on how they treat nurses and midwives when they are on sick leave and that the award will act as a deterrent to future similar behaviour by HSE management".

Beaufort ballot for industrial action over rosters

AS WE went to press, INMO members in St John of God's Services, Beaufort, Co Kerry were balloting for industrial action following a decision by management to impose a new roster on the staff from May 2.

Staff had previously rejected this roster, stating it was unworkable and would lead to a deterioration of the services in Beaufort, which is a residential centre for clients with intellectual disability.

INMO IRO Michael Dineen said: "Our members in Beaufort have reached the end of their tether with local management who are insisting on introducing this roster despite the real concerns of the staff who are charged with delivering care on the ground to clients within Beaufort. The staff maintain that the proposed new roster will lead to a deterioration in the services to the clients due to the unavailability of staff at key times during the day. Furthermore, it will prove onerous for staff due to the length of the working day and does not give a reasonable work/life balance to the staff involved."

Members are balloting on the withdrawal of labour from May 2, should management persist in implementing the unworkable roster.

Spotlight on Radiology Nurses Section

THE Radiology Section represents INMO members working in radiology departments across the country.

The section was reactivated in November 2015 at a meeting in INMO HQ in Dublin.

Priorities of the section include promotion of post graduate education in radiology nursing, providing a forum to discuss best practice and campaigning for the introduction of a Location Allowance to reflect the specialised work carried out by section members.

The section represents members working throughout the country, and teleconferencing has been a useful tool for members to participate in meetings.

Many radiology departments contain only one or two nurses, and the section provides an opportunity for networking and to exchange ideas.

Identification of INMO members working in radiology is ongoing and we encourage all radiology nurses to contact the membership office to affiliate.

Section Officers

Chairperson

Priscilla Alcos
prescyl@yahoo.com

Vice chairperson

Victoria Svejdar
vicksvejdar@gmail.com

Education officer

Sarah Higgins
sarahahiggins1@gmail.com

Secretary

Susan Rutledge
srutledge@gmail.com

Affiliation Form for INMO Section Membership

Name:_____

INMO membership No:_____

Home Address:_____

_____

_____

Tel (work):_____

Tel (home/mobile):_____

Email:_____

Place of employment:_____

Job title:_____

Second section option (to obtain information only):

_____

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

Tick ONE relevant Section you wish to affiliate with

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

International nurses hold conference and Culturefest in INMO HQ

THE International Nurses Section met recently in INMO HQ to hold their first conference in conjunction with Culturefest. Over 40 delegates attended what was a most informative and colourful day.

The lineup included Dr Anne-Marie Ryan, deputy chief nursing officer at the Department of Health, who spoke on 'exploring the values of nursing and midwifery'. This was followed by INMO deputy general secretary David Hughes, who spoke on recruitment and retention. Active international recruitment of nurses and midwives commenced in Ireland in 2000. By 2008, nurses trained abroad represented 47% of those working in Ireland. The current response to recruitment and retention is included in the *HSE People Strategy 2015-2018*, *Leaders in People Services*, including restoration of incremental credit for first years and improved internship pay, advanced clinical roles and extended roles.

Michelle Russell, nurse consultant, spoke on safe practice in the workplace, while Stephen Flynn, the information and legal support officer with the Immigrant Council of Ireland, gave an overview of the work of the Council. The final speaker was Edward Mathews, INMO director of regulation and social policy, who outlined the fitness to practise process, and the importance of maintaining INMO membership.

Lunch was cooked and served by a Nigerian chef, with catering being organised by Exquisite Catering. The afternoon Culturefest was packed with music, entertainment and fun, organised by section officers Ibukun Oyedele, Diana Malata, Grace Oduwole and Cres Abragan.

Members of the International Nurses Section with INMO President Claire Mahon pictured at the first International Nurses Section conference in conjunction with Culturefest

*Delegates at the International Nurses Section conference and Culturefest were pictured **(l-r)**: Cres Abragan, Diana Malata, INMO president Claire Mahon, Ibukun Oyedele, Grace Oduwole and Edward Mathews, INMO director of regulation and social policy*

Nigerian colleagues dancing at the International Nurses Section conference and Culturefest

Section roundup

CNM/CMM Section to hold 'Mindfulness Day'

The Clinical Nurse/Midwife Managers Section will hold a workshop on '*How to become a mindful nurse leader*'.

The workshop will take place on Saturday, May 14 from 10am in INMO HQ.

If you wish to attend the day please book your place on **www.inmoprofessional.ie** or contact Helen at Tel: 01 6640616.

Inaugural seminar for retired workers takes place

RETIRED nurses and midwives attended the recent two-day inaugural 'Retired Workers Seminar – North/South'. The seminar was organised by the Irish Congress of Trade Unions (ICTU) and held in the Communications Workers' Union's head office.

ICTU general secretary Patricia King gave the opening address. Ms King has represented workers in both public and private sectors and was a lead negotiator in the Croke Park and Haddington Road Agreements. Carla Cantone, general secretary of The European Federation of Retired and Older Persons (FERPA) spoke on the impact of the EU on retired workers. FERPA represents 10 million pensioners in 40 trade union organisations across Europe. Fergus Whelan, industrial officer with ICTU, delivered a talk on pension provision in Ireland.

Guest speakers from Northern Ireland discussed ongoing developments there concerning lobbying, the Age Sector Platform and the Northern Ireland Pensioners Parliament.

Other interesting lectures were given by Justin Moran of Age Action Ireland and Shay Cody, general secretary of Impact. Michael Collins of NERI (Nevin Economic Research Institute) also spoke on pension policy in Ireland. Journalist Padraig Yates gave a historical presentation on 'social policy Ireland 1916'.

Q and A Bulletin Board

With INMO director of industrial relations Phil Ní Sheaghdha

Query from member

I have been advised that I have to attend training on the safeguarding of vulnerable persons at risk of abuse policy. However, the INMO representative has informed me not to engage with this training as the matter is still under negotiation with HSE management. Can you please advise what the current situation is?

Reply

Thank you for your query. You are correct, this policy and the roll out of same was not agreed by the INMO and other health service unions. It was discussed with HSE management at a meeting on March 9, 2016. The HSE, at that meeting, accepted that it had not consulted with the INMO and the other unions in respect of this policy. The HSE confirmed that the Trust in Care policy is the policy that should and must be used by all services when there are allegations made against staff of abuse or neglect.

The INMO position remains that there is to be no engagement with training on this policy until matters have been agreed and concluded.

Should you require further information please contact the INMO Information Office *(details below)* or your industrial relations officer.

Query from member

I work on a busy medical ward in an acute hospital. It is nearly impossible to avail of uninterrupted meal breaks. I am constantly interrupted while attempting to take my break because we are very short staffed and our roster is supplemented by agency nurses and junior nurses who require assistance/guidance. I believe that I should be paid for this time and I have raised this with my ward manager. She states that there is nothing she can do as the agreement is that lunch breaks are unpaid. When I am rostered on night duty this problem is far greater and the interruptions are continuous. Please advise if you believe there is anything we can do to ensure that we are paid for the periods of time when we are not actually on a break.

Reply

When your break is interrupted it is not considered a break and you should engage with your ward manager, as a group, seeking to have this period confirmed as a paid break. The INMO will assist with this claim as it is increasingly obvious that due to the shortage of staff, skill mix and other acuity issues relating to patient need, that nurses and midwives are on duty for the entire period of their attendance and some of this time is unpaid.

As part of the Lansdowne Road Agreement, the INMO sought an examination of this issue and it forms part of that agreement that the employer must engage with the INMO and other health service unions, with a view to putting in place a mechanism to monitor all hours worked. We have commenced this process of engagement at national level, however, this does not mean that where the situation is constant, at local level, you should not seek to rectify it.

In many wards it is common practice to record these situations in order to demonstrate the frequency of occurrence and I strongly advise you, if you are not already doing so, to implement this practice in your ward. The INMO IRO for your area will meet with you and your colleagues to assist with this issue and I would encourage you to contact them with a view to having a ward meeting and progressing the matter.

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

Quality & Safety

A column by Maureen Flynn

Safer surgery – track and trace

THIS month we focus on the national solution to safely tracking surgical instrument trays and endoscopes through the decontamination process, linking these devices to the patient on whom they have been used. There is well documented evidence highlighting the importance of effective decontamination processes to prevent the spread of infections. The Medical Devices Directive (93/42/EEC) specifies the minimum standards required in relation to the decontamination of reusable invasive medical devices. Healthcare associated infections are a concern for all hospitals and their patients as surgical site infections can have an impact on both patient safety and hospital costs.

What is surgical track and trace?

The HSE has implemented a national tracking system for re-usable invasive medical instrument sets (trays) and endoscopes in 29 hospitals to date. This solution is currently being rolled out to the remaining Irish hospitals with full implementation scheduled for quarter four, 2017. This is the only known national solution of its kind.

Using the GS1 Individual Asset Identifier, in a barcode format, it uniquely identifies each instrument set or endoscope and allows the set or endoscope to be linked to a patient in theatre. As the set or endoscope passes through the hospital's decontamination unit every step of the decontamination lifecycle is electronically recorded, time stamped and linked to the set or endoscope by scanning the GS1 barcode which is attached to the instrument set or endoscope. When sets or endoscopes move between hospitals, each receiving hospital scans the barcode and imports the details from the previous location. This maintains the identification integrity of the endoscope or individual instrument set and its contents as well as its documentation. Automation of the process ensures accuracy and safety, as well as saving time.

The introduction of a national system reduces the manual processes, increases efficiency and creates assurances that an effective decontamination process has occurred.

Track and trace system for re-usable invasive medical instruments sets and endoscopes: *GSRN (global service relation number), which can identify either a recipient or a provider of the organisation's services. GTIN (global trade item number), which can identify types of products at any packaging level (eg. single use item/ implant; drug). GIAI (global individual asset identifier) – one of the two GS1 keys for asset identification. Hospitals can apply a GIAI on any asset to uniquely identify and manage that asset. Hospitals can quickly identify the individual asset, and register relevant data such as its location as well as repair and maintenance activities.*

Benefits and outcomes

Research conducted by Trinity College Dublin identified some compelling benefits of implementing a collaborative, interoperable solution such as surgical track and trace. Patient safety benefits include:

- Robust traceability of instrument sets and endoscopes, with audit trails for quality assurance electronically accessible
- Instrument sets and endoscopes can be located quickly in emergency situations
- Warnings are provided if a step is skipped in the decontamination process
- Links between patients, instrument sets/ endoscopes and the decontamination process are established.

Efficiency benefits include:

- Ability to analyse staff productivity to improve processes
- Ease of reporting both during and post event
- Automated validation and streamlined processes
- Inventory visibility available in real time
- Automatic generation of set lists/ endoscope handling instructions when the GS1 code is scanned, reducing administrative work
- Improved communication between CDU/ ERU and theatre staff, ensuring sets are ready where and when needed.

Get involved

Ask the staff in the operating department, endoscopy department or decontamination and sterilisation unit in your hospital for more information on track and trace. Further phases of the programme will involve single instrument marking, helping to ensure a level of traceability and reporting that would not have been previously possible with a manual or proprietary system of identification.

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

For more information, contact Pauline Biggane, OCIO HSE, RIMD/Endoscope Track and Trace project manager at email: Pauline.Biggane@hse.ie or Caroline Conneely, QID HSE, national decontamination quality lead at email: caroline.conneely1@hse.ie

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At the launch of the report on *Missed Care: Community Nursing in Ireland* were *(l-r): Madeline Spiers, ICTU candidate Seanad elections; Claire Mahon, INMO president; Liam Doran, INMO general secretary; Dr Amanda Phelan, author of the report; Jennifer Boland, retired INMO director of public health nursing; Elizabeth Adams, INMO director of professional development; Back row (l-r): Siobhan Devine, community RGN; Mary Leahy, PHN and member of INMO Executive Council; and Catherine Rotte-Murray, chairperson, INMO PHN Section*

Missed care in the community

Community nursing in Ireland is under severe strain according to an INMO/UCD report launched last month, writes **Amanda Phelan**

MISSED CARE refers to situations when required nursing care delivery has been omitted or is incomplete.[1] The concept has also been termed 'care left undone'[2] or 'implicit rationing of care'[3] and can lead to more serious issues in care delivery. While research studies using the concept of missed care have been carried out in the hospital setting, the INMO commissioned the UCD School of Nursing, Midwifery and Health Systems to carry out research to examine this concept in the community setting.

Context

Care in the community is delivered by various nursing specialisms, but this study focused on missed care in the context of public health nurses (PHNs) and community registered general nurses (CRGNs). PHNs and CRGNs work within a geographical caseload, cradle to the grave model. Within this model, anyone who has a medical card or who has legislatively mandated care provision (ie. newborns and child health) is potentially a caseload client.

In 2015, there were 2,645 nurses in the primary care division of the health service recorded by the HSE. Since the 1994 health policy, *Shaping a Healthier Future,*[4] the Department of Health has reorientated healthcare to community with a determined focus on preventative health, early intervention and tertiary care for positive population health. Moreover, the World Health Organization advocates health systems that are conducive to the role of community nursing and that "significantly improve the health and wellbeing of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality".[5]

Despite this imperative, many reports on community nursing in Ireland published since 1975 demonstrate a service that has struggled to meet the demands of not only changing health policy, but an increasing total population, more complex care delivery as well as the highest birth rate and the highest proportion of children 0-14 years in the European Union. Equally, our older person population, of which 94% live in the community, is increasing, leading to particular demands related to the care management of comorbidities, an increase in the older old age group and shorter hospital stays.

Yet community nursing staffing has not kept up with these realities, resulting in a service straining to provide care. Unlike hospitals, community nursing cannot contain client numbers through for example, closing wards or emergency departments.

The study aimed to identify what constituted missed nursing care in the community setting in Ireland and the reasons for such missed care. To begin with, a steering group was set up to guide the study, comprising members of the research team, representatives from the Institute of Community Health Nursing (ICHN), the chair of the National Committee of Directors of Public Health Nursing and a retired director of public health nursing. The first task was to look at the scope of activities undertaken by PHNs and CRGNs. Following a review of the literature, a list of domains was forwarded to 22 PHNs and CRGNs who agreed to participate in a consensus group.

The final survey comprised four sections:

- Section A requested demographic information from the respondent
- Section B covered items relating to the care delivery of CRGNs and PHNs (home nursing care, care management, family support, older people, health promotion, disadvantaged groups, education, provision of other community nursing services, primary care teams and administration)
- Section C covered items related to PHN only care delivery (child health, child protection and postnatal care)
- Section D requested the respondents to comment on reasons for missed care.
- There was also a qualitative section where PHNs and CRGNs could supplement their experiences of missed care.

Survey

The survey was delivered online through SurveyMonkey, and potential participants were alerted to it via the INMO and the ICHN webpages and email lists. Hard copies of the survey were also available on request. A total of 283 surveys were analysed for the final report. In addition to the survey, the research team undertook a small number of qualitative interviews and

engaged a health economist to examine the impact of community nursing missed care via a health economic assessment and a focus group with PHNs and CRGNs.

Findings

The main findings of the study have been compiled in a report, *Missed Care: Community Nursing in Ireland.*

Demographics

The majority of respondents were female, with 80% aged 35 years or over, and 59% had worked in a community setting for a period between six and 15 years. Although approximately 36% of the nurses reported a caseload population of 2,500-4,000, 17.1% indicated a caseload of 10,000+, with 28% indicating that they had worked more than their contracted time in the preceding week.

Missed care

The study found there were various degrees of missed care on every item within sections B and C. For the purposes of reporting, items were only included where more than 50% of PHNs and CRGNs had missed this form of care delivery in the preceding working week. The greatest level of missed care was in:

- Updating client notes (79%)
- Reassessment in case management (74%)
- Health promotion of older people (73.5%)
- Health promotion in relation to heart disease and stroke (71.8%)
- Community level health promotion (73.5%)
- Older people considered at risk (70.7%).

Although most nurses indicated that disadvantaged groups were not part of their caseload, those who cared for this population recorded missed care, for example, for homeless populations at a level of 70.7%. Other areas of missed care included engaging in continuous professional development (67.5%) and for PHNs child health promotion (62.9%) and child protection additional support and visits (51.6%).

Reasons for missed care

A prominent reason for missed care identified in the study was in relation to a lack of administrative support which reduced the time available to deliver direct nursing care. Another issue related to inadequate staffing and general cross covering caseloads, particularly in relation to filling service gaps, long term cover for retirement, maternity leave or long term sick leave. Missed care could also occur in the context of trying to manage when there was an unanticipated rise in client volume or acuity level.

Interviews

Interviews were undertaken with key strategic figures in community nursing. Findings demonstrate three themes that focused on the lack of national leadership for discipline development, challenges in the role of both CRGN and PHN and the urgent need for reform in community nursing.

Health economics

As there is an impoverished body of literature on primary care in general and on community nursing in particular, a focus group of both PHNs and CRGNs was convened to look at case scenarios and the impact of missed care in community nursing.

One scenario which was developed was the case of an older lady with failing eyesight who fell at home and required a hip replacement. In the acute care setting, it was discovered she had undiagnosed diabetes and the scenario progressed to a second fall and eventual admission to long-term care. It was estimated that, prior to long term admission, the care cost was over €18,600 with additional human costs in psychological trauma due to admissions to both hospital and long-term care as well as the avoidable reduction of functional capacity.

Other scenarios were also considered such as chronic illness, breastfeeding support and health promotion.

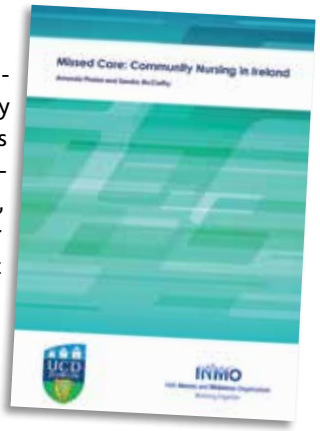
Discussion

The study findings point to a community nursing service under particular strain and unable to meet the imperatives of policy. A comprehensive community nursing service is essential and can impact on issues such as: reducing burden on acute care, particularly ED; improving discharge planning from acute care; and having a responsive service to accept such discharges in a timely fashion; and preventing premature admission to long-term care.

Challenges

Not only is the work of community nurses important for the promotion and optimisation of individuals, it is also fundamental for care delivery in relation to family support, interdisciplinary and multisector care input. These challenges in community nursing highlight the practical inability to meet policy imperatives and also the difficulty in meeting standards and requirements of the Nursing and Midwifery Board and expectations from legislative mandates.

Thus, the study makes 16 recommendations which call for the establishment of a commission to examine the role of community nursing and midwifery and consider issues such as structures, governance, skill mix, career advancement pathways for community nurses, as well as the demand for service expansion.



In addition, issues related to administrative support, suitable physical environments and information technology, the appointment of practice development coordinators, ring-fencing continuous professional development, improving acute-primary care communications and making community nursing's voice heard and acknowledged in political and policy discourses are central to service quality. Recommendations also include addressing the legislative challenges in the 1970 Health Act in relation to service eligibility, particularly if universal healthcare is progressed in Ireland.

As a lack of standardisation of community nursing practice was also identified as well as missed care, it is recommended that an independent monitoring body be established to ensure general community care standards.

Finally, it is recommended that missed care is recorded so that the service can identify challenges early and be flexible enough to respond in order to deliver comprehensive care to individuals, families and communities in Ireland.

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Sandra McCarthy was the research assistant and co-author of the report

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The Missed Care in Community Nursing report is available on **www.inmo.ie**

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Building a stronger organisation

INMO organiser **Albert Murphy** focuses on recent activities aimed at enhancing the structures and supports offered to members throughout the country

THE take-up of those using the INMO Group Scheme continues to grow. There are now more than 7,000 members in the scheme, meaning that one in six INMO members is registered.

Last month there were over 4,000 purchases through the scheme which generated savings for members of over €125,000. The scheme offers a wide range of products and services from companies at genuine discount rates exclusively for members. The Group Scheme is planning to launch an exciting campaign soon with prizes for top hotel stays for members who engage with the scheme.

Alastair Foley is the contact person between the INMO and Group Schemes, and can be contacted at Tel: 01 662 4170 or Email: alastair@groupschemes.com Alastair will be attending the INMO annual delegate conference in Killarney and will have a stand to answer all your queries and to register new members to the Group Scheme.

UH Limerick – information day

An INMO information day was held at University Hospital Limerick recently, which included a visit by Mary Fogarty, IRO and Dean Flanagan, student and new graduate officer. Bridget O'Donnell, Executive Council member also attended on the day. Ms Fogarty reported very positive feedback from members on the event.

Tools for Safe Practice course

Tools for Safe Practice courses continue to be popular with members and courses that took place in April in the Mater Misericordiae and Mater Private Hospitals was very well attended by members.

At the INMO training course for workplace representatives last month *(back, l-r): general secretary Liam Doran; Ann-Marie Codd; Eric Lawson; Phyllisa Mullen-Jones; Deirdre Forsyth; Albert Murphy, IRO/organiser; Fionnula Dore; Dave Hughes, deputy general secretary; (front, l-r): Helen Evans, Imelda Regan, Carol O'Connor-Bergin and Irina Lampadova*

These courses were designed by the INMO to assist members to stay safe in their practice. The courses are recognised by the NMBI for continuing nursing education credits. If you are interested in attending one of these courses, contact the INMO PDC centre at Tel: 01 664 0641 or Email: helen.oconnell@inmo.ie

INMO training courses

A training course for INMO workplace representatives took place at headquarters in Dublin last month. General secretary Liam Doran addressed participants and discussed a wide range of topics, including the recent report from the Task Force on Nurse Staffing and what this will mean for nurses in medical and surgical wards.

Mr Doran told the reps: "As part of building a stronger union, it is vital that we have active INMO representatives at the workplace level. The INMO is committed to delivering training to members, for their union activities, in a time and place which suits them best."

He also encouraged people who have an interest in becoming a rep, or learning more about the Organisation, to enrol in these courses which will be ongoing.

Come to see us at the ADC

For those who will be attending the INMO ADC in Killarney this month, we will have an organising stand. Please don't hesitate to come and speak to me at the conference with any ideas that you may have that could help us build a stronger organisation in your workplace.

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

Understanding the Code

In a series examining the new Code of Professional Conduct and Ethics, **Edward Mathews** discusses the final principle, Collaboration with others

THIS month we focus on the final principle of the Code, 'Collaboration with others', which focuses on the issues of collaboration, team working, communication and documentation.

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

Professional relationships

The first ethical value under this principle requires nurses and midwives to establish professional relationships with colleagues that are based on mutual respect and trust. A number of standards of conduct are associated with this principle, firstly that you should address differences of professional opinion with colleagues by discussion and informed debate in a timely manner. On a first reading of this standard of conduct, it could be associated with differences of professional opinion related to the treatment of a patient, and the necessity to resolve these to ensure the maintenance of quality of care for the patient, and to maintain the patient's interest as the focus at all times. Additionally, it refers to matters beyond patient care, and relates to the requirement for nurses and midwives to treat each other in a professional manner at all times, including in their interactions with colleagues who are not nurses and midwives. Indeed, we have seen cases where unprofessional behaviour between nurses and midwives, or between nurses/midwives and other colleagues, form the basis of complaints to the Fitness to Practise Committee.

The next associated standard, related to the first value, is that there is a requirement on all nurses and midwives to support junior colleagues and nursing, midwifery and other healthcare students in the learning and ongoing development of the professional values, practice and conduct. It is long recognised that registered nurses/midwives have a role in the education and support of their junior colleagues. However, remember that more senior colleagues, including nursing/midwifery managers, must have regard to the conditions in which they deploy people to work, and these must be such as to support junior colleagues in relation to their practice and conduct.

Sharing responsibility

The second value requires nurses and midwives to share responsibilities with colleagues for providing safe, quality healthcare. It is expected that nurses and midwives will work together to achieve the best possible outcome for patients. This ethical value speaks to the core of nursing and midwifery practice, which so often involves teamwork to achieve the best possible outcome for patients. It recognises that so often nurses and midwives do not work in isolation, and instead work as part of a team where communication within that team, and between teams, represents an important characteristic of a safe and quality healthcare environment. In terms of associated standards of conduct, the Code requires that nurses and midwives communicate and work with colleagues to provide safe quality healthcare to patients, and in doing so they must consult with the patient and refer them to appropriate healthcare professionals for further treatment if required. The Code further specifies that this should be done in a timely manner to ensure continuity of care.

What comes to mind immediately here are the gaps which can emerge between care providers, including nurses and midwives, and how, in the absence of effective handover of patients, there can be serious mistakes which impede the delivery of care, or in a worst case scenario care is not delivered at all. It is extremely important, whatever environment a nurse or midwife is working in, that they are clear that there are adequate systems in place to allow them to communicate key information, in an appropriate fashion, to colleagues whether they are nurses, midwives or others, to ensure that there is a continuity in the continuum of care, so that a patient receives all the care they require.

Quality and care

Running throughout this entire principle is the concept of working with others to deliver high quality care, and in that regard there is a standard of conduct, relating to the shared responsibility of nurses and midwives to deliver quality and care, which requires that if the safety or wellbeing of a patient or colleague is affected or put at risk by another colleague's actions, omissions or incompetence, that a nurse/midwife first takes appropriate action to protect that patient or colleague from harm. Thereafter, it is expected that the nurse/midwife immediately reports the conduct to their manager, employer and, if necessary, the relevant regulatory body. It is lamentable

that arising out of poor conduct or illness, we have probably all encountered someone we believed would put the safety or wellbeing of a patient or colleague at risk. This standard of conduct reminds us that it is everyone's responsibility to monitor the conduct of others in the care team, and it is simply not sufficient to state that others are responsible for the management of one's colleagues. Steps must be taken to immediately protect patients and colleagues from harm, and to bring errant behaviour to the attention of managers and employers. The last body whom the Code recognises should be informed of nurses'/midwives' conduct, which places the safety or wellbeing of a patient or colleague at risk, is the regulatory body, the Nursing and Midwifery Board of Ireland (NMBI). It is often asked when it is necessary to refer somebody to the NMBI – this is a question without an easy answer.

It would be very unusual for nurses and midwives working in a care environment to use the NMBI as their first port of call. Instead they would generally bring matters to the attention of their immediate line manager and, if this is not possible or does not give the right result, they can escalate the matter through the various lines of management in their employment structure. It becomes necessary in some instances to report nurses/midwives to the NMBI, and this is a duty that normally falls, though not exclusively, to a senior nursing/midwifery manager dealing with the nurse/midwife in question. When they should report comes down to a difficult professional decision, but it is my own view that where they are unable to manage the conduct of a person, or unable to remedy that conduct, and believe that there is a risk to the public from that nurse or midwife's practice, then a referral becomes necessary. Referrals may be necessary in various other circumstances, but there are too many to deal with here.

Documentation

The next professional value under this principle requires that nurses and midwives recognise that effective and consistent documentation is an integral part of their practice, and a reflection of the standard of an individual's professional conduct. In addition, it recognises that nurses and midwives support the ethical management of the documentation and communication of care. We have reflected in previous articles, considering other principles in the Code, on the importance of confidentiality in relation to patient information, and on the appropriate use of social media. In terms of appropriate standards of conduct, the Code requires that a nurse or midwife's documentation and communication of care should be carried out in a clear, objective, accurate and timely manner within a legal and ethical framework.

I cannot overestimate the importance of adequate documentation of care. It is with regret that we continue to encounter instances where care has been either inadequately documented or not documented in a timely fashion, such that it impedes a nurse or midwife in defending their practice should it be called into question.

It is important to reflect on the exact words used in this ethical value, which refer to effective and consistent documentation being integral to the nurse and midwife's practice, and a reflection of the standard of an individual's professional practice. It is so important that nurses/midwives take the time, in short supply as it may be, to adequately document the care they give, and if instances arise where they have to make a retrospective note of care, that they do so in accordance with the NMBI guidelines on this issue. Also reflect on the importance of ensuring that the language, tone and content of notes of care are in keeping with best practice and the guidance of the NMBI.

Delegation

Finally, there is an ethical value that requires nurses and midwives to recognise their role in delegating care appropriately and in providing supervision. The subject of delegation, particularly to unregistered colleagues, has been discussed widely. In terms of the Code, the first standard which comes to mind is the role of a nurse/midwife in guiding and directing student nurses/midwives, and the necessity to take responsibility for the care that they provide. The requirement to guide and direct student nurses/midwives goes of course beyond delegation, and is central to our professions which require that we instruct and guide others to reach an appropriate standard of professionalism, which we were once guided to during our own training. In specific terms, the Code requires nurses and midwives to support their students in learning, teaching, supervising, assessing practice and taking action to address concerns where they are identified.

Clearly student nurses and midwives work in the care environment, under the supervision and direction of registered nurses/midwives, and there is a requirement in the Code that each nurse/midwife ensures that the patient understands the role of the student nurse/midwife, and that the student be supervised by the registered nurse/midwife at all times. This is clearly challenging, in terms of the workload of nurses/midwives currently, and the numbers of students in the care environment. However, it is important to understand that each student nurse/midwife is availing of a learning opportunity, and consequently must be supervised and supported throughout this period.

The Code specifically states that each nurse/midwife is accountable if they make a decision to delegate a nursing/midwifery task to someone who is not a registered nurse/midwife. This is clearly an onerous responsibility placed on registered nurses/midwives, and in that regard they must be satisfied that they are in a position to be accountable for any task which they decide to delegate, and should resist any attempt at mass delegation which does not take place within an appropriate framework which ensures that the registered nurse/midwife in question is facilitated to appropriately delegate the task. If a nurse/midwife delegates tasks or roles, they should provide comprehensive and effective assessment and planning, communication, monitoring and supervision, and evaluation and feedback.

This adds to the responsibilities of a nurse/midwife who decides to delegate a task, and lamentably all too often we see circumstances where policies are simply developed that are supposed to act as a panacea and authorise the delegation of tasks, but which do not adequately take into consideration the decision of each nurse/midwife to allocate a particular task, at a particular time, in relation to a particular patient, and the residual responsibilities that lie with a nurse/midwife having taken that decision. This is not to say that tasks cannot be delegated, but where they are, the nurse/midwife must be comfortable in making a decision that they are happy to be accountable for the task they have delegated, and are in a position to provide the necessary assessment, planning, communication, monitoring and supervision.

Overall this is a principle which focuses on the team within the care environment, focusing on the requirement for nurses and midwives to maintain adequate communication between themselves and others.

Edward Mathews is INMO director of social policy and regulation

Venous leg ulcers

In the latest clinical update in this CPD series, **Ross Ferguson** and **Gerry Morrow** focus on the treatment and management of venous leg ulcers

A LEG ulcer is defined as the loss of skin below the knee on the leg or foot, which takes more than two weeks to heal.[1] Venous leg ulceration is caused by problems of high pressure in the veins of the leg. In a normal leg vein, pressure decreases with exercise as a result of the calf muscle pump, and valves in the veins prevent reflux of blood. If these valves are incompetent, or the muscle pump is impaired, the pressure in the vein remains high, which can cause ulcers.

Venous leg ulcers are a common, chronic, recurring condition, with an estimated prevalence of between 0.12% in people under the age of 70, rising to 1.03% in people over the age of 70 in Ireland.[2]

Risk factors for venous leg ulcers include obesity, immobility, personal/family history of varicose veins, history of deep vein thrombosis, arteriovenous fistula, increasing age and a history of leg fracture or trauma.[3] Healing rates of 70% at six months have been achieved for small venous leg ulcers managed in some specialist clinics but recurrence is common and ranges from 26-69% within 12 months.

To diagnose a leg ulcer, take the patient's history and ask about the following:

- Symptoms of venous insufficiency, such as leg pain, aching or heaviness, skin itching, odour, exudate, swelling, hyperpigmentation and eczema
- Risk factors which suggest a venous cause for ulceration, such as immobility, obesity, varicose veins or a history of deep vein thrombosis
- Smoking, high blood pressure, ischaemic heart disease and raised cholesterol
- A history of diabetes mellitus or rheumatoid arthritis
- Previous injury at the site of the ulcer, or previous ulcers or skin malignancy
- How symptoms are affecting the person's quality of life.

Examination

- Assess the site and edge of the ulcer
- Record details about the ulcer, to compare at follow up:
  - Size and depth – trace out the ulcer margin onto a transparent sheet, or take a photograph. Take measurements of the greatest depth of the ulcer, noting any exposed underlying tissue
  - Wound bed – look for granulation, fibrous or necrotic tissue and for exudate to help determine which dressing is needed
  - The position of the ulcer (medial, lateral, anterior, posterior or a combination)
  - Examine both legs, looking for signs of chronic venous problems, such as oedema, pigmentation and eczema.

Table 1. What else might it be?

Type of ulcer	Typical site	Ulcer edge characteristics
Venous ulcer	Medial malleolus (gaiter area)	Sloping
Arterial ulcer	Dorsum of the foot	Punched out
Vasculitic ulcer	Dorsum of the foot or calf	Punched out, deep, well demarcated
Diabetic ulcer	Plantar or lateral aspect of foot or toes	
Basal cell carcinoma	Sun exposed area	Rolled
Squamous cell carcinoma	Sun exposed area	Everted
Pressure ulcer	Sacrum, greater trochanter or heel	
Tuberculosis or syphilitic ulcer		Undermined

Infection

Look for signs of infection, such as an enlarging ulcer, increased discharge or pain, raised temperature, foul odour, or cellulitis, where the surrounding skin is painful, red, hot, swollen and tender. Examine the person for evidence of varicose veins. Assess for possible arterial disease by assessing capillary refill (greater than four seconds is suggestive of arterial insufficiency) and checking peripheral pulses.

Arrange a Doppler assessment of both legs to determine the ankle brachial pressure index (ABPI) to exclude arterial insufficiency. The ABPI provides a measure of vessel competency by giving a ratio of systolic blood pressure at the ankle compared to that in the arm. A value of 1.0 is normal. A ratio of:

- <0.5 indicates severe arterial insufficiency – compression treatment is contraindicated and indicates the need for urgent referral to a vascular surgeon
- Between 0.5 and 0.8 indicates arterial disease. These people should be referred to a vascular surgeon and compression bandaging should usually be avoided. However, reduced compression can be used under strict supervision if the ulcer is clinically venous and the healthcare professional has sufficient experience
- > 0.8 indicates that compression may be safely applied.

Be aware that the ABPI may decrease with time. Arterial disease can develop in people with venous leg ulcers, and the ABPI will also reduce with increasing age, so will need to be rechecked periodically.

ABPI may not be reliable in people with diabetes mellitus, atherosclerotic disease, rheumatoid arthritis and systemic vasculitis. These conditions can give falsely high ABPI readings due to hardening of blood vessels. Arrange blood tests including a full blood count to rule out anaemia, which may delay healing; high white cell count may indicate infection.

Dressings and compression

Ensure the ulcer is irrigated at each dressing change with warm tap water or saline, then dried. Ensure slough, necrotic, fibrous or excess granulation tissue is removed by gentle washing. Debridement is not usually necessary. Ensure low-adherent dressings are applied and replaced weekly. If the wound has a heavy exudate, more frequent bandage changes may be required.

Alternative dressings may be considered

to help with pain (hydrocolloid), heavy exudate (alginate) or slough (hydrogels). Ensure dressings for infected ulcers are replaced daily to assess for clinical improvement.

The most effective level of compression to overcome venous hypertension is around 40mmHg at the ankle. To achieve this pressure in a range of limb diameters, bandaging regimens must be adjusted according to ankle circumference. Ensure below-knee, graduated multi-layer high compression bandaging is applied and replaced weekly. For people who are immobile, four-layer or three-layer bandaging is more suitable. For people who are mobile, two-layer bandaging is more practical.

Do not use compression therapy if Doppler studies show an ABPI of ≤ 0.8, or if there is active phlebitis or infection, deep vein thrombosis, or cellulitis. If a venous leg ulcer becomes infected and compression bandaging is already being used, ensure the bandaging is removed, and restart compression therapy once the infection has resolved. Consider seeking advice on a prescription for pentoxifylline which may aid ulcer healing.

Provide lifestyle advice to reduce the risk of recurrence, including:

- Keep mobile with regular walking
- Elevate the legs when immobile
- Avoid injuries and wear well-fitting footwear
- Apply a non-sensitising emollient frequently
- Examine the legs regularly for broken skin, swelling or redness
- Lose weight (if necessary), eat a balanced diet (malnutrition impairs ulcer healing), only drink alcohol within recommended levels and stop smoking
- Wear the appropriate grade and type of compression stockings, ideally for a minimum of five years. Lifelong use of compression stockings may be considered in people with recurrent venous leg ulcers.

Class III (high) below-knee compression stockings should be recommended for most people but, if not tolerated, class II (medium) stockings should be used. Compression stockings should be put on first thing in the morning before getting out of bed.

Follow up

Ensure the ulcer is reassessed; uncomplicated ulcers should be assessed at least weekly for the first two weeks. If the ulcer is healing, this can be extended to fortnightly or monthly, and at three monthly intervals thereafter, depending on judgement. Ideally, people should be reassessed for skin complications within 24 to 48 hours of starting compression therapy. Check for complications related to:

- The ulcer – infection, sinus formation or fistula
- Compression bandaging – pressure damage or arterial insufficiency. Compression bandages should be removed immediately if the person experiences a change in foot colour or temperature, or increased pain. Seek further advice if there is no improvement after removing the bandages
- The dressings used – these can cause skin maceration or allergic contact dermatitis
- Ensure Doppler studies are carried out at the first sign of ulcer deterioration, ulcer recurrence, sudden increase in ulcer size or pain, or change in foot colour or temperature at three monthly intervals until the ulcer has healed and at six monthly intervals thereafter.

Management of infected venous leg ulcers involves:

- Taking a swab, ensuring that prior to this the infected ulcer is cleaned with tap water or saline
- Prescribing an antibiotic, such as flucloxacillin (or clarithromycin if the person is allergic to penicillin) for seven days, while awaiting swab results. The use of topical antibiotics is not recommended
- Ensure people with an infected venous leg ulcer are followed up daily or every two to three days until improvement is seen
- If infection is not showing signs of improvement check swab results and consider changing the antibiotic.

Pain management in venous leg ulcer

Determine the duration, nature and severity of the pain to exclude an additional underlying cause, such as arterial disease, diabetic neuropathy or cellulitis.

Venous leg ulcers are often painful, which may be constant or intermittent. Severe or worsening pain may indicate a complication. Constant pain can originate from vascular structures, pitting oedema, or infection. Intermittent pain can be related to dressing changes or debridement procedures.

Give advice about analgesia for pain relief, such as paracetamol or codeine, as needed. Advise the person that leg elevation may also help with the pain associated with oedema. To manage oedema in venous leg ulcers ensure the person is using compression bandaging, if appropriate. Advise the person to elevate their legs for 30 minutes, three to four times a day, and consider placing pillows under their feet and legs while sleeping. Exclude other causes of oedema such as medication (for example calcium-channel blockers) and heart failure.

To manage eczema exclude the possibility of cellulitis if there is worsening venous eczema and signs of active infection.

Table 2 outlines the features of venous eczema and cellulitis. If there is no clinical improvement, or allergic contact dermatitis is suspected, refer the person to a skin specialist. Common skin sensitisers include wool alcohols (lanolin), topical antibiotics, topical corticosteroids, cetyl stearyl alcohols, parabens and rubber mixes.

Consider referral to a specialist leg ulcer clinic, or to a dermatology or vascular specialist, if there is:

- An uncertain diagnosis
- A suspected alternative cause of ulceration such as arterial or mixed venous/arterial ulcer, suspected malignant ulcer, rapidly deteriorating ulcer, cellulitis, osteomyelitis or sepsis, atypical appearance or distribution of ulcers
- A complication related to the ulcer or treatment
- Uncontrolled pain
- An ulcer that has not healed after two weeks of treatment in primary care
- A recurrent ulcer.

Table 2. Features of venous eczema and cellulitis

	Venous eczema	Cellulitis
History	Long term (usually)	Rapid onset (24-72 hours)
Appearance	Red, painful, pigmented	Red, warm, tender
Margin	Diffuse	Well demarcated
Symptoms	Itchy	Not itchy, systemically unwell, pyrexia
Scaling	Yes	No

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

CPD Quiz

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

1. Varicose ulcers are more common in the following:

A) In people over the age of 70
B) In people who are overweight
C) In immobile people
D) All of the above

2. Before compression bandaging you should:

A) Measure the circumference of the ankle
B) Ensure that ABPI is less than 0.5
C) Advise antibiotics
D) Advise referral to vascular surgeon

3. Investigations for venous ulcers should include

A) Wound swab
B) Liver function tests
C) Blood glucose
D) Full blood count

4. Venous ulcers treatment include:

A) Simple pain relief
B) Elevation of the affected limb
C) Pentoxifylline
D) All of the above

5. Referral to a specialist should be considered if a venous ulcer:

A) Does not heal with standard treatment
B) ABPI is greater than 0.8
C) ABPI is less than 0.8
D) Is recurrent

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

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

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

Clarity informatics

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

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On the ground with the president

Thank you and farewell as president

I AM sad to say that this is my final page as president of the INMO, as my term of office finishes this month. I have been immensely proud to be the President of this organisation and to be in a position, as a nurse, to represent all of our members, right across the country. I would like to thank every member and representative and branch and section officers for their fantastic commitment to this organisation and indeed to the professions of nursing and midwifery. The work you do, mainly on your own time, is invaluable. I ask all members to actively participate in your local forum so your voice is heard. I also thank you for the support and kindness shown to me personally throughout my term of office. I hope to see many of you at the ADC and indeed other gatherings into the future. I would also like to thank all my colleagues on the Executive Council for their support during my tenure and for their hard work and dedication on behalf of the INMO during some very tough times. I wish every success to the incoming Executive Council.

Commemoration for Nurse Margaret Kehoe

I RECEIVED lovely news recently from Ann O'Neill, retired PHN and former Executive Council member. On reading the article in the March issue of *WIN* on 'Nurses and midwives in the 1916 Easter rising', Ann was particularly interested in the piece about Nurse Margaret Kehoe who was killed during the rising in St James's Hospital and the memorial plaque which went missing. She recalled her husband, who used to work in St James's, telling her that he came across a plaque in an old store room but did not follow through on it at the time. So, following gentle persuasion by Ann, he contacted the hospital and the plaque has been found and will be displayed. The family of Nurse Kehoe has been notified and a decision on its location is imminent. A commemoration for Nurse Kehoe is planned for this month. What a lovely end to the story of the bravery of a fellow nurse in 1916.

The plaque commemorating Nurse Margaret Kehoe

Operating department nurses annual conference

I HAD the pleasure of addressing the recent Operating Department Nurses Section annual conference in Dublin which had as its theme *'Perioperative nurses – the vital link for excellence in patient care'*. Sincere thanks to the officers and committee members for their hard work in putting such a successful day together – Audrey Al-Kaisy, Allison O'Connell, Teresa Herity, Monica Griffin, Liz Waters and Sandra Morton. I would like to take this opportunity to thank Caroline Higgins for her enthusiasm and hard work on behalf of the INMO during her term as president of EORNA which has now ended. Also a huge thanks to Liz Waters for her commitment during her long term on EORNA which has also come to an end. Sandra Morton continues as our representative on EORNA. I wish all our ODN members the best of luck in the future.

EFN assembly deferred

THE recent European Federation of Nurses Associations (EFN) General Assembly was deferred due to the terrorist attacks in Brussels. The hotel where our meetings occur was used as a temporary treatment and triage centre for those injured in the subway bombing. Thankfully none of our colleagues in the EFN office were physically injured. However, unfortunately a student nurse member of our sister organisation in Brussels was killed during the bombing of the airport. Although everyone acknowledges the need to show solidarity, the EFN Executive committee felt it was not appropriate to fly nursing leaders from over 70 countries to participate in a meeting so soon after the events. We wish the EFN well and send our solidarity and condolences.

Missed care report

The INMO launched a report last month on *'Missed Care – Community Nursing in Ireland'* by Dr Amanda Phelan and Sandra McCarthy, of the School of Nursing, Midwifery and Health Sciences, UCD. The report was commissioned by the INMO as part of our professional programme and strategy to develop community services in Ireland.

This new report indicates that community nursing in Ireland is under severe strain. Dr Phelan points to the lack of necessary reform in community nursing which has led to a service that is struggling to meet the demands.

The report recommends the establishment of a commission to examine and develop all aspects of primary services. *(see also pages 26)*.

Get in touch

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

Claire

Urgent call for pay restoration

The need for quicker recovery of pay and conditions for nurses and midwives hit the headlines this month, **Ann Keating** reports

THE *Irish Examiner* (April 20) informed readers about – **Industrial Unrest – What key groups want**. "In recent weeks, it has been their battle for improvements in the country's emergency departments which has seen nurses hitting the headlines. However, in recent days, the Irish Nurses and Midwives Organisation general secretary Liam Doran has spoken out about the need for a quicker recovery in pay and conditions. He said his members wanted an "acceptable" timeframe for restoration of what, he said, was still over 10% of pay cuts that remained outstanding.

"Mr Doran said that the "labour market" challenge could only be met by an upward adjustment in pay and conditions saying that his union would certainly be seeking that "before the year is out".

Launch of report on *'Missed Care – Community Nursing in Ireland'*

The launch of this report got widespread media coverage including the *Irish Independent* (April 5) – **Public Health Nurses 'forced to cut corners'**. "A new report found that nurses who work outside hospitals, across wide areas, are forced to prioritise patients who need injections and dressings at the expense of giving time to health promotions such as support of mothers who want to breastfeed. The report, carried out by the School of Nursing, Midwifery and Health Sciences in UCD, said that while nurses gave time to child protection issues, other youngsters were missing out on important checks which could pick up developmental problems early on.

"There was a high degree of missed care where caseloads included disadvantaged groups such as asylum seekers, the homeless, migrants and traveller population". Liam Doran said: "There needed to be a commission set up to report within 12 months on how to properly resource public health nursing and reduce the dependence on hospitals."

The story was also covered in the *Irish Examiner* (April 5) under a headline – **Stretched community nurses admit missing aspects of care.** Catherine Rotte-Murray, chair of the INMO PHN Section said: "Community nursing was largely invisible... Ours is the only service in the community that does not have a waiting list – we are expected to respond to referrals almost immediately." Executive Council member Mary Leahy pointed out that "just 5% of the country's nurses were delivering primary care in the community, compared to 15% in Britain and 14.6% in Canada."

St Camillus Hospital, Limerick

The *Limerick Post* (April 16) gave an update on the work to rule at St Camillus Hospital, Limerick – **Back to Work**. "Following an interim agreement reached at the Workplace Relations Commission, members... have suspended their work to rule...the HSE has agreed interim rosters with the INMO and SIPTU which acknowledge the hospital's staffing requirements and intensive efforts are being made to recruit the additional nurses required. The HSE has also committed to monitoring the admission of patients in tandem with the availability of staff."

Cork University Hospital

The *Evening Echo* (April 15) reported on a press release issued by IRO Mary Rose Carroll under a headline – **Nurses' industrial action ballot**. "The Irish Nurses and Midwives Organisation will ballot members at Cork University Hospital on industrial action, in relation to what they deem to be "ongoing, inadequate and unsafe nurse staffing levels." Members in the GB radiotherapy ward will vote on the matter and should the ballot pass, a work to rule would see nurses cease non-urgent clerical and administrative work."

Madeline Spiers bid for Seanad

The *Irish Medical Times* (April 15) reported – **Summit and Taskforce meeting urged by INMO**. "The Irish Nurses and Midwives Organisation has renewed its call for a national health summit and has urged TDs to demonstrate new politics by showing cross party and independent support for the voice of nurses and midwives in Seanad Éireann. INMO past president Madeline Spiers has been nominated for the Labour panel of the Seanad, following a decision at the union's annual conference last year to draw attention to the problems of the health service by putting a nurse or midwife in Seanad Éireann."

March trolley figures

An editorial in the *Irish Times* (April 12) discussed the March trolley figures – **Overcrowded hospitals – Unfinished business**. "...there is no indication that trolley numbers will level off, let alone reduce, such is the crisis in the health service... 9,381 patients who spent time waiting on trolleys for a bed in a ward during March represented a 100% increase compared with figures from March 2008. Despite additional money and effort spent dealing with the issue in the latter part of 2015, the numbers represent a 5% increase on the same month last year.

Cregg House, Sligo

The *Sligo Weekender* (March 24) gave space to – **INMO protest at Cregg**. The INMO "held a protest at the Sligo facility to highlight a review which they feel needs to be done in relation to staffing levels at the facility." IRO Maura Hickey said their protest was about having adequate staffing levels to provide a safe level of care....The protest at Cregg followed a ballot held by INMO members which saw a 98% vote in favour of industrial action in the facility."

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INMO WATERFORD BRANCH

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Branch workplaces and areas covered

- University Hospital Waterford
- Dungarvan Community Hospital
- St Patrick's Community Hospital
- Carriglea Cairde Services
- Belmont Hospital
- Public health nurses and community RGNs
- Whitfield Clinic, Waterford
- Mowlan Nursing Home, Waterford
- St Otterans Hospital
- Voluntary ID services

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Latest news

The Waterford Branch of the INMO meets at least four times per year. Our branch meetings are generally held in Waterford although we ensure that we hold a meeting in Dungarvan at least once a year to facilitate our members in the west of the county.

The branch has been very proactive both locally and at a national level. Locally, a regular INMO hospital meeting has been established in University Hospital Waterford and INMO rep training has been undertaken by a number of our members.

Nationally, branch members have played a key role in the recent ED negotiations and the PHN transfer policy. As a branch we have also been very active in local and national demonstrations.

We attend and support the national demonstrations. We are sending a full delegation to the ADC this year and always have member representation at any special delegate conferences.

Industrial relations update

Community hospitals

- The working life of nurses in community hospitals continues to be challenging with increased complexities of patient care demands, poor nurse staffing levels and skill mix issues. Numerous management meetings have occurred through reps and with the IRO seeking to highlight and request addressing of these issues.

ID services

- Local management meetings progressed through the Labour Relations Commission and most recently to the Labour Court seeking to prevent the Brothers of Charity Service downgrading one of the two senior nurse night duty positions at the service.

University Hospital Waterford

- Supported by a strong group of INMO reps, many local issues have been progressed including:
  - Emergency department concerns resulted in a ballot for work to rule and success in obtaining an increase in staffing levels x 5.8 WTEs to provide a ninth nurse on duty with a 10th nurse being progressed
  - ICU and HDU,staffing and equipment deficiencies
  - Orthopaedic services regarding staffing and interpersonal relationships
  - Surgical and maternity services issues also progressed locally. Additionally a number of individual issues continue to be progressed.

It is planned to establish a hospital committee at University Hospital Waterford, thus further strengthening the INMO presence and activities in this hospital.

Community care

A sizable number of individual and collective issues are being progressed, most recently being the difficulties PHNs have in obtaining release to transfer to other community care areas.

Taking care of your mental health

Seeking help for a mental health problem is the first step towards getting and staying well, writes **Dean Flanagan**

RESEARCH from the Royal College of Surgeons in Ireland has shown that one in five young Irish adults aged 19-24 have experienced some form of mental health problems.[1] This equates to three people on your GAA team, one person in your group of friends and possibly up to 40 people in your cohort.

'Psycho', 'oddball', 'doesn't fit in' are just some of the stereotypical terms flung around incorrectly in our society when talking about people who suffer from mental health conditions. Anybody acting in a way that is not deemed 'normal' and in a way others don't understand often gets stuck with the label of being 'mental'. These negative images and incorrect labels hugely impede young people from coming forward to discuss feelings they don't understand or to ask for help. The stigma and how others perceive us to be unfortunately paves the way for how we live our lives. In recent years many campaigns are working towards changing this mindset, and to finally accept that our health encompasses so much more than our physical health.

At 17 years of age, choosing what course to do after you finish school, leaving home and moving to a new place, as well as trying to find new friends and fit in, all within the space of six months are huge life changes that carry with them a lot of pressure for a very vulnerable cohort of our population.

Admitting you are struggling with college work, admitting you've realised this course is not for you, admitting to your family this is not what you want to do are seemingly simple issues for some. However, when balancing these with a mental health condition or when you are not feeling yourself make these much more complex. Most colleges will have a system in place to help students' needs, both from their academic faculty and the Student Union Welfare Office.

Don't feel ashamed if you need to seek these services; they are fantastic and more often than not, just having someone to listen to you is all that is needed. I am speaking from my own experience of using my college's support service when I was training due to feeling overwhelmed with course work – I still count it as the best 20 minute conversation I ever had.

Seeking help for a mental health problem can be a really important step towards getting and staying well, but it can be hard to know how to start or where to turn to. It's common to feel unsure about seeking support for your mental health and to feel like you can handle things on your own but it's always okay to seek help. Some reasons why you might choose to seek help include:

- Finding it difficult to cope with your thoughts and feelings
- Thoughts and feelings having an impact on your day-to-day life
- Wanting to find out about available support.

It can be hard to know how to talk to anyone about your mental health, especially when you're not feeling well but it's important to remember that there is no wrong way to tell someone how you're feeling. Here are some things to consider:

- Be honest and open
- Focus on how you feel
- Try to explain how you've been feeling over the past few months or weeks and anything that has changed
- Use words and descriptions that feel natural to you
- Try not to worry that your problem is too small or unimportant.

Taking that first step towards getting support can be difficult. Often, people feel afraid or embarrassed but it can also be the most positive move you can make. If you are worried, don't ignore it. Talk to someone, get support, or explore the little things that are good for mental health. Just remember you are never alone.

Table: List of mental health services available in Ireland

Service	Website	Contact details
Console Ireland	**www.console.ie**	1800 247247
Pieta House	**www.pieta.ie**	Regional numbers available on website
Spunout	**www.spunout.ie**	Tel: 01 6753554 Email: info@spunout.ie
Samaritans Ireland	**www.samaritans.org**	Tel: 01 6710071 or Freephone: 116 123
A Lust for Life	**www.alustforlife.com**	Email: info@lustforlife.com
Headstrong	**www.headstrong.ie**	Email: info@headstrong.ie
Mental Health Ireland	**www.mentalhealthireland.ie**	Tel: 01 2841166 Email: info@mentalhealthireland.ie
Reachout Ireland	**www.ie.reachout.com**	Tel: 01 7645666 Email: general@reachout.com
Aware	**www.aware.ie**	Tel: 01 6617211

Dean Flanagan is INMO student and new graduate officer

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Depression in new fathers

With a prevalence of up to 10%, paternal postnatal depression is a real and significant public health issue, writes **Lloyd Philpott**

OVER the past three decades, there has been a growing awareness and concern about the burden of ill-health experienced by men. Research has shown that fatherhood has a protective effect on men's health. However, there is also evidence that the transition to fatherhood can be complex and demanding, with many fathers feeling inadequately equipped as they begin their journey. This can subsequently cause distress, anxiety and increased risk of depression.

With a prevalence of approximately 10%, paternal postnatal depression (PPND) is a real and significant public health issue. However, PPND is not widely acknowledged and not well researched. In general, the mental health of fathers in the postnatal period is often not considered. This has resulted in men being underscreened, underdiagnosed and undertreated for PPND and other postnatal mental health problems.

The estimates of the prevalence of PPND within the first year vary widely, ranging from 1% to 27%. A review of 43 studies found that PPND affects up to 10% of new dads throughout the world.[1] However, the prevalence may be even higher as men are reluctant to report mental health problems.

Risk factors of PPND

Maternal depression has been reported as the most common predictor for PPND. Fathers are more likely to be depressed if their partner is experiencing PND.[2] A lack of social support also increases the risk of PPND. Fathers belonging to non-traditional families with lower levels of social support have a higher prevalence of PPND. An unplanned pregnancy is associated with depression in fathers. A lack of choice and preparation inherent in unplanned pregnancies increases the risk of PPND.[3]

Lower levels of education are linked to higher levels of PPND. Less educated fathers experience greater difficulty in gaining information about and access to services in the perinatal period. This subsequently results in these men being less informed and less prepared for the changes which an infant brings.[3] A previous history of psychiatric treatment is strongly correlated with the development of PPND. This may be due to predisposing genetic factors and/or enduring environmental factors, with the perinatal period acting as a stressful life event that triggers remission.[4]

Postnatal depression (PND) in women is characterised by low, sad mood, lack of interest, anxiety, sleep disturbance, reduced self-esteem and difficulty coping with day-to-day tasks.[5] PND in men manifests itself differently and includes such symptoms as hostility, conflict and anger. In the general population and during the postnatal period women tend to internalise distress while men tend to externalise through aggressive or coercive behaviour. As a result, more women are diagnosed with depression and anxiety (internalising disorders) while men have higher levels of substance abuse and antisocial disorders (externalising disorders).[6]

Impact of PPND

Depressed fathers display less positive behaviours such as sensitivity, warmth and responsiveness, and increased negative behaviours such as hostility and disengagement. The research concerning the effects of PPND on infant and child development and wellbeing has reported a higher risk for increased family stress, lack of bonding, increased incidence of spanking, and later child psychopathology such as emotional issues, conduct disorder and hyperactivity.[7]

There is no evidence that screening for PPND occurs despite the fact that there is research highlighting the importance of screening, especially where maternal PND has been diagnosed.[8] Furthermore, there is no screening tool specifically designed for PPND. There is no official set of diagnostic criteria for PPND. There is a diagnosis criteria for women outlined in the Diagnostic and Statistical Manual of Mental Disorders. The validation of diagnosis criteria for PPND and the development of a screening tool is crucial as there are differences in the risk factors for and the course (timing of onset, persistence) of PND for fathers and mothers.

Management and interventions

Support from family members helps fathers adapt to changes during the postpartum period. PPND is closely related to partners' mental health and the health of their relationship. Therefore, the most effective support for men comes from their partner. Support from society, such as paid paternity leave, helps fathers adapt to changes during the postpartum period. Paternity leave has been identified as one of the few policy tools available to governments to directly influence behaviour among fathers. It is also one of the strongest public statements that societies can make to show that they value the care work of men.[9]

Healthcare professionals need education in order to improve knowledge on how to identify and manage PPND. There is also a need to educate and advise fathers and their partners in relation to the signs and symptoms of PPND. The establishment of a referral pathway for fathers who screen positive for PPND and the creation of appropriate and timely interventions are necessary to ensure that practical and emotional support is available.

Lloyd Philpott is a college lecturer at the School of Nursing and Midwifery, Brookfield Health Sciences Complex, University College Cork

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A fond farewell to my EORNA operations

Pictured at the EORNA Congress 2015 in Rome, as EORNA president, Caroline Higgins, launched the first EORNA 'Standards and Guidelines for Perioperative Nursing Practice'

On completing her term as president of the European Operating Room Nurses Association, **Caroline Higgins** outlines how the association has developed over the years

I JOINED the INMO Operating Department Nurses Section what seems like a long time ago. I was secretary for two terms and on the planning committee for EORNA Congress in 2006. I was then elected as second European Operating Room Nurses Association (EORNA) representative. I took to the skies with Anne O'Brien (better known as AOB) from Temple Street Hospital and Maureen Flynn as my mentors.

At first, being on the board of EORNA was mind-boggling, all the different languages and the myriad of topics to discuss was such a challenge. However, I got the measure of it all with the support of my two great Irish colleagues. I was aptly taught the standard of dress for meetings, about political correctness and to remember to 'rise above it all'. These wise words of advice were often called to action and I find myself sharing it with others now.

Founding of EORNA

EORNA has its origins in the early 1980s in a group of visionary European perioperative nurses from France, the UK, Denmark and Ireland, among others. Eileen Malone, former theatre manager at Beaumont Hospital, was one of the original group. However, EORNA was officially established in 1992. Anne O'Callaghan (better known as AOC) from Temple Street Hospital, was the second representative. This stalwart and hard working group is rightly credited with creating a sound base for the growth and development of EORNA. Anne O'Callaghan and Maureen Flynn worked thereafter as the two Irish representatives and took on the inimitable task of 'the secretariat'. This was a mammoth task then, without email or computer facilities, but they did a superb job and were supported by INMO staff throughout their tenure. Anne O'Callaghan dedicated about a decade to the position. Some would say that is incredible, but as volunteers you give your time and input in the best interests of positively affecting the desired outcomes and with the passion that was so relevant then. Marie Woulfe, (formerly Beaumont Hospital and Bon Secours, Tralee) took over the EORNA representative role from Anne O'Brien.

Thereafter Liz Waters (theatre manager, Naas) and Sandra Morton (CNF St James's Hospital) held the positions. Recently Alison O'Connell, Portlaoise replaced Liz Waters as European representative for Ireland. Over the years all representatives have contributed enormously to the advancement of EORNA. They have given countless hours and days in the best interest of perioperative care, patient care and perioperative nursing.

Perioperative nursing in Ireland

The prestige and quality of the Irish perioperative nurse has been magnified across the globe and they are held in high esteem by the perioperative fraternity worldwide. Sadly it does not always feel that our profession is held in such light in our own country. Maybe it is a case of not always appreciating what you have on your own doorstep.

I have worked with most of the above named representatives at one time or another and have often made contact with one or other of them to seek advice or clarify points on certain issues. AOB has also just completed a term as an honorary member of EORNA. It is essential and so valuable to have had that network of experience and support. Somehow we have to recognise the value of quality. It is all too easy to be penny wise and pound (euro) foolish, which in health terms just leads to sub-quality care.

In 2009 I was elected EORNA president and have just completed my second three year term. It has been a great honour and privilege to hold this position and represent you and European perioperative nurses in this role. It has, at times, been challenging and a seemingly endless pit of work and consultative processes. I have on several occasions reflected on my deci-

sion to take on this role and wondered what possessed me. However, in truth it has been a rewarding and developmental experience. The opportunity to advance EORNA, patient care and perioperative nursing has been truly valuable to me. I found the meeting of colleagues from the various countries and diverse cultures so inspiring. It has been great to be able to assist them to develop and indeed learn from them.

Advancement

I am pleased with all the progress and advancement EORNA has made over the years of my tenure. EORNA's profile has risen significantly and the voice of the perioperative nurse has definitely been strengthened but still has a way to go! There have been many positive interventions and contributions to EU directives. Our participation and expertise is well recognised within the European Committee for Standardization (CEN), the European Specialist Nurses Organisations (ESNO) and the European Agency for Safety and Health at Work (EU-OSHA).

We have had a positive effect on patient safety and promoted the value of enhancing the work environment. The release of the EORNA perioperative nursing care standards and position statements is a valuable tool and is a great achievement for all involved, especially Sandra Morton and the perioperative care committee. The core curriculum for inclusion in perioperative education has been updated and the competency framework tool is widely used and lauded.

EORNA Congress

Ireland and the INMO was chosen to host the 2006 EORNA Congress in Dublin. Anne O'Brien was chairperson, while I was secretary. The local committee consisted of past representatives and Liz Waters, chair of the INMO ODN Section and our INMO colleagues. After much planning, deliberation, we eventually pulled the Congress together and it was a phenomenal success, attracting approximately 2,500 delegates. It was held in the RDS, and was officially opened by then President Mary McAleese, such was the prestige of the event. A diverse educational programme was delivered and it was a great achievement and honour for Irish perioperative nurses and the INMO.

Since then the Congress has been hosted in Copenhagen, Lisbon and Rome. It is always a wonderful educational and networking event. Last year in Rome there were 47 different countries represented. Irish perioperative nurses have been hugely successful on the European and indeed global stage. So many of you have had the opportunity to present your work and share your knowledge at this forum and many have been the recipients of the awards available.

Elizabeth Adams, INMO director of professional development, won the first research award for perioperative nurses in EORNA. Katie Tierney in Limerick won it a few years later. We have been extremely successful in the scientific poster competition and best speaker awards over the years. This year Margaret Given, Sligo General Hospital won the ARCSafe/EORNA safety poster competition and Therese Donnelly, also Sligo General Hospital, was voted as the best speaker at Congress.

In the ANSELLCARES/EORNA European Perioperative Nurses Hero programme Ireland had five nominees, who all got to the final stages. It was wonderful to find that Sandra Morton, St James's Hospital was one of the final winners. She nominated FoAN – Friends of African Nursing to receive the charity donation. EORNA's other supported charity Lifebox also received a donation.

There is no doubt that EORNA has expanded and developed, however challenges remain. While we are making steps to bridge the gaps and manage the challenges, the profession is evolving and we are sometimes faced with obstacles. One of the most basic issues within EORNA is managing the language barrier. The official language is English, but board members have varying degrees of ability with spoken English. The comprehension of a given issue has often been a concern. The diversity and cultures are a positive aspect and embraced by all. Across Europe all perioperative nurses have similar concerns and a lot of commonality. Perioperative nurses are a special breed, they have so many facets to learn and train in and they have a broad perspective as a profession. Nurses in the operating room provide the best safety and quality of patient care under the guidance of well trained leadership.

Anecdotal evidence

Over the years there has been much fun as well as hard work. There are always stories to relate or incidents to enjoy. Indeed it was back when a bus carrying board members was stuck during travels that then officers started the development of the core curriculum. Another time myself and AOB were due in Brussels for an important meeting, we were thrilled to book two Ryanair shuttles for €5 each only to be charged €140 to get a taxi into the city centre.

In Croatia a political leader was released from detention and a huge rally ended up at our hotel. In beautiful Tel Aviv we had a superb time and a wealth of culture and historic sights, which were amazing. However, at the airport we sat on a plane for three and a half hours due to a flash strike.

When the Icelandic volcanic ash put the brakes on air travel in 2010 we were in Strasbourg having a board meeting. As the situation became clearer the board members all started to leave, making plans to return home to over 20 different countries on trains, buses, boats – whatever was available. We three Irish tried all the boats and the Channel tunnel with no great success, so on invitation hopped onto our Dutch colleagues little 1960s minibus. Up through France, Belgium, Luxembourg and then to Friesland in the Netherlands where we stayed with them before eventually getting a train back to Paris and then to Cherbourg, overnight stay, only to have a bomb scare on the boat. After 18 hours sailing, we disembarked at Rosslare, got on the bus back to Dublin Airport to collect our cars, only to hear the rather strange sound of an aeroplane overhead. But it was a once in a lifetime experience, and created lifelong friendships and great memories which will always be treasured.

Acknowledgements

I would like to acknowledge all the Section officers and chairs that have given so much to Irish perioperative nursing over the years; to Audrey Al Kaisey, current chairperson and her predecessors who have been so supportive to all and voluntarily contributed such time and dedication to enhance perioperative care and nursing.

I would also like to acknowledge the INMO and the Professional Development Centre for their commitment to nursing development and unending visionary support of nursing representatives in a wider forum. In my experience, the INMO has always been there to assist, support, advise and encourage me as have most of the Section members. I will always hold with me the pride and achievements of my Irish colleagues in perioperative nursing both nationally and internationally.

You have so much to give and to offer, put what you do on paper and share it with the world, you are among the leaders in perioperative care without doubt. A heartfelt thank you to one and all.

Vital cancer care

Joan Kelly outlines the nursing services that are a core element of the Irish Cancer Society

THE Irish Cancer Society provides care, support and advice to cancer patients and their families. At the core of the Society is its nursing services, with it employing nurses with experience in cancer care for a number of its vital services.

These include the Cancer Information Service, incorporating the Cancer Nurseline and Daffodil Centres, as well as the Night Nursing Service, which provides palliative care. The Cancer Information Service is a wide-ranging service including 13 Daffodil Centres nationwide, the Cancer Nurseline and online and walk-in information services.

A recent report evaluating the Society's Cancer Information Service showed that the Society supported over 82,000 contacts annually to people worried about or affected by cancer across the country. With cancer numbers expected to increase to 40,000 cases diagnosed per year by 2020, the demand for expert information, support and advice is set to grow.

One area of the service is the society's Daffodil Centres, which are cancer information centres located in major general hospitals that are at the heart of diagnosis and treatment. They are open Monday to Friday with no appointment or referral necessary.

The Daffodil Centre nurse is responsible for the day-to-day management of the centre and is supported by trained volunteers. The nurse provides clear and accessible information on any cancer related issue. In 2014, 44,136 people had contact with the society's Daffodil Centres around the country.

Fiona Walsh, Daffodil Centre nurse in St Vincent's University Hospital, Dublin said: "Throughout the course of the day, I meet with a wide variety of people. These may be people who are newly diagnosed with cancer and want to learn more about their diagnosis and treatment options. Others may be family members or friends of people with cancer.

"Listening and emotional support are a big part of what I provide in the centre. We also get lots of people enquiring about ways to reduce their risk of cancer. The Daffodil Centre is a relaxed, friendly, personalised and professional environment for enquirers. It is a varied job that is challenging and rewarding, incorporating different aspects of cancer care and I feel that we really have a positive influence on someone's life at a difficult time."

The Cancer Nurseline is the longest standing part of the Cancer Information Service. Staffed by specialist cancer nurses, it provides information and support to anyone concerned about cancer. Cancer nurses talk to people on the Nurseline as well as via email and online, so that they can support the enquirer through their chosen communication channel.

The majority of callers to the Nurseline are those who are currently experiencing cancer (33%) or who have a family member who has been diagnosed with cancer (30%). A significant number (16%) who contact the Nurseline have not been diagnosed but are concerned about cancer.

The service was awarded Helpline Partnership Standard 2013 and 2015. This is an internationally recognised stamp of approval, ensuring all enquirers to the Cancer Information Service are dealt with by trained professional staff, operating under strict policies and procedures that are measured and monitored by an external objective body.

Aside from information services provided by specialist cancer nurses, the society's night nursing service also provides palliative care to patients who are at the end of their cancer journey. In 2014, 7,800 nights of care were provided by the society's night nurses to 1,934 patients across the country.

Night nurses work through the night caring for the patient and the availability of the service ensures patients can remain at home for the last days of their lives surrounded by their families and loved ones.

Night nurses care for dying cancer patients with complex and demanding care needs, offering advice, reassurance and friendship, while also providing the highest standards of nursing care.

The Irish Cancer Society provides ongoing education and training to its night nurses to ensure they have the confidence and competence to anticipate, assess and look after the patient's palliative care needs. The patient and the family remain central to the nursing plan, ensuring they are all fully informed and have the opportunity to plan the care they will receive with the night nurse.

The Cancer Society is seeking opportunities to collaborate with all nurses supporting cancer patients and their families.

If you would like to discuss opportunities, contact: Naomi Fitzgibbon, Cancer Nurseline manager: nfitzgibbon@irishcancer.ie For further information visit **www.cancer.ie**

The Cancer Nurseline number is: 1800 200 700

Joan Kelly is Cancer Support Manager the Irish Cancer Society

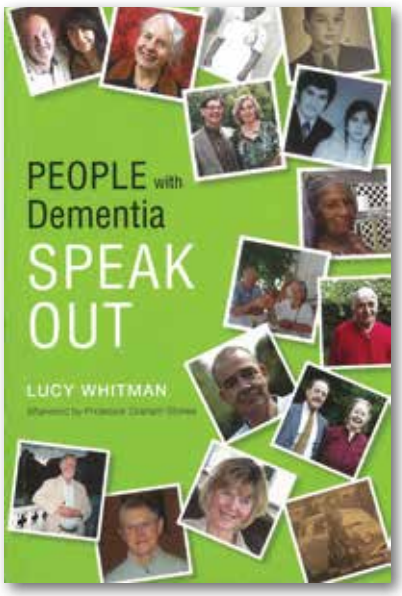
Speaking out on dementia

FROM doctors and nurses to engineers and lawyers, *People with Dementia Speak Out* chronicles the experiences of 23 people from all walks of life living with dementia, giving readers a deeper insight in to what it is really like to live with a chronic disorder that impairs your brain functionality.

Throughout this anthology, edited by Lucy Whitman, readers are taken into the minds of those living with dementia to learn about the different manifestations the disease can have depending on the individual, with some experiencing short-term memory loss, while others describe mild hallucinations and others tell of fits and blackouts.

While it is clear that dementia affects different people in different ways, a recurring theme throughout the 23 accounts is the delay or difficulty in accurate diagnosis. One particular person scored so highly on the Mini Mental State Examination that the first consultant she saw did not recognise the early signs of dementia she presented with. Another detailed how it took about six months to get the diagnosis.

Perhaps the most striking thing about



the narratives of the people with dementia is not the physical way in which dementia symptoms have affected them but rather how they are living with it, and their ability to transform a negative diagnosis into something positive. One person expressed how dementia has given him a new life and how he now has time to do the things he couldn't before because of work commitments; another revealed that "my dementia is a gift and I have got to use it to educate others."

People with Dementia Speak Out is aimed at anyone affected by dementia, either personally or professionally. It has an FAQs section for patients, family or friends who may be unfamiliar with the intricacies of the condition, and a section specifically focusing on what clinicians can learn from people with dementia.

Lucy Whitman also draws attention to the way in which other healthcare professionals who support people with dementia, whether as nurses, social workers or in any other role, can learn from the experiences of dementia patients by listening to what they have to say for themselves.

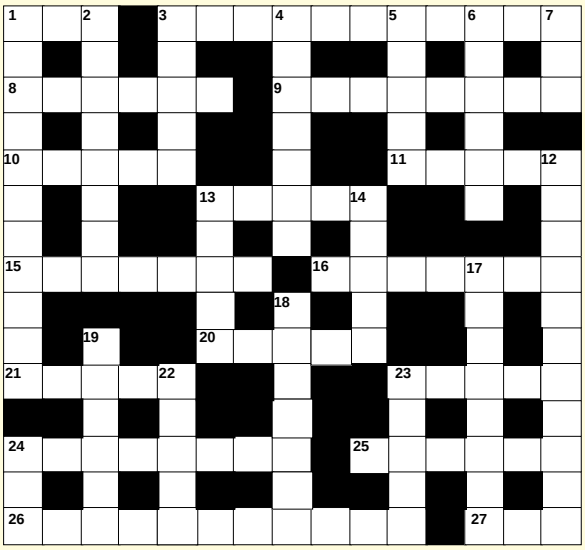
This anthology highlights the extraordinary diversity of people living with dementia and is a must-read for health and social care professionals at all levels.

– Sinéad Makk

People with Dementia Speak Out is published by Jessica Kingsley Publisher, RRP €19.50, ISBN: 9781849052702
In last month's WIN the publishing details of the book reviewed were omitted. They are as follows: ***Pain-free Life: My Journey to Wellness*** *is published by Mercier Press, RRP €14.99, ISBN: 9781781174067*

Crossword Competition

WIN A €30 BOOK TOKEN



Across

1. Pale (3)
3. Having rearranged an appointment, one may need cuddles here! (11)
8. Unbroken, in one piece (6)
9. Carried out a sentence of death (8)
10. Country where the laity are upset (5)
11. Reigned (5)
13. Candid (5)
15. Reply (7)
16. Skipper (7)
20. Such pears as are surplus to requirements (5)
21. Drive-in lodgings (5)
23. Ventured to make father blush (5)
24. Break a cup's rim to create hip-hop (3,5)
25. It's more than likely he's a strange member of the family (4,2)
26. Being chatty, Romeo disturbed a surgical procedure (11)
27. Be in debt (3)

Down

1. Stay at home, man, on your wedding day - and be patient in this chamber (7,4)
2. Such chemicals may be given a neat stir (8)
3. Mr Balboa, a boxer played by Sylvester Stallone (5)
4. Popular cheese (7)
5. Furnishings, interior design (5)
6. Small (6)
7. Performed (3)
12. It's not d'outer choreography that identifies this social occasion! (6,5)
13. Financial resources (5)
14. Varlet (5)
17. One might get a sore calf out-of-doors (2,6)
18. Tailless feline (4,3)
19. Place of perfection written about by Sir Thomas More (6)
22. Giggle (5)
23. Of dubious provenance (5)
24. Rodent (3)

Solutions to April crossword:

Across:
1. Mug 3. Moisturiser 8. Garage
9. Doughnut 10. Inert
11. Throw 13. Sunup 15. Careful
16. Notable 20. Aphid 21. Tiara
23. Fable 24. Anorexia 25. Saddle
26. Pass the buck 27. SOS

Down
1. Magnificent 2. Gardener
3. Might 4. Saddens 5. Right
6. Sentry 7. Rot 12. Water meters
13. Sauna 14. Proud 17. Barbados
18. Rhubarb 19. Famous
22. Agent 23. Flask 24. Asp

The winner of the April crossword is: Macy Cunningham, Galway

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

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

HSE partaking in landmark TV series

THE HSE has agreed to participate in a television series with the working title of *Keeping Ireland Alive – The Health Service in a Day*, which will explore all the work done in Irish healthcare services over a 24-hour period.

The documentary series is being produced by Independent Pictures for RTÉ and is based on the BBC's *Keeping Britain Alive – The NHS in a Day*. The Irish series seeks to show how the HSE and its healthcare workers manage to overcome an enormous range of challenges every day in caring for those that need it.

The HSE has had detailed discussions with RTÉ and has reviewed the BBC series and examined the approach that RTÉ intends to take in producing this documentary.

The series is a major undertaking with up to 50 camera crews attempting to capture the work of the health service in just one day – or as much of it as 50 cameras will allow. Over 24 hours the producers will film in hospitals, community services, ambulances and everywhere else the health services are at work. Out of this footage they will make four one-hour documentaries.

The collective intention is that such an ambitious series will do justice to the very great work done by those working on the frontline of the health services – often in very challenging circumstances.

Ahead of the filming, a production team from Independent Pictures will spend three months seeking out stories and individuals to follow on the chosen day of filming. They are looking for participation from nurses and midwives as well as other healthcare professionals. Participation is, of course, voluntary. It is also important to note that this is not a production for the HSE, it is a production about the work of the health services being made independently for RTÉ.

Ireland's first ICNP research and development centre launched

THE International Council of Nurses (ICN) has announced the accreditation of a new International Classification for Nursing Practice (ICNP) Research and Development Centre in Dublin City University, School of Nursing and Human Sciences. The INMO, which is a member of ICN, fully supports the development of this new centre.

"We are excited to welcome the DCU School of Nursing and Human Sciences ICNP User Group to the ICN Accredited Centres consortium," said Frances Hughes, ICN CEO. "We look forward to working with colleagues within the new centre to expand further the reach of ICNP, providing nurses with the tools they need to ensure safe, effective, high-quality care for the people of Ireland."

ICN-accredited centres provide nursing resources in terms of information, services, research and training.

ICNP research and development centres, which focus on the development, implementation and use of ICN's ICNP, are organised into a consortium that meets biennially, the next of which will be held in 2017 at ICN Congress in Barcelona, Spain.

For further information see **www.icn.ch**

Pictured (l-r) outside INMO HQ were: Liam Doran, INMO general secretary; INMO staff member, Lorcan Byrne; and INMO president Claire Mahon. Lorcan Byrne recently won three gold medals during a competition in Tallaght for new winter sport, floorball

UCD launches courses in child welfare

UCD School of Nursing, Midwifery and Health Systems recently announced a graduate diploma in child welfare and protection and a masters in child welfare and protection. The programmes will commence in September 2016 and are a collaboration between the School of Nursing, Midwifery and Health Systems, the School of Medicine and the School of Social Policy, Social Work and Social Justice. They are designed for individuals who work with children in the health, social work, social care, education, criminal justice and other relevant sectors.

For further information, contact Dr Amanda Phelan, Tel: 01 7166482 or email amanda.phelan@ucd.ie, Dr. Michaela Davis, Tel: 01 7168210 or email michaela.davis@ucd.ie or Prof Jim Campbell, Tel: 01 7168210 or email jim.campbell@ucd

IANO President's Prize 2016 launched

THE Irish Association of Nurses in Oncology (IANO) has launched the 2016 IANO President's Prize. Applicants are asked to submit a research project and one successful winner will be chosen to do a clinical placement in Memorial Sloan Kettering Cancer Centre (MSKCC) in New York for one week.

This is the fourth IANO President's Prize which is supported by an educational grant from Bayer. The prize in 2016 will be presented at the IANO session during the European Oncology Nursing Society (EONS) conference which is taking place in Ireland on October 17-18, 2016 in the Aviva stadium.

The deadline for submissions for this year's award is Friday, September 16, 2016. For further information please visit **www.iano.ie/conference.html**

MONEY MATTERS

Still time for a last-minute AVC

If you are planning to retire soon, there is still time to maximise your tax free lump sum, writes **Ivan Ahern**

ARE you a nurse or midwife working in the public sector? Are you approaching retirement? If you answered yes to both of these questions then it is worthwhile investigating if the tax free lump sum you will receive at retirement is the maximum amount you are entitled to.

Your 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 recent years?
- Have you more than 40 years' service and are over the age of 60 and have 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 additional voluntary contribution (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 past 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 fee of €450, a contribution charge of typically 4% and an annual management charge of typically 1%.

After Susan invests her €12,000, she can claim back €5,180 of her investment from Revenue as she is paying 40% income tax. When Susan retires she will receive back her investment of €12,000. After taking charges into account, Susan's bank account is now approximately €4,230 better off – not a bad day's work!

Remember, you can only do a last minute AVC *before* retirement, so please ensure you get in touch in advance of your retirement date.

To find out if you can avail of this tax break to increase your tax free lump sum at retirement, contact Cornmarket at Tel: 01 420 0986 to make an appointment with a retirement planning consultant.

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, including: AVCs, purchase of notional service, retirement savings plans or sometimes a combination of all of these. What works for one person may not work for another. It all comes down to your individual circumstances and needs.

Cornmarket has designed a software tool that to help work out the best retirement plan for you based on your individual circumstances. You simply need to decide the type of retirement lifestyle you think you'll want and when, and the tool will figure out the rest.

Ivan Ahern is a director of Cornmarket Group Financial Services Ltd

To make an appointment with a planning consultant contact Cornmarket at Tel: 01 420 0986

Warning: The value of your investment may go down as well as up. This product may be affected by changes in currency exchange rates. If you invest in this product you may lose some or all of the money you invest. If you invest in this product you will not have any access to your money until you receive your superannuation benefits

May

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

Saturday 14
CNM/CMM Section meeting INMO HQ. From 11am. Session on 'how to become a mindful nurse/ midwife leader'. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details for further details

Tuesday 24
Cork University Hospital inaugural nursing conference 'enhancing patient care through research'. For queries and registration, email: Eilish.Hawe@hse.ie

June

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

Thursday 9
ODN Section meeting. INMO HQ. From 6pm. Contact jean.carroll@inmo.ie f or Tel: 01 6640648 for further details

Saturday 11
Midwives Section meeting. 2pm. University Hospital Galway. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Wednesday 15
Director of nursing/midwifery/ public health seminar. From 12.30pm. Open to all directors. See page 22 for more information. Booking essential. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Tuesday 21
Care of the Older Person Section meeting. From 10am-1pm. Session on 'tools for safe practice'. Booking essential to obtain CEUs. Visit **www.inmoprofessional.ie** or contact helen.oconnell@inmo.ie to confirm your free place

Friday 24
Nurse/Midwife Education Section meeting. INMO HQ. 11.30am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Friday 24
Third Level Student Health Nurses Section meeting. UCD. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

July

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

Wednesday 27
CPC Section meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

September

Tuesday 6
Care of the Older Person Section meeting. INMO HQ. Session on pensions with Denis Brophy, financial consultant. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 10
Midwives Section meeting. 2pm. Limerick Regional Maternity Hospital. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Saturday 14
CNM/CMM Section meeting. INMO HQ. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Thursday 15
Retired Nurses/Midwives Section meeting. 11am. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Wednesday 28
Telephone Triage Section Annual Conference. Castletroy Park Hotel, Limerick. Contact jean.carroll@inmo.ie or Tel: 01 6640648 for further details

Condolences

- The INMO would like to extend its sincere condolences to Jennifer Bollard, retired director of public health nursing and former Executive Council member on the recent death of her mother Susan Byrne

INMO Membership Fees 2016

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

Retired nurses and midwives holiday

- The Retired Nurses and Midwives Section holiday to Harrogate will take place from Sunday, September 25, 2016 for five nights and six days. Price: €640 per person sharing

  Hotel: Yorkshire Hotel, Harrogate (Single room supplement of €25 per night). The Hotel is holding the rooms specifically for this event until Friday, April 29.

  Contact: Myra Garahan, Retired Nurses and Midwives Section social committee at Tel: 087 6305231. To book your place contact James McGinley at Tel: 074 9135201. The minimum booking required to go ahead with this event is 20.

Training programme

- One-day ear irrigation training programmes with Category 1 NMBI approval and four continuing education units will be held on June 16, September 22 and November 17, 2016 in the Education and Conference Centre, Royal Victoria Eye and Ear Hospital, Adelaide Road, Dublin 2. For further details contact Sabrina Kelly, nurse tutor at Tel: 01 6644652 or email: sabrina.kelly@rveeh.ie