€5.75 Vol 26 No 4 May 2018

WIN

INMO

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

World of Irish Nursing & Midwifery

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WIN – World of Irish Nursing & Midwifery is distributed by controlled circulation to **more than 35,000** members of the INMO. It is published monthly (10 issues a year) and is registered at the GPO as a periodical. Annual Subscription: €155 incl. postage paid. Editorial Statement: *WIN* is produced by professional medical journalists working closely with individual nurses, midwives and officers on behalf of the INMO. Acceptance of an advertisement or article does not imply endorsement by the publishers or the Organisation.

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WIN INMO Irish Nurses and Midwives Organisation
World of Irish Nursing & Midwifery

(ISSN: 2009-4264)
Volume 26 Number 4
May 2018

WIN,
MedMedia Publications,
17 Adelaide Street,
Dun Laoghaire,
Co Dublin.
Website: www.medmedia.ie

medmedia publications

Editor Alison Moore
Email: alison.moore@medmedia.ie
Tel: 01 2710216

Production & news editor Tara Horan

Sub-editor Sonja Storm

Designers Fiona Donohoe, Paula Quigley

Commercial director Leon Ellison
Email: leon.ellison@medmedia.ie
Tel: 01 2710218

Publisher Geraldine Meagan

WIN – World of Irish Nursing & Midwifery is published in conjunction with the Irish Nurses and Midwives Organisation by **MedMedia Group**, Specialists in Healthcare Publishing & Design.

INMO
Irish Nurses and Midwives Organisation

Editor-in-chief: Phil Ní Sheaghdha

INMO editorial board:
Martina Harkin-Kelly; Mary Leahy; Margaret Frahill; Frances Cullen; Kay Garvey; Mary Gorman; Karen McGowan

INMO editor: Ann Keating
Email: ann.keating@inmo.ie

INMO editorial assistant: Freda Hughes

INMO photographer: Lisa Moyles

INMO correspondence to:
Irish Nurses and Midwives Organisation,
Whitworth Building,
North Brunswick Street,
Dublin 7.
Tel: 01 664 0600
Fax: 01 661 0466

Email: inmo@inmo.ie
Website: www.inmo.ie

www.facebook.com/irishnursesandmidwivesorganisation

twitter.com/INMO_IRL

Time to right past wrongs

TRADITIONALLY, in Ireland we have determined nursing staffing levels based on available funding and empirical evidence – a process that has led to completely inadequate staffing. We should also recall that staffing levels were already inadequate before the recruitment moratorium.

Firstly, the inclusion of nursing and midwifery grades in the public service moratorium on recruitment and promotion that was introduced in 2008 was a hugely significant contributory factor to the staffing shortage. At that time a belief existed among politicians that we had "plenty of nurses, well within the OECD average etc". This was challenged by the INMO but was largely unquestioned by media or government at that time. It is disappointing that this opinion was repeated by the Taoiseach recently, no doubt causing our members to ask what country are these politicians living in? It is clear to patients, visitors and staff that nursing and midwifery numbers are grossly inadequate in the context of the safe delivery of current demands on the overcrowded public health service (see a critique of OECD calculations on *page 8* of this issue of *WIN*).

The second contributing factor is the lack of a scientific measurement tool to evaluate nurse and midwife staffing levels on the basis of patient dependency, skill mix and patient outcomes.

In April 2014, under pressure from the INMO, the then Health Minister James Reilly approved the establishment of a Taskforce on Staffing and Skill Mix for Nursing. The Taskforce began its work in September 2014 and continued with the support of subsequent ministers. Its core objective was the development of a framework to support the determination of staffing and skill mix requirements for the nursing workforce, which includes the nurse and healthcare assistant on specialist medical and surgical wards in acute adult hospitals. The optimum skill mix was determined as 80 RN: 20 HCA. This method was piloted on 16 wards across three acute hospitals. Phase two of this work is determining the staffing levels required for EDs and is about to go to pilot stage.

The evidence of improved patient outcomes when staffing levels are determined in this manner is significant. It is hardly surprising that the research found that correct staffing levels led to: reduced length of hospital stay; reduced mortality; reduced reports of care left undone; and reduced episodes of nurse sensitive outcomes, eg. hospital-acquired pneumonia, urinary tract infections, patient falls, pressure ulcers, etc. These findings were based on correcting and stabilising the nursing workforce on the pilot sites. The supervisory role of the CNM2 and their constant presence on the pilot sites was crucial to the success of this initiative.

In addition, the investment of appropriate levels of CNM1 to support the CNM2 and allow for succession planning was also significant. It was also vital that the roster allowed and provided replacement nursing staff to cover all leave including maternity leave as it was determined that staffing gaps were to be filled with the appropriate skill mix. The 80:20 skill mix was recommended as a baseline, depending on patient dependency but it is a ratio that must be constantly monitored.

Using this evidence-based approach to determine nursing staff requirements will be a first for Ireland and will challenge the belief that there are adequate nurse staffing levels in Ireland. However, this does not address the question of how to recruit and retain nursing staff in the current climate. The implementation of the framework would lead to dramatic improvements in patient outcomes and would revitalise and re-energise staff. From the outset, the success of the framework requires an investment in pay to attract and retain nurses and midwives in the Irish health service.

The time to correct past wrongs has arrived and the provision of optimal care and hope to patients and the nurses and midwives who care for them is a real possibility. The question is: do our politicians have the courage to step into the future where optimum levels of nursing staff deliver optimum levels of care in a modern and successful Irish health service? Time will tell.

Phil Ní Sheaghdha
General Secretary, INMO

Your priorities with the president

Martina Harkin-Kelly, INMO president

Annual conference season

I LOOK forward to meeting delegates at our ADC in Cork, where our theme is 'Innovation in Practice – Nurses and Midwives Leading the way'. Our agenda is that prize of pay fairness. The Public Service Pay Commission (PSPC) will be deliberating on Module 1 during our ADC – which allows the Commission to examine nurse and midwife recruitment and retention issues. The PSPC is conducting its own research and while we acknowledge its right to do so, we believe this process is unnecessary. Many of you will have completed this survey which contained only one real question on pay with many other questions setting out the factors affecting recruitment and retention. The Executive Council considered these matters at its most recent meeting and as a result has prepared an emergency motion to be debated at conference. The INMO has also contacted all political party leaders asking them to pledge their support in respect of implementation of outcomes of the PSPC *(see page 12)*. It is my hope that debate at conference will be robust, engaging and clarifying. Let us all stay focused and get the message across on the need to ensure that our pay is dealt with once and for all.

Official opening of The Richmond

WIN went to press early this month, therefore I have not had the opportunity to recount the official opening on April 20 of the Richmond Education and Event Centre by Health Minister Simon Harris, general secretary Phil Ní Sheaghdha and myself. We look forward to a future of continuous growth and development as an Organisation in this magnificent, lovingly restored building in the heart of Dublin. One key member of staff in HQ, Elizabeth Adams, director of professional development and The Richmond, is owed a debt of gratitude for her attention to the restoration. We bid farewell to Elizabeth as she leaves the INMO and our loss is indeed the gain of the Department of Health, where she will lead the Patient Advocacy Project. Health and happiness is extended to her in her new position.

RNID Section national conference

IT WAS indeed an honour to address this conference and to have the opportunity to deliver our message to key policy influencers Finian McGrath, Minister of State with responsibility for disabilities, and Siobhan O'Halloran, chief nurse at the Department of Health, who were in attendance. I did not hold back regarding the role played by the RNID and the insidious nature of the social care model, which is in essence a cost of care model, that denies the individual with an intellectual disability the right to have an RNID care for them. The Section committee: Ailish Byrne, chairperson and serving member of the INMO Executive Council; Patricia McCartney, vice chairperson; Marian Spelman, secretary; Anne Marie O'Reilly, education officer; and Jacinta Mulhere, PRO, are to be congratulated on the programme of speakers they arranged, whose geographical spread, both nationally and from across the water in the UK, ensured that practice developments for the RNID, or those nurses working in ID settings, was relevant and underpinned by evidence-based practice.

Liam Doran honoured at the RCSI

Liam Doran, former general secretary of the INMO, was presented with a fellowship of the RCSI at a recent gala event. Congratulations to Liam from all at the INMO for this well deserved acknowledgement of his contribution to the development and progression of nursing and midwifery in Ireland. On behalf of all at the INMO, congratulations Liam, this accolade is truly deserved – *see page 11 for photo*.

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

Quote of the month

"Success is no accident, it is hard work, perseverance, learning, studying, sacrifice and most of all, love of what you are doing" – Pele

Report from the Executive Council

WITH the incoming Executive Council for 2018/20 now elected, I would like to thank all those who put themselves forward. The new Executive will be formally introduced to the delegates at ADC in Cork on Friday, May 4 by Phil Ní Sheaghdha the electoral returning officer. To the former Executive, first and second vice presidents, Mary Leahy and Margaret Frahill, please accept my sincere gratitude – the past two years were busy to say the least. We had our ups and downs with many brave decisions taken along the way. Friendships were formed and it was an honour and a pleasure to have served with you.

Centenary plans are ongoing and the theme has been decided as 'Remembering the Past, Navigating the Present, Modelling the Future'. A stand will be at this year's ADC with the purpose of ascertaining your views and ideas as to how this landmark should be celebrated. A calendar of events will inform you of those celebrations already planned. The Mansion House holds a central place in the plans as this is where the first AGM was held. We are awaiting confirmation of its availability to commemorate this inaugural meeting. The President, Michael D Higgins has also received correspondence re the Centenary and our national broadcasters have been asked to host a commemorative programme. Please do get involved. This is your celebration as you are the union.

The next meeting of the Executive Council will be on Wednesday, May 2, prior to the commencement of ADC.

Get in touch

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

Reliance on OECD figures masks chronic shortage of nurses

THE use of OECD figures to measure available nursing/midwifery staff is not reliable and in fact masks the reality of a chronic shortage of nursing staff in our health services, which are dangerously and chronically overcrowded.

Reports and publications from the OECD, which compare the number of nurses per 1,000 of the population for each of its member states, collates figures based on the number of nurses recorded as professionally active.

The OECD records for Ireland are taken from samples obtained from the Quarterly National Household Survey (QNHS) which could record any person with a nursing qualification, for example, dental nurses or qualified nurses employed in non-nursing roles. QNHS data (for Ireland) for those professionally active relies on a respondent's self-report.

In respect of its figures, the OECD states: *"Nurses are defined as all 'practising' nurses providing direct health services to patients, including self-employed nurses. However, for some countries (France, Ireland, Italy, the Netherlands, Portugal, Slovakia, Turkey and the US), due to lack of comparable data, the figures correspond to 'professionally active' nurses, including nurses working in the health sector as managers, educators, researchers, etc. For Austria and Greece, the data include only nurses working in hospitals. Midwives and nursing aides (who are not recognised as nurses) are normally excluded."*

The INMO understands that when the calculation in Ireland is undertaken the figures for midwifery are included. This means two professional grades are being compared to one across the European comparative states. Clearly this is an incorrect comparison. The OECD's most recent figure for Ireland is 11.9 nurses per 1,000 people. The INMO believes the relevant measure is that of employed nurses in the public/private health service which is shown in *Table 1*. At 9.04 WTE staff nurses per 1,000 population, across the public and private health service, this falls well below the OECD average ratio.

Table 1. Calculation of employed staff nurses in the public/private health service (Nov 2017)

Number of nursing/midwifery posts – HSE (WTE) Nov 2017	36,616
Number of nurses/midwives - private sector (WTE) *Estimated on headcount of 10,000 and based on ratio of 13% differential which exists in public sector between part time and WTE*	8,700
Sub-total	45,316
Minus number of midwives (public and private)	-2,000
Minus unqualified students	-571
Total	42,745
Population	4,724,925
Nurses per 1,000	**9.04**
Staff nurses per 1,000 in the public service	
Staff nurses (WTE) posts listed on HSE census	25,220
13% translating WTE to headcount of population (4,724,925)	28,498
Staff nurses per 1,000 population	**6.04**
WTE staff nurses per 1,000 population	**5.3**

The following factors also need to be considered:

- The total employment figure includes all grades of nurses, including those not involved in clinical care
- The figure in Ireland, resting 'within the OECD average', must be viewed in the context of the dangerously high level of occupancy of Irish hospitals, which is far more than regional comparisons, and reduced level of acute beds per 1,000, resulting in high acuity, dependency and turnover
- High bed occupancy rate which, internationally, would be seen as ongoing overcrowding
- The inclusion in Irish figures of undergraduate nurses/midwives being counted as 0.5 of a WTE post when on rostered placement, which confirms their inclusion as an integral part of the qualified nursing workforce even though they are not. In comparison the UK excludes all reference to undergraduate nurses/midwives on clinical placements, when it calculates its nursing/midwifery numbers.

RN4CAST study

The Registered Nurse Forecasting (RN4CAST) study funded by the European Union also found that the Irish nurse per 1,000 population falls within the average OECD ratio. The RN4CAST studied features of hospital environments that impact on nurse recruitment, retention and patient outcomes in approximately 500 general acute care hospitals in 12 EU countries. It found that workforce planning for nursing in the Irish health service was limited due to poor information on public health workers and inadequate information on the supply and demand of healthcare workers in the private and voluntary sectors.

RN4CAST found that the determination of staffing levels on Irish wards (30 participating hospitals) was: largely historical (n=24); not based on a formal system (n=25); variable across wards (n=23); reviewed regularly in almost half the hospitals (n=14); not determined by reference to benchmarks in just over half of the hospitals (n=17); not set to match existing benchmarks (n=20); not set to exceed existing benchmarks (n=28); not matched to patient acuity or dependency (n=21); somewhat based on informal review of patient acuity (n=18); and not planned on a shift-by-shift basis using patient acuity/dependency (n=23).

Taskforce on nurse staffing

In April 2014, the then Minister for Health James Reilly, under pressure from the INMO about poor and worsening nurse staffing levels, approved the establishment of a Taskforce on Staffing and Skill Mix for Nursing.

The outcome of this is the *Framework for Safe Nurse Staffing and Skill Mix*, which was launched last month *(see opposite page).*

The evidence of improved patient outcomes when staffing levels are determined using this framework is significant. This is the future, and the framework needs to be the agreed, funded method of determining nursing staffing levels for our hospitals.

– Phil Ní Sheaghdha, INMO general secretary

INMO welcomes staffing framework

Safe staffing/skill mix initiative requires full roll out without delay

IN WELCOMING the *Framework for Safe Nurse Staffing and Skill Mix*, launched by Minister for Health Simon Harris last month, the INMO called for a fully-funded roll out of the initiative.

The Organisation further welcomed the commitment given by the government at a cabinet meeting following the launch, where it agreed, in principle, that the plan would be extended to hospitals nationwide. However, the INMO cautioned that this will not happen without immediate investment in the recruitment and retention of nurses and midwives, including improvements in pay, without which the necessary nurses will not be available for implementation.

The evidence from the testing of the framework shows overwhelmingly that a funded national roll out, associated with pay adjustments to improve recruitment and retention of nurses, will save lives, make services safer and reduce costs for the health services.

The INMO has lobbied government to introduce an evidence-based approach to determining nurse staffing levels since the introduction of the moratorium on staffing and the subsequent introduction of the detrimental 20% lower salaries for new entrant nurses in 2012, which caused a mass exodus of nurses from the country and left workplaces dangerously short staffed.

As a result of this pressure, the then Minister for Health James Reilly established the Taskforce on Staffing and Skill Mix for Nursing in September 2014, which led to the development of the framework. The Taskforce began its work in September 2014 and continued with the support of the subsequent Ministers for Health. INMO general secretary at the time Liam Doran welcomed the initiative and said the union would be "loud and active" in pressing for improved staff ratios.

The INMO acknowledges the work of the Nursing Policy Division of the Department of Health on the development and piloting of the framework over the past three years, the UCC research team and the nurses involved in the pilot sites.

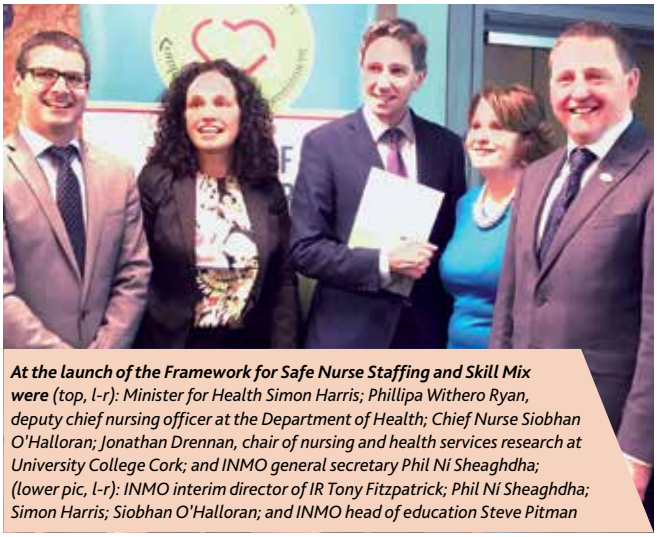
The core objective of the taskforce was to develop a framework to support the determination of staffing and skill mix requirements for the nursing workforce on specialist medical and surgical wards in acute adult hospitals. The optimum skill mix was determined as 80% RN to 20% HCA. This method was piloted on 16 wards across three acute hospitals. Phase two of this work is determining the staffing levels required for emergency departments and is about to go to pilot stage.

The evidence from the specialist medical/surgical pilot is overwhelmingly in respect of the measurable benefits from ensuring that correct nurse staffing levels are constantly protected and supported.

The research found that correct nurse staffing levels led to:

- Reduced length of hospital stay
- Reduced mortality
- Reduced reports of care left undone
- Reduced episodes of nurse sensitive outcomes such as hospital acquired pneumonia, urinary tract infections, patient falls, pressure ulcers, etc.

The supervisory role of the clinical nurse manager 2 (CNM2) and their constant presence on the pilot sites was crucial to the success of this initiative. It was also vital that the roster allowed and provided for replacement nursing staff to cover all leave, including maternity leave, as it was determined that staffing gaps were to be filled with the appropriate skill mix.



***At the launch of the Framework for Safe Nurse Staffing and Skill Mix were** (top, l-r): Minister for Health Simon Harris; Phillipa Withero Ryan, deputy chief nursing officer at the Department of Health; Chief Nurse Siobhan O'Halloran; Jonathan Drennan, chair of nursing and health services research at University College Cork; and INMO general secretary Phil Ní Sheaghdha; (lower pic, l-r): INMO interim director of IR Tony Fitzpatrick; Phil Ní Sheaghdha; Simon Harris; Siobhan O'Halloran; and INMO head of education Steve Pitman*

INMO general secretary Phil Ní Sheaghdha said: "Using this evidence-based approach to determine nursing staff requirements will be a first for Ireland and will challenge those who believe that there are adequate nurse staffing levels currently.

"The implementation of the framework would lead to dramatic improvements in patient outcomes and it would revitalise and re-energise nursing staff. From the outset, the success of the framework requires an investment in pay to attract and retain nurses and midwives in the Irish health service. It is very clear to patients, visitors and staff that nursing and midwifery numbers are grossly inadequate in the context of the safe delivery of current demands on the overcrowded public health service."

Ms Ní Sheaghdha concluded: "The provision of optimal care and hope to patients and the nurses who care for them is now a real possibility. This requires real investment in attracting nurses to work in Ireland and retaining those who are leaving. Pay remains the single area not addressed, and the framework requires full roll out without delay."

• *See also report from Siobhan O'Halloran, page23*

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

EXECUTIVE COUNCIL 2018-2020

Clinical

- **Ailish Byrne** - Staff Nurse, Muiriosa Foundation, Monasterevin
- **Kathryn Courtney** - Clinical Nurse Specialist, Palliative Care, Marymount Hospice, Cork
- **Breege Creaven** - Staff Nurse, St Pius Ward, University Hospital, Galway
- **Frances Cullen** - Senior Staff Nurse, St Joseph's District Hospital, Ballina, Co Mayo
- **Karen Eccles** - Staff Nurse, Cavan General Hospital
- **Ann Fahey** - Staff Nurse, Our Lady's Hospice, Harold's Cross, Dublin
- **Eilish Fitzgerald** - Public Health Nurse, Block 38, St Finbarr's Hospital, Cork
- **Maeve Gaynor** - Registered Midwife, Our Lady of Lourdes Hospital, Drogheda
- **Clare Hoban** - Staff Nurse, Children's University Hospital, Temple Street, Dublin
- **Donna Hyland** - Staff Nurse, Sacred Heart Hospital, Castlebar, Co Mayo
- **Niamh McKeon** - CNM2, Roscommon University Hospital, Roscommon
- **Ann Noonan** - Senior Staff Nurse, Ophthalmic Theatre, University Hospital Limerick
- **Marie O'Brien** - CNM1, Ennis General Hospital, Co Clare
- **Sean Shaughnessy** - Staff Nurse, Surgical Day Ward, University Hospital Galway
- **Catherine Sheridan** - Staff Nurse, Paediatrics, University Hospital Galway (children's seat)
- **Bernadette Stenson** - ANP Candidate, St Vincent's University Hospital, Elm Park, Dublin
- **Grainne Walsh** - Public Health Nurse, Waterford Community Care

Education (Category A)

- **Martina Harkin-Kelly,** Specialist Co-Ordinator/Nurse Educator, CN/ME, Sligo/Leitrim and West Cavan

Administration

- **Helen Butler** - Director of Nursing, St Luke's Hospital, Kilkenny
- **Karen McGowan** - ANP, Beaumont Hospital, Dublin
- **Margaret Frahill** - CNM3, Mercy University Hospital, Cork

Undergraduate Student

- **Ethan O'Regan** - University College Cork/Mercy University Hospital, Cork

Executive Council 2018-2020 elected

FOLLOWING the recent election process, the INMO Executive Council for the period 2018-2020 has been elected *(see opposite)*.

The new Executive Council will officially take up office on May 4, 2018, following the close of business at the annual delegate conference in Cork. The newly elected Executive Council will meet for the first time in June.

New officers

The three officers were elected unopposed for the 2018-2020 period and are:

- Martina Harkin-Kelly, president, who will take up her second term in office
- Catherine Sheridan, first vice president, who is a staff nurse in paediatrics at UHG
- Eilish Fitzgerald, second vice president, who is a PHN working from St Finbarr's Hospital, Cork.

INMO general secretary, Phil Ní Sheaghdha 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 Executive and officers in the months and years ahead."

Executive Council election: *INMO staff in action counting the votes to elect the INMO Executive Council for 2018-2020, overseen by general secretary Phil Ní Sheaghdha*

Pay issue top of agenda for ADC delegates

The INMO is holding its 99th annual delegate conference in the Silver Springs Hotel, Cork on Wednesday, May 2 to Friday, May 4. The theme this year is *Innovation and Practice – Nurses and Midwives Leading the Way.*

Delegates will debate over 50 motions over the three days and pay will be top of the agenda, with an emergency motion to be debated on Thursday. The full text of all motions can be viewed on **www.inmo.ie**, where you can also access updates on the proceedings throughout the ADC.

Apart from the debate on motions, other events over the three days include:

Wednesday, May 2

- Introduction by Steve Pitman, head of professional development and education to debate on educational motions
- Dinner, raffle and quiz in aid of a local charity at 7.30pm.

Thursday, May 3

- Introduction by Tony Fitzpatrick, interim director of industrial relations, to debate on industrial motions
- Address by Emily Logan, Human Rights Commissioner
- Introduction by Edward Mathews, director of regulation and social policy to debate on social policy motions
- Address by Roisin Shortall TD
- Dinner at 8pm followed by presentation of awards to the winners of the Gobnait O'Connell Award, CJ Coleman Research Award and the Preceptor of the Year Award.

Friday, May 4

- Presentation on Taskforce on Nursing/Midwifery Skill Mix
- Address by Minister for Health Simon Harris and response by INMO president Martina Harkin-Kelly
- Review of the year by deputy general secretary Dave Hughes
- Introduction of Officers and newly elected Executive Council for 2018-2020
- Drinks reception at 7.30pm. followed by the Annual Gala Dinner.

Speaking ahead of this year's conference INMO general secretary Phil Ní Sheaghdha said: "Recruitment and retention are top of the agenda for our members and pay is the main factor in this. We welcomed the recent launch of the Framework for Safe Staffing and Skill Mix and have also welcomed the commitment by government to roll it out nationally. However, major investment is needed in order to recruit and retain nurses and midwives so that improvements can be made in all areas of the health service, and the recruitment and retention issue can be resolved once and for all."

Liam Doran honoured: *Former INMO general secretary Liam Doran was made an Honorary Fellow of the Royal College of Surgeons in Ireland (RCSI) Faculty of Nursing and Midwifery Fellowship in recognition of his contribution to the development of nursing and midwifery in Ireland. He is pictured here being presented with the fellowship by Mary Jacobs, dean of the Faculty of Nursing and Midwifery, RCSI*

INMO lobbies TDs on nurse/midwife pay

THE INMO is seeking assurance from all political parties that they will support commitments already made by government to address the very real crisis in recruitment and retention of nursing and midwifery grades as a matter of priority in 2018 and 2019.

The INMO wrote directly to the leaders of all political parties seeking their party's support and promotion of the Organisation's efforts to ensure that government honours the commitment on the implementation of improvements required for nursing and midwifery, in the context of recruitment and retention difficulties and the terms of the Public Service and Stability Agreement (PSSA).

In the letter, INMO general secretary Phil Ní Sheaghdha pointed out that retention of nurses and midwives in the public health service is a substantial challenge. Indeed, a recent Public Health England draft report on workforce strategy also identified pay as the significant factor in recruitment and retention of nursing staff in the NHS.

"It is entirely reasonable to argue that Ireland is no different in this regard in the areas of nursing and midwifery. Indeed, Ireland is likely to come under increasing pressures stemming from Brexit, whereby the UK will refocus its efforts and seek to recruit Irish nurses and midwives with more attractive terms and conditions of employment," Ms Ní Sheaghdha said, pointing to domestic and international pay comparisons *(see Tables)*.

The PSSA 2018-2020 recognised, and gave priority to, the recruitment and retention of nurses and midwives, along with medical staff, under phase II of the Public Service Pay Commission's work. The Pay Commission has committed to producing its report on health services in June 2018.

A subsequent clarification to the PSSA committed the Department of Public Expenditure and Reform to meeting the INMO, and other nursing unions, within four weeks of the issue of that report.

However, INMO members are becoming increasingly concerned that government may fail to honour this commitment in its entirety. As a result this matter will be the subject of an emergency motion at the INMO annual delegate conference, which takes place in Cork from May 2-4, 2018.

The letter highlighted that nurses and midwives are the lowest paid professional grades in the public service *(see Table)*.

The INMO stated that the Organisation is committed to honouring the Public Service Stability Agreement, which its members voted to accept. "However, we cannot countenance this exercise being used to prolong or divert attention from the urgent requirement to address nursing and midwifery pay," Ms Ní Sheaghdha said.

"Our members will expect government and opposition parties to ensure the agreement will be honoured and that any pay adjustments required will be budgeted for in the 2018 estimates leading to payment in the 2019 budgetary period."

The Organisation will inform delegates at the ADC of the responses received from the party leaders on this issue.

Table 1. Annual nursing and midwifery whole time equivalent (WTE) census

(Note: annual census figures include approx. 800 nursing students as WTE per annum)

December of year:	Total WTE	Change
2007	39,006	N/A
2008	38,108	-898
2009	37,466	-1,540
2010	36,503	-2,503
2011	35,902	-3,104
2012	34,637	-4,369
2013	33,768	-5,238
2014	34,505	-4,502
2015	35,353	-3,653
2016	35,835	-3,171
2017	36,777	-2,229

Table 2. Purchasing power parity of nurses working in the public sector hospitals

International Council of Nursing (ICN) data on the purchasing power parity of nurses working in the public sector hospitals in eight countries, including Ireland. Figures show that Irish nurses and midwives are better off financially if they move overseas

Canada	54,536	Denmark	37,537
USA	46,834	Sweden	34,025
Australia	42,446	New Zealand	33,502
Japan	40,951	Ireland	32,718

Table 3. Comparisons between nurses/midwives' pay and other public servants in Ireland (€)

Grade	After 1 year	After 5 years	After 10 years	After 15 years	% increase after 5 years	% increase after 10 years	% increase after 15 years
Teacher*	€ 37,430	€ 42,261	€ 49,999	€ 58,081	12.91%	33.58%	55.17%
Resp technician	€ 37,052	€ 42,936	€ 49,355	€ 52,843	15.88%	33.20%	42.62%
O/T & other AHPs***	€ 37,410	€ 42,539	€ 48,114	€ 51,543	13.71%	28.61%	37.78%
Radiographer	€ 35,869	€ 40,850	€ 46,284	€ 49,544	13.89%	29.04%	38.12%
Garda**	€ 31,382	€ 41,495	€ 47,793	€ 49,512	32.23%	52.29%	57.77%
Staff nurse	€ 30,802	€ 36,023	€ 42,644	€ 45,248	16.95%	38.45%	46.90%

*Using scale of those appointed after 1/1/2011 ** Using scale post Oct 2013 scale with LRA ***Allied health professionals

INMO joins the call for housing as a basic human right:
INMO staff and members attended the National Homeless and Housing Coalition demonstration on April 7, 2018 in Dublin city centre. The coalition is supported by the organisations such as Focus Ireland, the Peter McVerry Trust, Merchants Quay Ireland, as well as ICTU, a number of activism and trade union groups, political parties, actors and musicians. With Ireland currently in the grip of a chronic housing crisis, the INMO joined the call for housing as a basic human right for all and the provision of more social housing

March trolley figures break several records

THE INMO trolley/ward watch figures for March 2018 broke all records for the month of March since records began, with 10,511 admitted patients waiting for an inpatient bed.

The month also saw a new high figure of 714 patients waiting on trolleys on one day and a record-breaking 3,112 in just one week in March. There were also 191 children waiting on trolleys in the month.

As part of its drive at national level to address hospital and ED overcrowding, the INMO has sought specifically that the HSE Acute Hospital Division intervenes in hospitals where the trolley numbers are simply out of control, and where local management is not adhering to the ED Agreement brokered between the INMO and the HSE in January 2016. This requires site visits which the INMO requested several times recently.

Where implemented correctly, the ED Agreement has made remarkable improvements and better use of extra beds, both in community and acute hospitals. The RCSI Group figures (Beaumont, Connolly, OLOL Drogheda, and Cavan hospitals) clearly demonstrate this and have significantly reduced ED overcrowding since the agreement. However, Connolly Hospital is now experiencing a rise in figures again with 453 trolleys in March 2018 compared to 239 in March last year.

INMO officials representing hospitals with consistently high numbers made the following remarks in recent weeks:

- On Thursday, March 29, leading into a bank holiday weekend and with 72 patients awaiting an inpatient bed in University Hospital Limerick, INMO IRO Mary Fogarty said: *"There is an urgent need for additional nursing staff and more beds. Patient safety and clinical care is compromised due to the inability of the hospital to retain and recruit nurses with 60 nursing vacancies currently confirmed."*
- On South Tipperary General Hospital which had 589 patients on trolleys in March, more than twice the hospital's total 255-bed capacity,

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

Hospital	Mar 2006	Mar 2007	Mar 2008	Mar 2009	Mar 2010	Mar 2011	Mar 2012	Mar 2013	Mar 2014	Mar 2015	Mar 2016	Mar 2017	Mar 2018
Beaumont Hospital	514	598	615	744	937	610	655	581	342	643	721	294	210
Connolly Hospital, Blanchardstown	244	288	176	288	170	375	257	573	364	452	300	239	453
Mater Misericordiae University Hospital	598	416	422	375	496	311	380	262	264	541	356	419	404
Naas General Hospital	478	286	225	384	234	778	240	227	234	389	426	338	504
St Colmcille's Hospital	216	32	34	155	219	210	189	150	n/a	n/a	n/a	n/a	n/a
St James's Hospital	670	95	257	234	136	210	75	216	152	335	162	336	282
St Vincent's University Hospital	413	464	429	515	594	560	456	404	178	599	672	131	268
Tallaght University Hospital	734	339	381	686	509	643	211	389	392	409	506	485	508
Eastern	**3,867**	**2,518**	**2,539**	**3,381**	**3,295**	**3,697**	**2,463**	**2,802**	**1,926**	**3,368**	**3,143**	**2,242**	**2,629**
Bantry General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	42	39	146	79	62
Cavan General Hospital	355	238	121	113	312	489	249	125	36	65	117	31	54
Cork University Hospital	467	341	373	331	586	843	596	308	304	412	550	716	877
Letterkenny General Hospital	228	275	42	11	86	51	43	180	277	281	191	450	366
Louth County Hospital	12	12	26	1	2	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Mayo University Hospital	281	163	148	48	216	68	220	203	186	247	235	200	301
Mercy University Hospital, Cork	200	145	98	163	135	186	172	292	222	251	194	362	302
Mid Western Regional Hospital, Ennis	71	128	38	38	27	81	27	58	n/a	14	36	22	28
Midland Regional Hospital, Mullingar	6	11	11	28	230	331	288	403	250	562	468	434	433
Midland Regional Hospital, Portlaoise	56	39	78	63	24	90	55	60	166	217	260	358	202
Midland Regional Hospital, Tullamore	4	0	0	5	68	224	158	199	396	204	568	537	528
Monaghan General Hospital	3	45	37	35	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Nenagh General Hospital	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	15	7	5	7
Our Lady of Lourdes Hospital, Drogheda	405	386	194	398	356	541	660	333	474	533	474	216	205
Our Lady's Hospital, Navan	41	100	55	105	66	249	117	175	60	75	46	235	172
Portiuncula Hospital	78	23	38	16	74	71	105	162	45	99	86	259	133
Roscommon County Hospital	108	36	95	91	55	121	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Sligo University Hospital	161	46	77	96	153	156	104	242	238	235	213	301	357
South Tipperary General Hospital	111	88	55	53	89	104	150	158	250	233	552	496	589
St Luke's Hospital, Kilkenny	n/a	n/a	n/a	n/a	n/a	48	49	214	265	284	357	364	603
University Hospital Galway	258	189	209	305	443	626	409	401	387	634	539	638	709
University Hospital Kerry	159	30	148	12	69	81	34	118	76	125	89	232	297
University Hospital Limerick	223	42	188	199	237	269	319	924	499	558	710	699	1,022
University Hospital Waterford	n/a	n/a	19	69	64	148	110	102	352	289	306	420	407
Wexford General Hospital	294	86	112	159	34	348	127	273	42	194	94	163	228
Country total	**3521**	**2,423**	**2,162**	**2,339**	**3,326**	**5,125**	**3,992**	**4,930**	**4,567**	**5,566**	**6,238**	**7,217**	**7882**
NATIONAL TOTAL	**7,388**	**4,941**	**4,701**	**5,720**	**6,621**	**8,822**	**6,455**	**7,732**	**6,493**	**8,934**	**9,381**	**9,459**	**10,511**

Comparison with total figure only:

Increase between 2017 and 2018: 11%
Increase between 2016 and 2018: 12%
Increase between 2015 and 2018: 18%
Increase between 2014 and 2018: 62%
Increase between 2013 and 2018: 36%
Increase between 2012 and 2018: 63%
Increase between 2011 and 2018: 19%
Increase between 2010 and 2018: 59%
Increase between 2009 and 2018: 84%
Increase between 2008 and 2018: 124%
Increase between 2007 and 2018: 113%
Increase between 2006 and 2018: 42%

– overcrowding now simply out of control

Ms Fogarty said: *"The situation is further compounded by the shortage of nursing staff to look after patients. The conditions for those who are ill and the frail elderly are inexcusable."*

- With 55 patients awaiting a bed in Cork University Hospital on March 29, IRO Liam Conway said: *"There is an ongoing issue with regard to delayed discharges to step down facilities. The INMO is highlighting this to the South/South West Group and Community Health Organisations."*
- Joe Hoolan, IRO for Tallaght Hospital, where there were 508 patients on trolleys in March, said: *"The hospital has yet to recruit any additional nursing staff to care for admitted patients in the ED. This is a feature throughout the Dublin/Midlands Hospital Group."*
- Galway University Hospital, which has 708 beds, had the equivalent of the full hospital on trolleys in March, with 709 waiting for a bed. IRO Anne Burke said: *"The nurse staffing levels on the wards in GUH have been decimated since the moratorium and have not recovered. The INMO is calling on management to address recruitment that will see the complement of nursing staff on wards increased to reflect the complexity of patient care and increased activity levels."*

Crisis continues in April

There was little improvement in the trolley figures in early April: on Monday, April 9 there were 532 patients on trolleys, which rose to 591 and 595 on the following two days. The most overcrowded hospitals over the three days were:

- Cork University Hospital, 159
- University Hospital Limerick, 135
- University Hospital Galway, 125
- South Tipperary General Hospital, 106
- St Luke's Hospital, Kilkenny, 93.

INMO general secretary Phil Ní Sheaghdha said: "These figures confirm that hospitals cannot cope, the system is unable to manage patient flow and the burden is falling on nursing and medical staff who are forced to work in intolerable conditions. Staff are constantly apologising to patients for the inhumane conditions in which they are forced to care for them and they cannot see any reprieve as we leave the winter period.

"It is time for the government as a whole to recognise that the health service is in crisis and requires immediate emergency intervention. These numbers are the equivalent of three whole hospitals of patients for whom there are no beds. This is a national emergency inflicting indignity and unnecessary suffering on patients and subjecting staff to extraordinary health and safety risks.

"The INMO is again calling for the protocol applying to any emergency to be applied immediately. This should include utilisation of the private sector, cancellations of all elective day and inpatient procedures, and concentration on de-escalation procedures. There must be an immediate focus on realistic recruitment and retention measures for nursing staff to prevent this situation continuing to deteriorate."

INMO backs single-tier health system

THE INMO made a detailed submission to the Independent Review Group, which is chaired by Dr Donal de Buitléir, on the proposal for the removal of private practice from public hospitals. The INMO, represented by general secretary Phil Ní Sheaghdha, then met, as part of an ICTU delegation, with the committee.

This proposal was part of the *Sláintecare* report, published by the Oireachtas Committee on the Future of Healthcare in May 2017.

In its submission, the INMO stated it has consistently argued in favour of a single-tier health system in this country, which would provide the full range of health services, with access being solely determined by need. It states Ireland's current two-tier health system is deeply flawed and inequitable, with speed of access to services being primarily determined by a person's ability to pay.

"The two-tier public health service has created instability, inequality of access and dissatisfaction amongst patients, clients and staff. The commitment to a single-tier health system, where access to care is determined solely by need and not ability to pay, is most welcome and will be strongly supported by the INMO," the submission stated. "This system must offer, at its core, speedy access and quality-assured services to every citizen, if it is to become a cornerstone of Irish society."

In determining the impact of removing private practice from public hospitals, the INMO said several key areas must be considered, including:

- Equity of access to healthcare services must be prioritised for all in society, in particular vulnerable sections of society
- Funding arrangements for the acute services, which must include an increase in employer PRSI to make up for loss in revenue associated with loss of private bed use
- Adequate staffing must be maintained as a priority to ensure safe patient care.

"Healthcare is a social good and a human right which, if provided in a quality assured way, brings societal, communal and economic good to a nation. A properly funded health system, which is required to be accountable, productive and efficient, must also be transparent, must guarantee equity and must guarantee world-class outcomes," the submission said.

The Organisation stressed it is imperative while removing private practice from public hospitals, that the aim of protecting vulnerable sections of society, through ensuring equity of access and access based on clinical need are to the forefront of all decisions.

"The establishment of a single-tier, quality-assured and universally-accessible healthcare system must be underpinned by a willingness to commit to additional resources, in terms of finance, staffing and infrastructure," the INMO said.

"All approaches taken to funding must secure and maintain the support of both the political system and the taxpayer. The shift to funding, through general taxation, and the phased abolition of tax reliefs and subventions for healthcare, must be undertaken in a very open and transparent manner if it is to enjoy community support."

Tony Fitzpatrick reports on issues discussed at the

National Joint Council

The National Joint Council (NJC) is the primary forum for the management of industrial relations in the health service. The NJC meets every two months when the staff panel and senior managers within the HSE and Section 38 organisations address national matters and local issues that require national input.

The INMO plays a pivotal part on the NJC staff panel, which also includes SIPTU, FORSA, IMO, MLSA, Connect and Unite. The purpose of the staff panel is to use the collective might of all the unions involved to work as one on behalf of all our members within the health sector. Matters discussed at the most recent meeting on March 27, 2018 are outlined below.

Managing attendance IT system

Management is seeking to introduce a pilot in the South east that would involve South Tipperary General Hospital, the South-East Ambulance Service, and Services for Older Person in Dungarvan. The INMO has difficulties with the proposed pilot and one meeting has taken place to date. There is no agreement to proceed with the pilot before a further meeting, which was planned to take place in April involving national officers of the unions involved.

Pension matters

The INMO and other unions have raised a number of matters with regard to superannuation. It was agreed that the HSE and the Department of health will meet with the unions to discuss these matters at a specific meeting on superannuation.

Matters raised by the INMO include: pension credit for non-sponsored public health nurses; delays with regard to staff receiving their lump sum and pension payments following retirement; and issues relating to senior staff nurses.

Joint Declaration on lifelong learning/ CPD

An agreement was reached between the EPSU and HOSPEEN in November 2016 on employer support for lifelong learning and continuous professional development. A working group was established to implement the Joint Declaration, however progress on this has been extremely slow. The parties met on February 1, 2018 and it was agreed that an independent chair would facilitate the process.

Fixed travel, subsistence and subsidised canteen

A number of unions have raised the issue of discrepancies across the 26 counties with regard to the application of circulars on fixed travel and subsistence rates and on subsidised canteens. In regard to fixed travel, the HSE is seeking to eliminate this practice and have all staff apply for motor travel expenses in line with the normal process. A WRC hearing took place on this matter and it has been agreed that further dialogue is required and a number of meetings are scheduled to resolve these matters.

The HSE has advised that approximately 690 staff continue to receive a fixed travel allowance. These are mainly nursing grades including assistant directors of public health nursing, clinical nurse manager 3s, public health nurses and community nurses. The areas where this practice continues are CHO6, CHO7, CHO9, Midlands and CHO4.

Revenue granted a derogation to the HSE which allowed the practice of paying fixed travel allowance on a concession basis, subject to certain conditions being met. This concession was given for a finite period of five years from 2014 and subject to complying with the rules of the derogation. If individuals are not complying, a tax liability arises. The HSE is of the view that in order to avoid any individual tax liabilities, the staff currently on the fixed travel allowance system must migrate to the normal travel rate arrangements. The INMO will be consulting further with members at local level on this matter.

Compassionate leave

The staff panel, involving the INMO, has lodged a claim seeking the application to the health sector of the civil service circular issued in January 2017, which substantially increased the level of compassionate leave available to civil servants. The HSE outlined a costing exercise it had done which found that additional funding of €11 million would be needed to implement the civil service circular in the health service. The unions raised concerns about the methodology applied to the costing exercise and sought that the HSE re-examine its figures. The unions said the HSE failed to factor in that individuals who lose a spouse or child often take sick leave as well as compassionate leave when such tragic events occur, which had not been costed. This matter has been before the WRC on three occasions to date and when the HSE provides further documentation we will be returning to the conciliation services.

Ballincollig

A number of issues have been raised by the unions with regard to the in-sourcing of services that were outsourced previously in Ballincollig Community Hospital. This matter has also been raised with the Health Service Oversight Committee. A conciliation meeting has been arranged under the auspices of the WRC for May 16, 2018 in Cork.

Theatre on-call

The matter of theatre on-call has been outstanding for some time, with the HSE committing in September 2017 to providing terms of reference for a review of the issue. Since then the HSE has shared the terms of reference with the Department of Health and the Department of Public Sector Expenditure and Reform. At the NJC on March 27, the HSE committed to reverting to the INMO within two weeks. The INMO is also seeking separate engagement on other significant matters within theatre services.

Daughters of Charity on-call

Labour Court recommendation 21437 regarding Daughters of Charity and on-call was issued in 2017 and to date has not been implemented. Part of the recommendation proposed that the matter be raised at a national level as it affects all S38 intellectual disability services. A number of meetings have taken place on the issue and a further meeting was due to take place on April 23, 2018.

latest National Joint Council forum

Cath labs

The INMO has raised several concerns with regard to cath labs at local and national level. A number of emergency cath lab services operate 24/7, including St James's, Mater, Crumlin, CUH, UHL, and Galway, while other cath labs operate during core hours.

As many of these labs have grown organically without adequate resources, the INMO has sought an engagement process to address concerns including: staffing levels within cath labs; the interface currently in place in some locations with regard to coronary care units and cath labs and the requirement of CCU staff to assist with the staffing and manning of the cath labs on a 24/7 basis; and arrangements regarding the provision of on-call. This matter was raised at the NJC on March 27, and a meeting took place with the HSE and voluntary hospitals on April 11, 2018. A further meeting is scheduled for May 2018.

SATU nurses

The INMO has been pursuing matters for a considerable period of time on behalf of nurses working in sexual assault treatment units (SATU). Indeed, recently SATU nurses, along with INMO general secretary Phil Ní Sheaghdha, met with the Minister for Health Simon Harris. As well as clear policy issues that need to be addressed via the Department of Health, there are also significant industrial relations issues that need to be resolved.

The INMO raised these matters at the NJC with the HSE and the Department of Health. The INMO has indicated that this matter needs to be referred to the conciliation services but the HSE and Department of Health wanted to convene another meeting at a local level. The INMO has written to the HSE seeking an early date for this engagement.

Student nurses

The INMO has raised the issue of the supernumerary student nurses being required to work weekends in breach of a national agreement. The HSE has confirmed that it will issue a letter to the system confirming the WRC agreement on this and the supernumerary status of students.

South Tipperary General Hospital staffing framework

The INMO raised the non-implementation of the Labour Court recommendation 21570 issued in 2017 regarding staffing levels in South Tipperary General Hospital and an exercise where the staffing framework was used to estimate staffing requirements in that facility. Management indicated they were proactively examining the matter and would meet with the INMO in April 2017.

Application of injury allowance in S38 ID facilities

The INMO originally raised this matter as an individual case further to an adjudication decision involving St Michael's House, Dublin. A meeting has taken place involving the Federation of Voluntary Bodies, St Michael's House and Corporate Employee Relations Services.

The individual case discussed at that meeting has now been resolved. However, there is an outstanding issue regarding the application of the injury grant within intellectual disability services, particularly section 38 organisations. A further meeting is planned on this.

HR Investigation Manual

The INMO recorded on behalf of the staff panel that consultation was required on the HR Investigation Manual circulated by the HSE. The staff panel has not agreed to the manual and there is a requirement for further engagement. The employer is clear on the union position on this.

PSA reduced hours

Members had the opportunity from January 1-April 1, 2018 to revert to their pre-Haddington Road hours as per the recent circular. The INMO outlined the fact that this was introduced in the civil service on January 1 but not introduced in the HSE until February 1. The HSE has conceded that an additional month will be provided to individuals to seek the reduction in hours. The INMO and other unions requested that we would be provided with the detail of the number of applications to reduce hours and the numbers that were granted their request.

Time and attendance system

The management side raised issues on the introduction of a time and attendance system and difficulties around this. The staff panel has been clear that we are willing to engage with the employers at a national level to agree a framework around introduction of time and attendance systems. This offer remains available to the HSE and the voluntary sector.

Policies and procedures

All proposed HSE polices and procedures must be agreed with the staff panel before being introduced. Policies formally signed off at the NJC meeting on March 27 included:

- A dress code and uniform policy
- Manual handling and people handling policy
- Policy on the management of health and safety in contract work
- Policy on the prevention and management of stress in the workplace.
- A policy on safe driving for work was also signed off but there are several issues outstanding on this with regards to the National Ambulance Service.

Staff mobility/ transfer policy

The INMO and other unions are working with the HSE to agree a national transfer panel. The INMO's aim is to allow staff nurses within the health service and voluntary sector to transfer to other facilities rather than go through a recruitment process to move from one part of the HSE to another.

The staff side has sought clarification on the involvement of voluntary hospitals and section 38 organisations. The voluntary sector accounts for 40% of employment within the heath sector and for a transfer policy to be effective, they need to be involved. Further meetings are planned on this.

Good Friday

It was confirmed at the NJC that there has been no change to the prior arrangements that exist with regards to Good Friday. This was raised by the INMO and was reaffirmed by HSE management that the rules about Good Friday working have not altered.

– Tony Fitzpatrick, INMO interim director of industrial relations

Failure to address back-pay in OLOL

NURSES and midwives who graduated since 2011 have expressed their ongoing frustration at the failure of their employer, Our Lady of Lourdes Hospital, Drogheda, to address the issue of their back-pay.

These members, for whom the INMO reached a national agreement in respect of their incremental credit in December 2016, find themselves in the position of being the only such people in the country who have not had their pay fully addressed to date.

INMO IRO Noel Treanor said: "There has been an inordinate delay on behalf of this employer in addressing the incremental credit agreement. In the first instance, and despite a circular to that effect, the nature of the agreement had to be explained, then it took an unreasonable amount of time to process the members on to the correct salary scale and, currently, the back-pay hasn't been addressed.

"These are the same nurses who continue to provide the service in the most difficult and stressful of environments, have kept the service going during the storms earlier this year and yet, they still haven't received the pay that is due to them."

Noel Treanor, INMO IRO: *"The INMO is continuing to put pressure on management to expedite payment of full back-pay owed to nurses and midwives"*

The INMO is continuing to put pressure on management to expedite this matter to full resolution. The agreement with regard to recognition of fourth year placement as first year of service was reached by the INMO at the end of 2016 and implemented throughout the country shortly afterwards.

Talks on CUH ED recruitment shortfall

AN emergency meeting held between management at Cork University Hospital and INMO reps to address ongoing concerns highlighted by staff in the emergency department.

CUH management gave a commitment to recruit the 9.3 WTE nursing staff to care for admitted patients which was part of the WRC ED agreement in 2016. Management said it was only now in a position to recruit these 9.3 WTE nurses as it had been dealing with filling longstanding vacancies in the department's funded WTE complement. Recruitment to fill the 9.3 WTE posts to care for admitted patients in the ED while awaiting beds on wards is now ongoing with vacancies having been advertised.

Liam Conway, INMO IRO: *Talks with Cork University Hospital management to address staffing and other issues in the emergency department*

Further issues highlighted by ED staff at the meeting included equipment and security, which management has committed to addressing in the near future.

– Liam Conway, INMO IRO

Northwest update

- The INMO held three safe practice workshops in Sligo on March 21, 2018, facilitated by Michelle Russell. Each workshop was tailored to a specific type of workplace, and were aimed at: members working in an acute setting; PHNs and CRGNs working in the community; and RNIDs, working in residential and community settings. Feedback from attendees indicated that the workshops were most informative and that they would benefit nurses and midwives of all grades.
- The INMO recruitment and information clinic held in Sligo University Hospital on March 20, 2018 was well received, with many enquiries and members seeking clarification on such issues as annual leave, incremental credit, parental leave, contracts and allowances. The INMO team included: Martina Harkin-Kelly, president; Neal Donohue, student officer; Karen McCann, information officer, and Maura Hickey, INMO IRO. The INMO is planning to run bi-monthly clinics for members.
- The INMO held advanced rep training in the Mount Errigal Hotel, Letterkenny on March 27-28, 2018. The course was very well received with one of the participants stating "I feel so empowered with knowledge and skills, I feel like I could take on the world". The INMO team included: Albert Murphy, Organiser; Dave Hughes, deputy general secretary; Maura Hickey, IRO; Dean Flanagan, IRO; Catherine Hopkins, information officer; and Freda Hughes, media office. The INMO is always interested in hearing from members who want to advance the rights and entitlements of their co-workers by becoming a rep for the Organisation. The INMO is holding a basic rep training on June 19-20 in Sligo.

– Maura Hickey, INMO IRO

Rostering and continuity of care in Mallow

Members working at Mount Alvernia Hospital, Mallow, Co Cork are pursuing a change in the current rostering arrangement to allow for continuity of patient care.

The matter is being progressed with local HSE management, with the option to enter Workplace Relations Commission conciliation services to resolve the dispute.

– Liam Conway, INMO IRO

St Vincent's, Athlone staffing

Management at St Vincent's Care Centre, Athlone has recently sought to meet with the INMO and members to discuss the opening of all the beds in St Vincent's with the current staffing levels.

The INMO has informed the general manager Donal Fitzsimons, as well as HR of CHO 8 and local management that the Organisation will not accept any change to the ratio of nurses to healthcare assistants at the facility. These talks remain ongoing and we are due to meet again on May 1, 2018.

– Dean Flanagan, INMO IRO

No agreement on UHL Group standardised uniform plan

THE WRC chaired a meeting between the HSE, the INMO and SIPTU in Limerick on April 10, 2018 on the ongoing dispute where the UHL Group wants the unions to agree to its planned introduction of standardised nurse uniforms in the group.

No agreement was reached at the meeting as the INMO's position is that it is not prepared to local agreement on this if management's plan is the introduction of new HSE nursing uniforms with the UHL hospital group logo, which nurses would have to purchase from an online provider.

Mary Fogarty, INMO IRO: *"Change in uniform practice has wider implications and needs to be dealt with by the HSE at national level"*

The INMO considers this change in practice to have broader implications for nurses in the group and is therefore a HSE national issue.

The Organisation said it is not a requirement of the HSE Dress Code and Uniform Policy that hospital groups have specific nurses' uniforms while being a unitary employer, ie. the HSE.

Management agreed not to progress implementation of the new uniforms at present and will revert with its position.

– Mary Fogarty, INMO IRO

Daughters of Charity delay payment of time plus one-sixth

IN February the INMO formally requested confirmation from the Daughters of Charity of payment of monies to nurses under the agreement on the reintroduction of time plus one-sixth payment for hours worked between 6pm and 8pm. These monies are due to all nurses in the intellectual disability and older persons services from July 1, 2017.

The INMO had previously received confirmation that the Daughters of Charity was authorised to reintroduce this payment. To date the Daughters have declined to confirm payment of these outstanding monies which has now been referred by the INMO to National Implementation and Verification Group. Other monies will also be due to nurses in these services dating back to September 1, 2016 as the roll out of the transfer/sharing of tasks is verified at national level.

– Mary Fogarty, INMO IRO

Conciliation ongoing for St Christopher's, Longford

THE INMO, along with other trade unions, remain in conciliation with the CEO and HR within St Christopher's Services, Longford. The issues referred to the WRC centre on:

- Non-payment of increments
- Stability of the organisation
- Tentative nature of the employment contracts.

While the INMO notes that management has engaged with the high level review being conducted nationally, the Organisation has requested a copy of the documentation forwarded. While this may address the pay restoration, the issue of increments remains unresolved.

Management has put forward a proposal to pay one employee one increment, but this would leave more that 80% without any movement along their incremental scale. At the last WRC hearing the union side sought a return of increments that are equal to all, which remains our position.

– Dean Flanagan, INMO IRO

Dean Flanagan, INMO IRO: *"The union is seeking a return to payment of increments that is equally applied to all staff"*

World news

Nurses and midwives in action around the world

Australia
- Nurses and midwives gather outside Wagga Base to demand hospital addresses staffing concerns

Canada
- Union 'disappointed' nurses left out of proposed PTSD legislation
- Talks with Algoma public health nurses not going well workload, staffing top priorities for nurses in contract talks

Honduras
- Auxiliary nurses end nationwide strike

Kenya
- Government moves quick to solve nurses' plight

New Zealand
- 'Exhausted' nurses give Govt, DHBs ultimatum as they begin rallies
- 'It's at breaking point' - nurses begin protest action

Peru
- Nurses commit to reduce waiting time for appointments

South Africa
- Student nurses have no books

Spain
- Physical aggressions increase for healthcare professionals, according to SATSE

Uganda
- Nurses' Union threatens another sit down strike

UK
- RCN to research how far view of nursing as 'women's work' negatively affects pay

US
- Workplace Violence Prevention Plans Now Mandatory for California Hospitals and Skilled Nursing Facilities

In all her activities Elizabeth Adams has worked tirelessly on behalf of nurses and midwives in Ireland and globally

So long but not farewell Elizabeth

IT'S WITH a heavy heart that the INMO says so long to our colleague Elizabeth Adams, director of professional development and also director of the Richmond Education and Event Centre.

Elizabeth is leaving the Organisation as of the end of April, having made an enormous contribution to the INMO over the past six years.

Elizabeth took over as director of the Professional Development Centre, following the retirement of Annette Kennedy who had established a great foundation.

Elizabeth arrived in the INMO with an impressive CV and a massive record of educational achievement. Among her previous employments was a temporary short spell with the INMO before she took up a key role with the HSE as national director of nursing and midwifery for the implementation of nurse/midwife prescribing.

It was under Elizabeth's direction and huge influence that Nurse and Midwife Medicinal Product Prescribing successfully passed through the Irish legislature and enabled the efficient and safe progress of drug prescribing for the professions. Indeed one could suggest that the most significant progress of that important patient friendly development happened during Elizabeth's time with the HSE and that the progress has not been as great at any point since.

Among Elizabeth's major achievements since her nurse training at the Mater Hospital in Dublin where she worked for 17 years is that she is an adjunct associate professor with Curtin University of Technology, Western Australia where she was principal advisor to the chief nurse and also acted as chief nurse when required. During her time in Western Australia, Elizabeth also developed and guided successfully through nurse prescribing for nurses in that province.

Internationally Elizabeth worked with the ICN as a consultant in nursing and health policy and during that time she established key contacts across the globe on all issues relevant to nurses and midwives. Those contacts proved extremely valuable when Elizabeth came to work with the INMO and her educational research abilities made her an exceptional and outstanding leader of the INMO Professional Development Centre and representative of INMO at a European and international level.

In addition to broadening, deepening and expanding the range of professional development courses provided by the INMO, Elizabeth represented the Organisation on:

- Department of Health policy steering committee on graduate, specialist and advanced nursing and midwifery practice
- The HSE advisory group on occupational health services standards
- The DOH education training and standards committee
- The Institute of Public Administration (as the INMO nominee via the ICTU)
- The Health Informatics Society of Ireland nurses and midwives special interest group
- Partner planning group for nursing and midwifery organisations – an initiative by the Irish Association of Directors of Nursing and Midwifery
- The NMBI working group developing the scheme to meet part 2 of the Nursing and Midwives Act 2011
- In 2017 Elizabeth was elected as the president of the European Federation of Nurses' Associations (EFN).

In all these activities Elizabeth has been a perfect advocate on behalf of Irish nurses and midwives. Her work rate is second to none and the phenomenal output during her five and a half years with the INMO makes one wonder if she ever rested from her commitment to the Organisation and its members.

To work with, Elizabeth is an extremely kind and generous person showing exceptional commitment, professionalism and empathy for colleagues in spite of her busy schedule. The networking opportunities that she has opened up for the INMO in respect of nursing and midwifery at a European and global level will be of enduring value to the organisation. In particular, her work with Leonard Rubenstein, chair of the Safeguarding Health in Conflict Coalition, has allowed the INMO and other global partners to highlight attacks on health workers in war zones across the globe.

When the Organisation decided to purchase the Richmond Hospital building with the vision of developing it as an iconic educational and event centre for INMO members, Elizabeth stepped up to the plate and, along with her already exceptionally heavy workload, undertook the oversight of the development of that new magnificent building.

As director of the Richmond Education and Event Centre, she practically lived there night and day and ensured that the 150-plus contractors engaged to carry out the extensive renovation and restoration work did the job they were employed to do. The result now is a wonder for all to see; the elegance and class of the décor along with the quality of the restoration of its salvageable antique floors, walls, ceilings and features are down to her exceptional stewardship of that project. The Richmond is a testament to Elizabeth's high standards and professionalism in everything she works at. However, her contribution to the INMO overall is a much greater than simply the Richmond building.

As Elizabeth leaves us, it is truly appropriate to say that our loss is the Department of Health and the health services of Ireland's gain. She takes up a role with the department leading out in respect of patient advocacy. There is no doubt that the patients of Ireland will see in a very short time the brilliance of Elizabeth Adams and what she can bring to organisations and health services.

Elizabeth will remain as the INMO representative on and president of EFN. She will always be a friend to the nurses and midwives of Ireland. Her achievements for the Organisation and her legacy will mean that she will never be forgotten and will always be welcome at any forum of INMO.

It is therefore so long to Elizabeth but not farewell, and best wishes for her endeavours on behalf of the patients of Ireland.

– Phil Ní Sheaghdha on behalf of the president, Executive Council, management team and staff of INMO

New framework for safe nurse staffing

For the first time in Ireland, the new Framework for Safe Staffing sets out how to determine the appropriate number of nurses and HCAs based on the number and needs of patients, writes Siobhan O'Halloran

The *Framework for Safe Nurse Staffing and Skill Mix in General and Specialist Medical and Surgical Care Settings in Adult Hospitals in Ireland* was launched by Minister for Health Simon Harris on the April 16, 2018. This document provides an overview of the approach to the development and testing of phase I of the framework, and importantly sets out the key information to guide services on how to determine safe nurse staffing and skill mix in general and specialist medical and surgical care settings.

The Taskforce for Safe Nurse Staffing and Skill Mix was established in April 2014, by the then Minister for Health James Reilly. The Taskforce began its work in September 2014, and has continued to be supported by both successive Ministers for Health, Leo Varadkar and Simon Harris.

The Taskforce was charged with developing a framework to support the determination of safe nurse staffing and skill mix in a range of major specialties. Nurse staffing refers to the nursing team including both nurses and healthcare assistants. This objective was to answer the age old question of 'how many nurses do we need'. In phase I, this Taskforce focused on the development of a framework for safe nurse staffing and skill mix in general and specialist, medical and surgical care settings.

The framework sets out, for the first time in Ireland, the methodology to determine the appropriate number of nurses and healthcare assistants required for medical/surgical wards based on the number of patients and their particular needs.

The framework aims to set out the clear assumptions on which the staffing and skill mix ranges are determined and make recommendations around implementation and monitoring, including the necessary education, training and guidance required. The framework was developed by a group of experts, including nurses, trade unions and staff associations. Development occurred in stages which included:

- Establishment of a steering group
- Development of a draft document
- National consultation with stakeholders
- Undertaking and evaluation of a pilot
- Research
- Development of the final framework document.

The implementation of the framework involves regular monitoring of patient dependency and acuity alongside the use of professional judgement to determine optimal staffing levels. The framework emphasises the need to factor in the necessity of having a workload management ICT system, an 80:20 (nurse:healthcare assistant) skill mix and highlights the importance of good clinical leadership and support. It stresses the importance of ensuring the clinical nurse manager 2 remains 100% supervisory.

The approach taken to the development of the framework was underpinned by evidence, not only in its development but also testing its capability to deliver in practice. The framework was piloted in three hospital sites; Beaumont Hospital, Our Lady of Lourdes Hospital, Drogheda and St Colmcille's Hospital, Loughlinstown.

Siobhan O'Halloran: *"Wards that received the greatest increase in staffing levels during the pilot recorded a decrease in mortality"*

Results from the pilot showed that using the framework has led to:

- A decrease in patients' length of stay
- An increase in patient satisfaction with the care they receive
- A decrease in nurse sensitive outcomes, such as hospital acquired infections and falls
- A decrease in care left undone events
- It also led to a sustained decrease in the use of agency staff and an increase in staff satisfaction.

The pilot also found an uneven distribution of nurses and healthcare assistants across the wards involved. This resulted in wards requiring a staffing uplift, changes to skill mix or the conversion of agency posts to substantive ones.

There is an emerging, promising trend in relation to mortality. Wards that received the greatest increase in staffing levels during the pilot recorded a decrease in mortality. During the pilot, the amount of hours required for one to one nursing care of a patient ('specialling') was also recorded. This demand was very substantial and in the majority of cases was delivered by agency healthcare assistants. The results of the pilot have demonstrated a decrease in the demand for this resource. A pilot of an 'enhanced care team' approach to specialling is currently being undertaken in Our Lady of Lourdes Hospital, Drogheda.

Next steps

The next step is to commence national roll out of the framework. This will be done in an incremental fashion. The framework will be rolled out on a ward by ward basis across hospital groups.

A significant first step in moving forward with implementation is to put in place the necessary national ICT system for workload measurement which is capable of capturing:

- Acuity and dependency levels of patients
- The nursing hours and skill mix both available and required.

Work on this has commenced. Implementation will also involve putting in place arrangements to monitor the outcome for patients arising from this model of staffing.

Siobhan O'Halloran is chief nurse at the Department of Health

Over 120 people attend RNID Section's conference in Portlaoise

THE RNID Section met in Portlaoise recently, hosting their National Conference. In excess of 120 people came to the conference which was evaluated very highly by all in attendance.

INMO President Martina Harkin Kelly delivered a welcome address and formally opened the conference. The Minister of State for disability issues Finian McGrath was the first guest speaker on the day.

Prof Kay Mufaba, professor of learning disabilities in the University of West London, spoke on the lessons learned in the UK from the decongregation process, with a view to Ireland benefiting from their experience.

The topic of behaviours that challenge and fully understanding positive behaviour support was delivered by Brian McDonald and Maurice Healy. This presentation was very practical and talked about how to make changes in practice thus positively impacting the lives of people living with disabilities.

Siobhan O'Halloran, chief nursing officer at the Department of Health, also presented on the day speaking about her vision of the current and future role of the RNID nurse.

We had the pleasure of the Lisnagry Special Olympics Athlete Leadership programme members attending conference, and speaking on the research they have carried out which was entitled 'Do you like the term service user?'.

Siobhan Rogan who is the manager of the Child and Adolescent Mental Health Service in Northern Ireland spoke about developing mental health services for children and young people with intellectual disabilities. This is something that our members are very interested in replicating in this jurisdiction.

Allison Buggie and Joan Gilvarry spoke on the mental health of intellectual disabilities and the conference concluded with a presentation from St Michael's House entitled 'The Pea and the Princess'.

Pictured at the RNID Section conference in portlaoise last month were (l-r): *Derek Kearon, second-year RNID student, TCD; Niamh Donohoe, second-year RNID student, TCD; Martina Canavan; second-year RNID, Student UL; Dolores Shanahan, second-year RNID student, UL; and Neal Donohue, INMO student/new graduate officer*

Also pictured were (l-r): Brian O'Donnell, speaker; Ailish Brennan, RNID Section chairperson; Siobhan O'Halloran, chief nursing officer, DOH; Ann Marie O'Reilly, RNID Section education officer; Phil Ni Sheaghdha, INMO general secretary; Ann Harney, Executive Council; Martina Harkin-Kelly, INMO president; Patricia McCartney, Section vice chair; Marian Spellman, RNID Section secretary; and Maurice Healy, speaker

Retired Section trips

AT THE time of going to print, members of the Retired Nurses and Midwives Section are enjoying a four-night break in Kenmare, Co Kerry. Their next event – a visit to the Mary Aikenhead heritage centre in Harold's Cross, Dublin – is scheduled for May 15.

Emergency Nurses Section addresses need to prepare for Coroners Court

THE Emergency Nurses Section held a meeting in early April, at which Edward Mathews, INMO director of social policy and regulation, spoke to the Section on writing statements and an overview of the Coroners Court procedures.

Unfortunately, given the ever increasing pressure our members working in emergency departments are under, the turn out for the meeting on the day was very low.

The next meeting is scheduled for Tuesday, June 5, 2018.

If you are working in an ED and do not already receive notifications about these Section meetings, please contact the INMO membership department to align yourself to the Emergency Department Nurses Section.

EU leaders must engage with nurses for patient benefit

Elizabeth Adams reports on the general assembly of the European Federation of Nurses held in Brussels in April

AS PRESIDENT of the European Federation of Nurses Association (EFN) it was a great pleasure to host the 107th general assembly in Brussels last month. The EFN is the former Standing Committee of Nurses of the European Union (PCN) and there were over 90 participants, 31 member countries present from across Europe.

The EFN represents over three million nurses across 36 European countries represented by national nursing associations. The INMO has been a member of EFN since its inception. There is a number of significant projects and policy developments that the INMO is central to due to being a member of EFN. Issues concerning health, patient care, mobility of health professionals, education, terms and conditions, working environments, technology and health funding continue to be central to the EU debate and the culmination of these debates results in legislation which all member states have to implement. It is therefore imperative that EFN, in representing 36 national nursing associations, is strengthened and empowered to influence the EU political agenda, particularly in the current economic climate.

Member associations share information regarding the effects of the economic crisis on healthcare. This exchange of information is essential to the strategic policy and lobbying activities of EFN, in portraying the difficulties facing nurses in providing a safe and quality service and the inequalities of citizens in regard to nursing services in the EU.

The EFN members had the opportunity to analyse the key political topics that are driving the EU agenda and discuss the nursing contribution, in addition to their impact on the nursing profession and the citizens of Europe. We also welcomed the four directors of the European Nursing Research Foundation (ENRF), that was established by the EFN. The ENRF directors presented and reported progress on their work to support the EFN members to ensure EU policies are informed by nursing and underpinned by best evidence.

In advance of the EFN general assembly, as president with Paul De Raeve, EFN general secretary, we met Commissioner, Vytenis Andriukaitis who is responsible for health and social rights. Mr Andriukaitis was very positive about supporting nurses and nursing in the EU.

He was informed that the EFN has monitored the impact of the economic crisis on nurses and the nursing profession across Europe since 2008. In the analysis, it is evident that the negative impact on nurses and the nursing profession has demonstrated serious consequences for health systems outcomes, not only with regard to the safety and quality of care, but the attrition in significant numbers of nurses leaving the profession. Ten years later, doing more with less has created increased unsustainable workloads with a high price being paid for employees and employers. Furthermore, financial cuts and regressive spending review policies have shaped a new austerity environment within the EU that focused and over depended on meeting financial and economic targets rather than defending the values that constitute the basic fundamental principles of the European project: prosperity for all.

Mr Andriukaitis, articulated the vision of delivering new and more effective rights for European citizens. It builds upon 20 key principles, structured around three categories:

- Equal opportunities and access to the labour market
- Fair working conditions
- Social protection and inclusion.

The proclamation of the European Pillar of Social Rights has created a momentum to address key political topics that are crucial to nurses. The EFN is carefully monitoring the initiatives that the EU is undertaking to ensure the implementation of the Pillar's 20 Principles.

The Social Pillar Chapter 1 – Equal opportunities and access to the labour market, education, training and life-long learning – has been key for EFN since 1971, when the discussion on the nursing education and free movement commenced. The contribution of the nurses to the EU policy process, especially related to the free movement of nurses within the EU, resulted in the Directive 2005/36/EC, modernised by the Directive 2013/55/EU and importantly, in the co-design of the Proportionality Directive, strengthening nursing as an independent profession in the EU.

Chapter 2 is entitled 'Fair working conditions and work-life balance is a key principle for nurses to stay in their profession. Nurses with caring responsibilities have the right to suitable leave, flexible

working arrangements, and most importantly, safe environments with a specific attention to the increasing violence against nurses in different working settings. The EFN has lobbied that work-life balance is a core priority to retain nurses in the profession. The EFN contributions to the EU legislative initiatives is building on the current debate of the EU Parliament on work-life balance for parents and carers.

Improving the quality of working conditions for nurses and ensuring that the workforce remains skilled and motivated are key priorities for the EFN. It is focused on working to promote the right workforce composition, and to provide clarity in relation to the different nurses' roles, responsibility and scope of practice. To ensure this vision becomes a reality it is important that we continue to call on EU institutions to use the EFN Workforce Matrix, which is underpinned by Article 31 of Directive 55. Facilitating nurses and midwives to work to their full potential within their scope of practice is central to achieving many of the EU legislative priorities to improve the health and social circumstances of the citizens of Europe.

To measure progress throughout the EU, our attention is focused on the developments of the European Semester. As the Country Reports have demonstrated, considerable work still needs to be done in terms of ensuring timely access to affordable healthcare to EU citizens, being one of the pillars of the European Social Rights agenda.

The EFN General Assembly believes that nurses' working to their full scope of practice and evolving advanced roles are crucial in boosting patients' empowerment and the implementation of meaningful value-based healthcare systems. Nurses' close relationship with patients is fundamental to ensuring what is developed in policy is delivered appropriately in practice. Therefore, EU and national governments need to concretely engage the nursing leaders in the co-design of the health and social care systems in the EU.

The EFN members are committed and fully engaged to make a difference to the current EU policy agenda and are working relentlessly to ensure that the contribution of three million nurses is valued and the potential of the nursing profession is maximised to positively benefit patients and health systems.

Nursing Now

At the EFN General Assembly members were briefed on the Nursing Now Campaign. This campaign focused on raising the status and profile of nursing globally and maximising the contribution that nursing makes to universal health coverage, women's empowerment and economic development.

European stage: pictured (l-r) at the EFN meeting in the European Commission in Brussels recently were: *Elizabeth Adams, president EFN, Vytenis Andriukaitis, European Union Commissioner and Paul De Raeve, EFN general secretary*

Pictured (l-r) recently were: *Janet Davies, chief executive officer and general secretary of the Royal College of Nursing, UK and Elizabeth Adams, INMO director of professional development. The RCN made a presentation to the INMO to commemorate the opening of The Richmond Education and Event Centre*

Nursing Now will run to the end of 2020 – the 200th anniversary of Florence Nightingale's birth and a year when nurses will be celebrated worldwide. The EFN Board, through the Campaign, aims to improve perceptions of nurses, enhance their influence and maximise their contributions to ensuring that everyone everywhere has access to health and healthcare. There are many organisations worldwide playing powerful roles in developing nursing and midwifery. Our aim is to complement and support them – bringing nursing to the forefront of thinking on global health and enabling nurses to do even more in improving health globally. By the end of 2020, we want to see the following goals achieved:

- Greater investment in improving education, professional development, standards, regulation and employment conditions for nurses
- Increased/improved dissemination of effective and innovative practice in nursing
- Greater influence for nurses and midwives on global and national health policy, as part of broader efforts to ensure health workforces are more involved in decision-making.
- More nurses in leadership positions and more opportunities for development at all levels.
- More evidence for policy and decision makers about: where nursing can have the greatest impact, what is stopping nurses from reaching their full potential and how to address these obstacles.

Further information is available at: **www.nursingnow.org**

RCN presentation to the INMO on the opening of The Richmond

I was very humbled to be presented on behalf of INMO members with this first piece of art given to the INMO for The Richmond by the Royal College of Nurses (RCN). The RCN is the second largest nursing association in the world and is a significant resource to the INMO across a diverse range of issues. We have a long partnership and friendship with the RCN but to have the opportunity to work in collaboration with Janet Davies, its chief executive officer and general secretary, on the Executive Committee of EFN is of enormous benefit to the INMO and personally it is a pleasure and privilege.

Elizabeth Adams is INMO director of professional development

Managing the measles

In the latest article in this CPD series, **Rebecca Pearsall, Stephanie Laidlaw** and **Gerry Morrow** focus on measles

MEASLES is a highly contagious infection caused by a morbillivirus of the paramyxovirus family. Measles has an incubation period of about 10 days, with a further two to four days of prodromal symptoms (including malaise, fever, and cough) before the characteristic skin rash develops. A person is infectious from when symptoms first appear to four days after the onset of the rash. Measles is an airborne infection, spread by droplets from coughing or sneezing, close personal contact, or direct contact with nasal or throat secretions. Measles infects nearly all susceptible people who come into contact with it; on average, 15-20 susceptible people will be infected from a single case. Once infected, a person develops lifelong immunity to the infection.[1,2,3,4]

Measles has been endemic in Ireland in the past, but has become relatively rare since the introduction of measles immunisation. The incidence of measles in Ireland declined after the introduction of the monocomponent measles vaccine in 1985 (10,000 cases reported in 1985; 201 cases reported in 1987). In 1988 a combined measles, mumps and rubella vaccine (MMR) was introduced in Ireland and reported cases of measles fell again. However, from 2001-2015 there were 2,693 cases of measles notified in Ireland. Incomplete vaccine coverage together with a pool of susceptible unvaccinated older children resulted in rapid spread of the infection during these outbreaks. Measles vaccination has had a significant effect on reducing measles cases, resulting in an 84% reduction in measles deaths globally between 2000 and 2016.[4,5]

Between 10-20% of people living in developed countries will develop complications associated with measles infection. The measles virus suppresses the reaction of the immune system to other pathogens, causing an increased susceptibility to opportunistic infection in the weeks following recovery from measles infection. Secondary infections of the respiratory tract include otitis media, pneumonitis, tracheobronchitis and pneumonia.[1]

The most common complication of measles is diarrhoea, which affects approximately 8% of all cases and may cause dehydration. Central nervous system complications include convulsions (about one in 200 cases), encephalitis (about one in 200 cases), blindness and sub-acute sclerosing panencephalitis (SSPE). SSPE is a rare but serious degenerative disease involving seizures and a decline in motor, cognitive and behavioural function, affecting about one in 25,000 people with measles. It occurs most commonly in children who contract measles at less than one year old. SSPE occurs a median of seven years after exposure to the virus and is invariably fatal.[1,4]

Complications of measles may be more severe in adults and infants, who are more likely to develop complications than older children. Immunocompromised people, and chronically or malnourished children are at particular risk of developing severe and prolonged measles with an increased risk of complications. Infection with measles during pregnancy can lead to an increased risk of miscarriage, premature birth and intrauterine death or stillbirth; however, there is no evidence associating measles with congenital defects.[1,3]

Most people with measles make a full recovery with symptomatic management after around seven days of symptoms. Death from measles is rare in developed countries, but there were 89,780 measles deaths worldwide in 2016.[4]

Diagnosis

A diagnosis of measles should be considered in people presenting with a rash, fever and other symptoms suggestive of measles infection. Clinically typical measles is defined as presenting with cough and coryzal symptoms and conjunctivitis and fever of 39°C or more and maculopapular rash.

The prodromal phase occurs 10-12 days after contracting the infection and lasts two to four days before the rash becomes apparent, symptoms include increasing fever, malaise, cough, rhinorrhoea and conjunctivitis. Kolpik's spots may occur on the buccal mucosa at the end of the prodromal phase, around the same time as the rash. Kolpik's spots consist of 2-3mm red spots with white or blue centres. The rash is erythematous and maculopapular and may become confluent as it progresses. It appears on the face and behind the ears first, before descending down the body to the trunk and limbs and forming on the hands and feet. The progression of the rash takes about three to four days with it fading after being present on an area for about five days. The total duration of the rash being approximately seven days.[3]

Check the person's immunisation history and whether they have previously had measles. Measles is much more likely in people who have not been fully immunised and have no history of measles infection, with the most at-risk group being adolescents and young adults.[3]

Determine whether the person has had significant contact with a possible case of measles (significant contact is defined as being in the same room for 15 minutes or more, or face-to-face contact). Consider contacting the local Department of Public Health to find out if there are any localised outbreaks of measles and enquiring if the person has recently travelled to a country where measles is endemic.[3,6]

If there is any suspicion of measles infection, immediately notify the medical officer of health (MOD)/director of public health (DPH) at the local Department of Public Health. Measles is a notifiable disease. Confirm the infection through laboratory investigation – notification should not await laboratory confirmation.[1,6]

Consider a different cause for the rash if the person is likely to have immunity to measles, clinical features are atypical and there is no history of contact with measles. Infections which may be misdiagnosed as measles include; parvovirus B19, streptococcal infection, herpes virus type 6, rubella, early meningococcal

disease, Kawasaki disease and infectious mononucleosis.[3]

Management

Immediate advice on management should be sought from the local Department of Public Health if a person has a measles-like rash and is younger than one year of age, pregnant or immunocompromised, regardless of immunisation status.[3,6]

For people with suspected measles advise that measles is usually a self-limiting condition but is likely to cause unpleasant symptoms which usually take about a week to resolve. For symptomatic relief advice rest, adequate fluid intake and taking paracetamol or ibuprofen. People with suspected measles infection should stay away from work or school for at least four days after the initial development of the rash (ideally until full recovery to reduce the risk of infective complications) and avoid contact with susceptible people – those not fully immunised through vaccination or natural exposure, infants, pregnant women, or the immunosuppressed.[3]

Admission should be considered if the person develops a serious complication of measles, for example, pneumonia, or neurological problems such as convulsions or encephalitis. The local hospital should be contacted before admission regarding appropriate isolation.[3]

Follow up is not always necessary, but consider contacting the person a week after the rash develops to ensure symptoms have resolved or are resolving adequately, depending on their circumstances and clinical judgement. When the person has sufficiently recovered from the acute symptoms, encourage them to undergo any outstanding vaccinations if appropriate.[1]

Contact management

Determine the persons immunisation status and whether they have had significant contact, being in the same room for 15 minutes or more, or face-to-face contact, with a possible case of measles. Assume a lack of immunity if the person has not been fully immunised and has not previously had laboratory-confirmed measles. [3]

Contact the local Department of Public Health for advice if the person is immunocompromised (even if they were previously fully immunised or have a history of laboratory-confirmed measles), pregnant (even if they are thought to be immune to measles, as assessment for contact with possible rubella or parvovirus B19 is required after contact with a maculopapular rash), younger than one year of age, susceptible to measles infection but the MMR vaccine is contraindicated (for example, a previous anaphylactic reaction to a previous dose of the vaccine or to neomycin or gelatin).[1,3,6]

If the person is susceptible to measles infection and is not younger than one year of age, immunosuppressed or pregnant and has no other contraindications to the MMR vaccine offer immediate vaccination. Ideally the vaccine should be given within three days of contact with a possible case of measles and repeated after an interval of at least one month. If a child is younger than 18 months old when they receive the second dose, and this is within three months of the first dose, the routine pre-school (ie. a third dose) should still be given.[1,3]

People who have been in contact with a suspected case of measles should be given written information of the clinical features of measles and advised to seek medical advice if they develop symptoms. They should be asked to telephone, if possible, before arriving at the surgery or emergency department, and/or advise the receptionist immediately on arrival that they may have measles. [3]

Rebecca Pearsall is clinical author at Clarity Informatics, Stephanie Laidlaw is information specialist 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 and Care Excellence (NICE) to provide clinical content for the Clinical Knowledge Summaries service available through the Clarity Informatics Prodigy website at: https://prodigy-knowledge.clarity.co.uk/

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Full reference list available from the Prodigy measles topic. https://prodigy-knowledge.clarity.co.uk/
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CPD Quiz

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

1. Complications of measles include:
A) Otitis media
B) Convulsions
C) Congenital defects
D) Diarrhoea

2. How is measles transmitted:
A) Direct physical contact
B) Airborne transmission
C) Faecal-oral transmission
D) Indirect physical contact

3. Symptoms of measles include:
A) Fever
B) Nosebleeds
C) Conjunctivitis
D) Rash

4. Differential diagnoses for measles include:
A) Parvovirus B19
B) Streptococcal infection
C) Rubella
D) Chickenpox

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

Clarity Informatics

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

Answers: Question 1 = a, b, d, Question 2 = b, Question 3 = a, c, d, Question 4 = a, b, c

Understanding preliminary FTP proceedings

In the first of a series of articles **Edward Mathews** discusses the fitness to practise process

THE fitness to practise (FTP) process, is essentially divided into two stages. The first involves the consideration of a complaint against a nurse or midwife by the Preliminary Proceedings Committee (PPC). This is a committee which considers the complaint, along with other relevant matters, and makes a recommendation as to whether or not a full inquiry into one's fitness to practice should take place. Where a hearing is to take place, this finding then leads to the inquiry stage, at which a nurse or midwife is presented with evidence ahead of the hearing, and subsequently will participate in a public hearing to determine fitness to practise.

In this article, we will consider the PPC stage of the process, and later articles will deal with applications to suspend registration pending an inquiry, preparation for an inquiry, the public nature of the inquiry, in addition to the test for a hearing to take place in private, the hearing itself, the publication of the results of the hearing, and what happens where a nurse or midwife is convicted of certain criminal offences.

The complaint

Any person can make a complaint regarding a nurse or midwife's fitness to practise based on professional misconduct, poor professional performance, a relevant medical disability, non-compliance with a code of professional conduct, and a number of other headings set out at section 55 of the Nurses and Midwives Act 2011. Our experience shows that complaints may come from patients, their family, other professionals, employers, regulatory bodies such as HIQA, the Department of Health Nursing/Midwifery Officers, and indeed the NMBI itself may initiate a complaint where they become aware of matters they believe to be of concern.

Initial correspondence

Once the complaint is made to, or initiated by, the NMBI, then the nurse or midwife concerned will receive correspondence from the FTP department of the NMBI. This will explain that a complaint has been made, who made the complaint and the process for dealing with the complaint, which includes the option of submitting a statement to the committee to assist them in their deliberations as to whether or not the matter should proceed to a full inquiry. Attached to that correspondence will be a copy of the complaint, and a copy of the procedures of the PPC.

Representation

At this stage it is imperative that the nurse or midwife concerned obtain representation prior to responding to the complaint. Any response made will be used by the committee to assist them in determining whether or not a full inquiry should take place, or if another form of action should be taken. A very important point, which may not be clear, is that a copy of any statement submitted by the nurse or midwife at this stage will be available to the team presenting the case against the nurse or midwife before the FTP committee if an inquiry later takes place and may be considered by the committee itself.

Therefore, at this stage, there are two key reasons for having representation: first, in many cases, a comprehensive, properly-worded, and well-informed statement by a registrant may assist the PPC in determining that there is no cause for a full inquiry to take place, and this may end the matter. Where an inquiry is directed, you want to ensure the content of your statement does not prejudice you at a later inquiry.

The FTP process takes places in an exceptionally legalistic forum, based on law and the rules of evidence, and in this context you need to ensure that the position you advance at this stage does not prejudice your later defence against the allegations made before the FTP committee, and for many who are not represented, or not properly represented, mistakes made at this stage have a significant, negative impact at a later date.

The PPC is not confined to the complaint made against you. While a complaint may relate to the manner in which you spoke to a patient, if the records, statements of other individuals, or your own statement disclose conduct which may amount to other wrongdoing, then the PPC may make a decision that an inquiry is warranted based on other matters which have come to light. Thus, you can see the importance of sound advice when analysing the complaint and any response you make.

Once this initial correspondence is received it is imperative that you do not contact the NMBI and that your first port of call is the INMO. You can contact either your IRO, or my office, and we will take over management of the case for you. In order to qualify for representation by the INMO you must have been a member of the Organisation both at the time that the subject matter of the complaint occurred, and when the complaint is made. Once you meet the criteria for representation then we will 'come on record' as representing you, and we will then receive all the relevant correspondence.

The Statement of Response

The next step is generally the preparation of a statement. In general, you will have several weeks to submit a statement, if you wish, and we can request an extension of time to allow us to prepare a statement. In many cases we will defer submitting a statement initially as we must wait to see

if the NMBI will procure further documents. We do this as the PPC has the powers to compel the release of information and will often request a patient's file, HR files, investigation files, or health records.

Once we are satisfied that we have all the information we need, our office will invite you to a meeting where we will discuss the contents of the complaint, your response to the complaint, and the best possible statement we should submit depending on the circumstances of the case. At the conclusion of our meeting, I will ask you to prepare a draft statement, and I will provide you with detailed guidance in relation to the format and content of the statement, based on the instructions that I take at our meeting. Generally, you then submit the statement by email to me, and we exchange drafts. We can meet again to discuss the statement until you are satisfied with the content and, ultimately, you sign the document as an accurate representation of your position. We then submit this to the PPC on your behalf.

There may be some delays at this stage if we feel that sufficient documentation has not been provided, or if we feel that further materials are required. In addition, we may ask you to obtain documentation from your hospital or employer to assist you in answering the complaint. It is very important that you do not obtain any patient records or confidential information without the express permission of your employer and in accordance with the legislative and professional boundaries in relation to dealing with confidential records.

In certain cases, we may ask you to obtain a reference from your current or former managers if we feel this would assist the PPC in its deliberations. One point that often arises is whether or not you are obliged to tell your employer that a complaint has been made against you, the simple answer is that absent special circumstances you are not, though in certain circumstances it may be advantageous to do so, but we decide that on a case-by-case basis. One other point to note is that the PPC often will send your statement to the complainant for comment, and we will the have the opportunity to comment again. Depending on the case this can happen once, or more often.

PPC functions and powers

The PPC carries out its functions in accordance with Part 7 of the Nurses and Midwives Act 2011, and its activities are also guided by the procedures of the committee. While in many cases the PPC considers the complaint made as well as any response by the registrant and makes its decision, there are other powers and functions available to the committee. Often consideration of the complaint will be deferred if there is an on-going criminal investigation. In addition, the committee may direct the complainant to provide additional information or to verify existing information by means of a legal declaration, and where the complainant fails to do so, without reasonable excuse, the committee may refuse to consider the complaint any further. If any additional information is furnished to the committee, a further opportunity to comment on this information will also be provided. The committee may also direct the nurse or midwife subject to the complaint to provide certain information, and they must comply with that direction.

The PPC may also commission an expert report in relation to the complaint, or appoint an investigating officer to prepare a report on the complaint using all the documentation compiled, including taking statements from relevant persons. The nurse or midwife will be offered an opportunity to comment on that material prior to the PPC making its determination.

Decision of the PPC

The PPC will then consider all the information it has gathered and make a determination as to whether or not there is a *prima facie*, or face value, case against the nurse or midwife for further action to be taken, or whether it is trivial, vexatious, without substance, or made in bad faith. The committee will provide reasons for their decision, and to find that there is a case to answer the PPC should be satisfied that there is a reasonable prospect of making out a case on one of the grounds set out in the Act, most frequently – professional misconduct, poor professional performance, non-compliance with the Code of Conduct, or that the registrant suffers from a relevant medical disability.

If they find that a case exists, then the matter will be referred to the FTP committee, and a hearing will take place in due course. However, where the PPC determines that the matter does not evidence sufficient cause to warrant further action then it informs the overall Board of the NMBI of that opinion.

Thus, where the PPC determines that further action should not be taken in relation to a complaint, they bring this to the attention of the Board. The Board then, pursuant to section 59 of the Act, may accept that view and the matter is then closed, or they may direct that the matter should be subject to a FTP inquiry notwithstanding the view of the PPC.

These options are all based on the current state of the legislation. In the future, there may be further options open to the PPC or the Board of the NMBI, including referring a complaint to a mediation process for resolution or to the professional competence scheme once established, instead of the current situation, which in general involves either the matter being closed or proceeding to a full inquiry.

Withdrawal of the complaint

One matter that can arise is where a complaint is withdrawn while still being considered by the PPC. In these circumstances, and in accordance with Section 57(11) of the Nurses and Midwives Act 2011, the PPC may, with the agreement of the overall Board of the NMBI, either decide that no further action should be taken in light of the withdrawal or proceed as if the complaint had not been withdrawn. As such, it can be seen that a withdrawal does not necessarily end the matter, and this should be borne in mind, particularly by employers who have made premature referrals before employment procedures have concluded. As a consequence of hasty referrals, we have often encountered cases where no wrongdoing was found on the part of a nurse or midwife at the end of a disciplinary investigation, but the matter was referred to the NMBI precipitately, and may proceed to an FTP hearing evening though no wrongdoing was evident locally.

Complex process

As you can see this is a complex process which can take many turns on the road to conclusion. The essential point is that expert representation at this stage has the potential to either prevent a complaint proceeding any further or, where it does, in ensuring that a nurse or midwife's career is not prejudiced by poor decisions at this early stage.

The INMO FTP department manages all matters relating to complaints at this stage, and this is included in your membership fee; conversely, were you to obtain independent advice, it could cost anything from €5,000 to €15,000 even at this initial stage, and, moreover, where you are dealing with a regulatory body, you want professionals who are experienced and expert in both law and our professions by your side. You have that with the INMO.

Next month we will look at how matters proceed if the PPC decided that further action is warranted.

Edward Mathews is INMO director of regulation and social policy

Q and A Bulletin Board

With INMO interim director of industrial relations Tony Fitzpatrick

Query from member

I am a staff nurse working in a large Dublin hospital. I have become increasingly aware of colleagues posting comments online about their work. These remarks are often quite forthright and I wonder if there are risks associated with making such comments online?

Reply

It is very important that nurses and midwives comply with the guidance provided by the NMBI on social media and social networking. The key elements of this advice are the '6 Ps', which are:

- Professional – act professionally always
- Positive – keep posts positive
- Person free/patient free – keep post person or patient free
- Protect yourself – protect your professionalism, your reputation and yourself
- Privacy – keep your personal and professional life separate. Check your privacy settings and respect the privacy of others
- Pause before you post – consider the implications of what you are posting. Avoid posting in haste or in anger. Don't respond to other posts in haste.

Therefore, it is vitally important that when nurses and midwives use social media that they comply with 'netiquette', act professionally and always be respectful of others. The guidance from the NMBI can be found at **www.nmbi.ie**.

Query from member

I was recently promoted from staff nurse to CNM1. However, as I was moving from an area that had a location allowance to an area that did not, I was advised that I would actually incur a reduction in salary. Is this correct?

Reply

Congratulations on your promotion. The simple answer is no, as there are clear rules on starting pay and promotion that are covered by the Department of Health Circular 10/71. When a nurse or midwife is promoted to a higher grade, he or she is placed on the appropriate point of the salary scale applicable to that grade. This process is known as assimilation and depending on the circumstances, the nurse or midwife may be placed on:

- The minimum point of the new scale
- The point on the new scale which is nearest but not below existing pay, plus one increment, or
- The point on the new scale, which is nearest but not below existing pay, plus two increments.

This is a simplified version of the starting pay and promotion rules that are laid down in the Department of Health Circular 10/71 which you can access on **www.inmo.ie** In reference to your issue in relation to pay and promotion and inclusion of allowances, it is important to know the following:

The starting pay and promotion rules described in 10/71 only allow for existing pay, exclusive of allowances, to be taken into consideration upon promotion. Because the normal pay and promotion rules do not provide for allowances to be taken into consideration on promotion, a situation could arise where a nurse or midwife could be financially worse off following promotion. This is where the marked time scheme for nurses and midwives comes into play. It was introduced to offset any financial loss a midwife/nurse may incur under the normal pay and promotion arrangements and is effective from November 5, 1999. This scheme applies where a nurse or a midwife is in possession of either a location, specialist or a red-circled allowance, or a combination of two of these, or where she/he is promoted to a grade that does not attract one or any of these allowances and where application of the starting pay and promotion rules described earlier would result in a loss of pay.

For example, if a nurse/midwife is on the 12th point of the staff nurse/midwife salary scale, €43,469, and is also in receipt of a location allowance of €1,858. Total basic salary plus allowance is €45,327. They are promoted to CNM1 position in an area where no allowances are applicable. Under pay on promotion arrangements, the nurse/midwife would be assimilated to the appropriate point of the CNM1 scale, exclusive of allowances, ie. minimum point, €44,288. This assimilation, however, would result in an actual loss on promotion of €1,039. Under the Mark-Time Scheme the nurse/midwife would be allowed to retain her/his basic salary, inclusive of allowances (€45,327) on a mark-time basis. When the nurse's/midwife's next normal incremental date comes around, she/he would have moved to the second point of the CNM1 scale, ie. €45,100. However, because this would also result in a loss of pay, ie. €227, the nurse/midwife would continue to retain existing pay of €45,327 on a mark-time basis.

On their next normal incremental date she/he would have moved to the third point of the CNM1 scale, ie. €46,245. Mark-time would then cease because the nurse's/midwife's salary would be higher than the mark-time salary by €918. They would then be placed on the third point of the CNM1 scale and would move up the scale on a normal incremental date.

Trolley figures soar as taskforce backs call for more nurses

Need for the correct skill mix in hospitals underlined as trolley figures continue to peak month on month

Taskforce on Nurse Staffing

RTÉ (April 16) reported – **Taskforce recommends streamlining nurse recruitment**. – "A Department of Health Task Force Report on nurse staffing has recommended that recruitment be streamlined, to ensure timely recruitment and avoid gaps in nurse staff replacement. It also says that the nurse/healthcare assistant grade mix be at 80/20%, once a safe nurse staffing level exists. It recommends that a patient safety 'tipping point' regarding staffing levels at ward level be determined and monitored locally. The report calls for ward and organisation-wide monitoring of areas such as patient falls, pressure ulcers, staff and patient experience. It also says that the clinical nurse manager 2 role should be 100% supervisory, in general, specialist and surgical wards…Speaking on RTÉ's *Drivetime* Phil Ní Sheaghdha said that the conclusions of the report need to be implemented and funded. She said nurses want to provide the best care they possibly can and can only do that when they are working with a full team. Ms Ní Sheaghdha added that the outcomes of the report are scientifically measured and she called for a fully funded roll out.

Irish Examiner (April 16) also carried the story **Simon Harris announces new nursing audit to evaluate number and type of nurses needed in every ward**. "An audit of nursing staff is to be carried out at every hospital ward around the country, in a new plan announced by the Health Minister. It will evaluate the number and type of nurses needed in each ward. Simon Harris says it will change the way wards are staffed, improve patient outcomes, reduce agency spend and increase job satisfaction…Phil Ní Sheaghdha said "These findings provide a positive and promising approach to determining the nursing workforce requirements. Using this evidence-based approach to determine nursing staff requirements will be a first for Ireland and will challenge those who believe that there are adequate nurse staffing levels currently…The provision of optimal care and hope to patients and the nurses who care for them is now a real possibility. This requires real investment in attracting nurses to work in Ireland and retaining those that are leaving, pay remains the single area not addressed, and the framework requires full roll out without delay."

Under a headline in the *Irish Examiner* (April 12) – **Government proposes radical reform of how hospital wards are staffed** – Minister Harris said he "was given sign-off to extend the plan, which is backed by the Irish Nurses and Midwives Organisation and the HSE, to hospitals nationwide at the latest cabinet meeting yesterday."

Recruitment and retention

HSE struggles to recruit and retain nurses was a headline in *The Sunday Times* (April 8). "The proportion of middle and senior management hired by the HSE over the past year has increased at more than twice the rate of frontline nurses and doctors. According to the health agency's latest manpower figures for February, the number of grade VIII management staff, who earn from €65,000 to about €80,000, rose from 1,467 in February 2017 to 1,629, an increase of more than 11%. In the same period, the total number of nurses rose from 36,311 to 37,857, or 4.3%. Even that figure was boosted by the large increase in student nurses in training. The number of staff nurses rose from 24,750 to 25,221, or less than 2%…The figures highlight the continuing problem the HSE has with recruitment of nurses, in particular…. Phil Ní Sheaghdha, the general secretary of the INMO, said there were not just recruitment problems but also difficulty in retaining serving nurses, as burnout is at "an extraordinarily high level".

Record breaking trolley figures

Irishhealth.com (April 3) reported on record trolley figures in March – **10,500+ patients on trolleys in March**. Some 714 in just one day. "According to the INMO's latest Trolley/Ward Watch figures, 10,511 patients were left waiting on trolleys during March. Some 191 children were also on trolleys during the month. A record 3,112 patients were left on trolleys during just one week and the highest ever recorded in one day was 714." Phil Ní Sheaghdha, general secretary was quoted "In this crisis, all measures to properly resource and staff the health service must be explored and the assistance of services in the private acute hospitals must also be sought…She added that it is 'simply not possible' for staff to continue to provide safe care under current conditions."

The Irish Times (April 16) ran a headline **Hospital denies 'hiding' patients on trolleys for Taoiseach's visit. INMO reports sharp drop in numbers last Thursday for visit of Leo Varadkar**. "Saolta University Health Care Group has denied that patients on trolleys in University Hospital Galway's emergency department were "hidden" for the visit of Taoiseach Leo Varadkar last week. According to figures from the Irish Nurses and Midwives Organisation (INMO), there were 43 patients on trolleys on Tuesday, 58 on Wednesday, but just 26 on Thursday for Mr Varadkar's visit. The figure rose again to 36 on Friday… INMO spokeswoman Anne Burke said "great efforts" were made to get patients off trolleys, but added she was bemused "at the sudden reduction in numbers."

Ann Keating is the media relations officer for the INMO. email: Ann.Keating@inmo.ie

Quality & Safety

A column by Maureen Flynn

Introducing NOCA's Irish Hip Fracture Database

HIP fractures are a devastating injury that affect over 3,600 people in Ireland annually. There are significant morbidity and mortality issues associated with this injury and healthcare costs are high. This month's column introduces the Irish Hip Fracture Database (IHFD), a quality improvement initiative which will be of particular interest to nurses working in older persons residential services, community care, orthopaedic services, emergency departments, operating theatres and health promotion.

Irish Hip Fracture Database

In 2012, IHFD a clinically led, web-based audit was established to measure the care and outcomes for patients following a hip fracture. The data is gathered mainly by nurses in the 16 hospitals that operate on hip fractures and is entered through the Hospital In-Patient Enquiry (HIPE) system, which is supported by the HSE Healthcare Pricing Office (HPO). The IHFD measures case-mix, care and outcomes for patients against what are called the six core 'Blue Book Standards (*see Figure below for the latest findings – NOCA, 2017*).

The National Office of Clinical Audit (NOCA) governs the IHFD and the IHFD Governance Committee includes representatives from management, patients and all the clinical specialties involved in the care of patients with hip fractures. To date, the IHFD has published four national reports and provides quarterly reports to the hospital groups and individual hospitals. The most recent report, published in November 2017, details the care of 3,159 hip fracture cases in patients aged 60 years and over; showing comparison of individual hospital performance.

Since its inception, more than 10,000 patient records have been entered on the database, making the IHFD a powerful resource. The IHFD has a clear focus on driving improvements in patient care and data quality. As a maturing database, its remit has naturally broadened and the ability of the database to influence other areas has also grown e.g. national service re-design, research etc.

Key messages for nursing practice

There is good evidence to show that clinical audit, care standards and feedback improve the care of patients with a hip fracture. One standard particularly relates to nursing care – all new incidences of pressure ulcers (grade 2 or higher) that develop after admission are recorded. In 2016, 5% of hip fracture patients developed a new pressure ulcer following their admission. Advice and educational resources and supports are provided by the HSE's 'Pressure Ulcer to Zero' programme. Another area that nurses play an important role in is falls prevention, and as most hip fractures are a result of a low mechanism injury (94%), most likely a fall, nurses providing patient education around falls prevention and bone health is essential.

The results from IHFD reports provides many more insights that can signpost opportunities for improvement in our practice.

Get involved

At your next team, unit or ward meeting, you might talk about how the 'Blue Book Standards' can help you examine care in your area or ask your manager for more information on the most recent results from the IHFD in your hospital.

If you have any queries about the IHFD, please contact the National IHFD audit co-ordinator, Louise Brent at louisebrent@noca.ie. The report is available for download from **www.noca.ie**. Further information on pressure ulcer to zero can be accessed at: **www.qualityimprovment.ie** or by email to: pressureulcerstozero@hse.ie

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

Acknowledgements
A particular thanks to Louise Brent and Aisling Connolly for assistance in preparing this column. The IHFD National Clinical Leads, Conor Hurson and Dr Emer Ahern, along with the IHFD Governance Committee and NOCA wish to extend thanks and gratitude to the clinical leads and data co-ordinators entering this data locally. These efforts are continuing to ensure hip fracture patients receive 'better, safer care' in our hospitals.

Figure: Blue Book Standards

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive
Quality Improvement Division

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

Tús Áite do Shábháilteacht Othar
Patient Safety First

Our students have the answers

INMO student and new graduate officer **Neal Donohue** says that where there is reason to complain there is reason to take action for change

A COLLEAGUE recently sent me an article entitled 'The normalisation of deviance in healthcare delivery'.[1] This article examines how violations of standards of practice become normalised in healthcare delivery systems. Prior to reading this article I met with a group of students from the INMO Student Section. These students spoke about the effects the nursing and midwifery shortage is having in hospitals. They highlighted how it affects their learning as supernumerary students and how staff are burnt out with the increased workloads.

Need for change

Interestingly, rather than shy away from the challenge of working in an environment that is notoriously stressful and toxic, these students want to be part of a movement that affects change.

This would seem an insurmountable task and one could disregard the students' enthusiasm considering it to be naive. I asked, how do we do this? How do we change an entire health service that is working beyond capacity, with insufficient resources in the form of staffing and funding, and the demands are expected to grow going forward?

The students' answer was an interesting one, and before I explain I would like to look at how we got here.

Standards and quality in practice

In 2016 the deficit in nursing and midwifery staffing levels was -3,171. This has increased the workload for the staff remaining within the system. Due to increases in population and increases in patient acuity there is a further strain on the available resources and one must ask the question: how does the increase in quantity of care required influence the quality of care provided?

When did it become acceptable for a vulnerable and frail patient to lie on a trolley in a corridor for hours with no comfort, no privacy, and no dignity. Is there any person in our society that finds the current experiences acceptable? As explained by Banja[1], this type of deviance is not the result of criminal or malicious intent.

Although no body wants to take responsibility for this practice, it has become normalised, even justified, by those in authority as a necessity to relieve the pain and suffering of the individual. We carry on regardless.

Blame

One could easily blame those in authority for these horrible conditions and I'm sure many have been branded as evil and heartless people to find these standards acceptable. However, it is not logical to presume that individuals in governance have the intent of holding patients to ransom in accident and emergency departments.

Accountability

This is where the student's responses make sense. The students believe finding someone to blame is counterproductive. Rather than lay blame we must focus on accountability and responsibility.

These students have already seen nurses and midwives fill our risk assessments, complete incident forms and INMO disclaimer forms and nothing is done. If managers, directors and all those in governance were held accountable the same way nurses and midwives are then perhaps something would change. Essentially, the students were alluding to the recommendations in the *Sláintecare* Report 2017.

Legislation is needed for national standards in clinical governance and those in positions of authority must be held accountable for their actions and omissions.

Advice

When I was a student, one of my mentors gave me some advice that has stayed with me. This preceptor told me that no matter how much I study, and no matter how high I climb I should look at the NMBI Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives at least once a week and reflect on my practice. This is perhaps the best advice any nurse or midwife could give a student, especially considering the current state of the public health service. I have found in recent years there is a tremendous disconnect between the core values of nursing and midwifery and the standards and practices within our health services.

I hope that students will read this and be aware that while you are training and learning, you must not allow institutionalisation and socialisation to impair your ethical and professional standards. Do not rationalise the current practices and experiences as acceptable because there is nothing 'I' can do or because you were not directly the cause of the situation. While we wait for staffing levels to improve you will still be held accountable for your practice.

Take action

If there is a reason to complain, then there is a reason to take action. If you are interested in making a difference join the INMO Student Section, or you may be eligible to join the Youth Forums.

To join these groups, please contact me, Neal Donohue, INMO student and new graduate officer, at email: neal.donohue@inmo.ie or Tel: 01 6640628.

Reference

1. Banja, J. (2010). The normalization of deviance in healthcare delivery. Business Horizons, 53(2), 139

Finding our best workplace reps

INMO organiser **Albert Murphy** discusses the Organisation's focus on training new workplace reps

THE INMO's rep training courses are designed to give those who participate the skills and confidence to represent members in their own workplace. Our most recent basic rep training course took place in Tralee on April 10-11 and the participants were as follows: Elaine Moloney; Norma Wyse; Sunita Corcoran; Maria Kennedy; Siobhan O'Donoghue; Catherine Gibb; Joann Malik; Nicola McGovern; and Geraldine McCarthy.

This is a very positive development in terms of organising the South West. Mary Power, IRO for the region, stated that she was very impressed with the attendance and enthusiasm of the participants in the course and she looks forward to working with the reps in their places of work with the aim of building a stronger INMO in Kerry.

Advanced reps course in Letterkenny

An advanced reps course took place in Letterkenny in March 2018, the participants were from the north west. Maura Hickey, IRO for the region, was delighted that the participants enjoyed the course and learned the importance of advanced negotiating skills, developing their critical thinking and how to handle and analyse members' problems. The course also included an exercise in building a stronger union at local level. It highlighted the significance of recruitment and retention and the importance of mapping the workplace to ensure there is good communication among INMO reps at local level and that all new and existing nurses and midwives were given the opportunity to join Ireland's largest dedicated nursing and midwifery union.

Next stop, Cork

I can confirm that there will be further rep training in Cork and Sligo in June and also in Limerick in September. *For details of dates and venues please see the notice below.*

Getting your message across

The participants at the recent Tralee training course had a session on public speaking in a trade union context. This session aimed to encourage members to participate in the democratic structures of the Organisation.

While most speakers may be nervous, the participants on the Tralee course did not show any nerves when they made their presentations, so well done to all concerned.

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

INMO

REP TRAINING

Would you like to become an INMO workplace leader?

Date	Course	Venue
June 12 & 13	Basic	INMO Cork
June 19 & 20	Basic	Forsa Offices, Sligo
Sept 11 & 12	Basic	INMO Limerick

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

Assessing the burden of diabetes

In the face of the increasing incidence of diabetes, we need to invest now in quality care and effective prevention, writes **Patricia Kearney**

THE number of people with diabetes has increased four-fold in the past 35 years and diabetes is now the seventh leading cause of years lived with disability worldwide.[1,2] The impact of diabetes on health systems and national economies is of growing concern. In 2015, the global cost of diabetes was estimated to be US$1.31 trillion, with direct medical costs accounting for two-thirds of the costs.[3] It is a major driver of healthcare expenditure and poses a significant challenge to healthcare systems in Europe.

Most of the economic burden of diabetes is due to the cost of managing diabetes-related complications.[4] The Cost of Diabetes in Europe – Type II study reported that nearly three-quarters of people had at least one diabetes-related complication.[5]

The burden of diabetes

We undertook a systematic review to identify and summarise the existing evidence on the burden of diabetes in Ireland.[6]

Using data from four Irish nationally representative samples (Survey of Lifestyle, Attitudes and Nutrition [SLÁN] 1992, SLÁN 1998, SLÁN 2007 and The Irish Longitudinal Study on Ageing [TILDA] 2010) we estimated trends in diabetes prevalence by gender and age group. We found the national prevalence of diabetes significantly increased from 2.2% in 1998 to 5.2% in 2015.6

Prevalence

Based on TILDA data we estimated the prevalence of type 2 diabetes in adults aged 50 years and over as 8.4% and prevalence was higher in men (10.3%) than women (6.6%). It was found that the prevalence of macro- and microvascular complications among those with type 2 diabetes was 15.1% and 26% respectively.[7]

Blindness

Trends in blindness due to diabetic retinopathy among adults in Ireland aged 18-69 years were calculated using registration data from the National Council for the Blind of Ireland.[8] In 2013, 9% of the risk of blindness in the entire population aged 18-49 years was attributable to diabetes.

Need for health systems to reorganise

The human and economic cost of diabetes highlights the need for health systems to reorganise healthcare from acute reactionary services to systematic planned chronic disease management including systems level approaches to prevention.

The sugar sweetened beverage tax

In terms of system level approaches to prevention, at UCC we are assessing the impact of a sugar-sweetened beverage (SSB) tax on 10-year diabetes incidence in Ireland.

Habitual consumption of SSBs is associated with type 2 diabetes incidence. A recent meta-analysis using data from 17 cohorts estimated an 18% increase in type 2 diabetes with higher SSB consumption.[9] Using a risk prediction model, we are estimating individual 10-year risk of developing type 2 diabetes.

SSB consumption and 10-year risk

We applied the risk prediction model to the SLÁN dataset to estimate 10-year incidence of diabetes if the current SSB consumption remains constant. Using these risk estimates, we modelled the potential impact of a reduction in SSB consumption on 10-year diabetes incidence.

In Ireland, over 50% of the population consumes SSBs with a mean daily consumption of 38.1g. When applied to the national adult population in Ireland, we estimated that 2,334 cases of diabetes over a decade are potentially attributable to SSB consumption.

Screening and treatment

Among those who have already developed diabetes, screening and diagnosis are needed to identify diabetes-related complications. Our work on trends in blindness and visual impairment due to diabetic retinopathy provides baseline data for comparison with the introduction of Retinascreen, the national screening and treatment programme.

There is largely a consensus on what constitutes optimal diabetes care, yet gaps persist between the ideal and the reality. Access to a range of specialist health services is essential for those with diagnosed diabetes, and our work with diabetes nurse specialists has highlighted the variability of service provision nationally. A shortage of allied health professionals has previously been identified as a barrier to delivering diabetes care in Ireland.[10]

Variation in accessibility

Nurse specialists with referral access to podiatry services for example, varies from 76-96%; while psychologist services range from 7-42%.[10] Using data from TILDA, we reported that less than a quarter of people with diabetes reported attending ancillary state services such as chiropody and dietetic services.[11]

Bariatric surgery is both clinically and cost-effective, with the largest benefit among those with type 2 diabetes. Despite this, there is huge variation in provision of this intervention between countries. Bariatric surgery is severely under-resourced in Ireland.

We estimated the number of people in Ireland who would potentially benefit from bariatric surgery based on established clinical criteria using the TILDA dataset and the

2011 census population. Approximately 11,000 people with type 2 diabetes in Ireland are potentially eligible for bariatric surgery. Current public service provision of bariatric surgery in Ireland meets less than 0.1% of that need.[12]

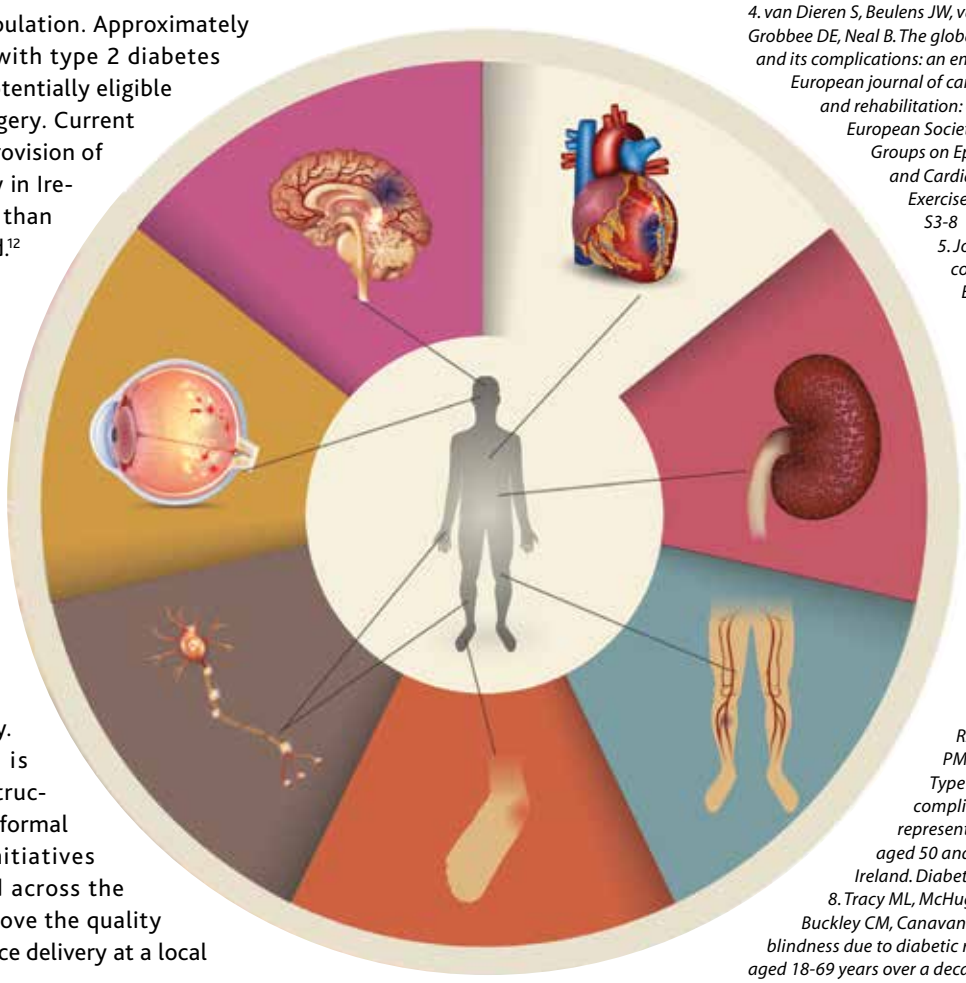
Moving care to the community

In Ireland, as elsewhere in Europe, national policy in recent years has focused on moving from hospital-led management to delivering care in the community. Diabetes care is historically unstructured; however, formal primary care initiatives have developed across the country to improve the quality of care and service delivery at a local level.

The longest running is the HSE Midland Diabetes Structured Care Programme (Midland Programme), established in 1997/1998. We examined the quality of this structured care programme by analysing trends in the processes of care performed for people with type 2 diabetes and found significant improvements over time.[13]

The reality is that many people are living with diabetes in Ireland today and we know a lot about how to treat or prevent it. We need to invest in prevention for the future and in providing quality care for people with diabetes now.

Patricia Kearney is professor of epidemiology at University College Cork



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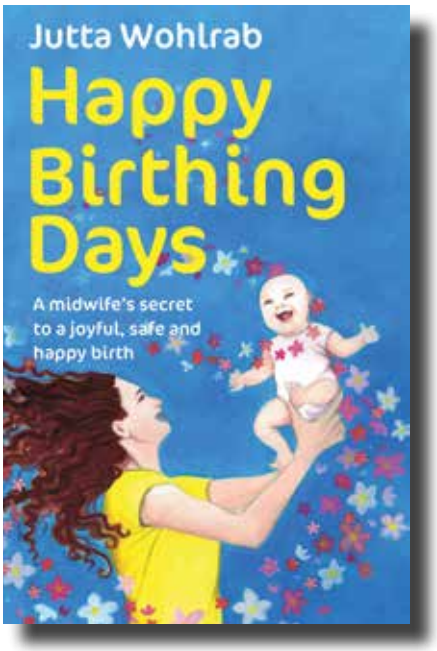
A positive approach

PIZZA and parcels should be delivered but babies should be born is the key message of the newly published book from midwife and positive birth campaigner Jutta Wohlrab entitled *Happy Birthing Days – A midwife's secret to a joyful, safe and happy birth*.

The book describes a three-step birthing method that Wohlrab calls 'the Happy Birthing Days' which she says has helped hundreds of women and couples to have more choice and a better birthing experience.

Wohlrab believes that one of the biggest problems that pregnant women face is that of fear and the worry if they will be able to handle a normal, physiological birth. It is no wonder, she says, citing a Cochrane study, that rates of Caesarian sections are rising internationally. This, added to increasing rates of maternal mortality and postnatal depression, she says, can 'paint a rather grim picture' of what should be one of the happiest moments in life.

Combining positive birth stories with practical tips for body and mind, this book provides a guide that enables pregnant women to prepare themselves in a positive way. It is set out in three main chapters, one on each of Wohlrab's 'birthing steps':



birthing theory; a happy birthing body; and a happy birthing mind. These chapters are divided into concise segments with case studies and tips which are delivered in clear and accessible language. The segments (such as explaining the stages of labour, the physical benefits of movement in labour and self hypnosis) are peppered with informative and inspirational quotes, mostly from midwives and doctors who have seen it all.

The case studies are wide ranging and include occasions where emergency sections and ventouse deliveries were required, alongside cases of obsessive fear in pregnancy and other complications.

Throughout, Wohlrab shares her experience from over 30 years as a working midwife – mainly in Germany and Australia where she is based – and overlaps this with her knowledge of neuro-linguistic programming, hypnosis and yoga. Her aim is to give pregnant women more confidence in their body; to teach birth breathing for deep relaxation; to offer effective hands-on tips and tricks for birth partners; and to create more choice for women, their partners and babies, all to enable the release of unwanted fears and doubts.

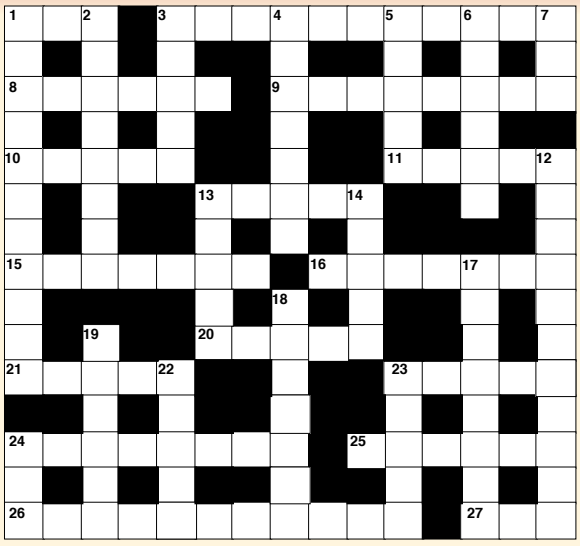
This is a positive book with a warm approach but one that is rooted in an evidence-based background. It would make an excellent gift for mothers to be who are hoping for a positive birthing experience.

– Alison Moore

Happy Birthing Days – A midwife's secret to a joyful, safe and happy birth is published by Rethink Press
ISBN 9781781332016 RRP STG £11.99

Crossword Competition

WIN A €30 BOOK TOKEN



Across
1 No score (3)
3 & 19d A casseroled minion involved such sweetened vegetables (11,6)
8 Mathematical digit (6)
9 This herb is somewhat arrogant (8)
10 Brownish-yellow (5)
11 The backs of the feet (5)
13 & 15 Not arena king, perhaps, this former Boyzone member (5,7)
16 Scottish purse (7)
20 Convenient (5)
21 Gives voice in song (5)
23 Evening of traditional Irish music and dance (5)
24 An old serum mixture can fume (8)
25 Rebound, like a ball (6)
26 With such taste, perhaps one minds recent disruption (11)
27 Part of the mouth (3)

Down
1 & 2 Yon highland monk mops up a blood cancer (3-8,8)
3 Greek island, capital Heraklion (5)
4 Aerial (7)
5 Move suddenly and clumsily (5)
6 Drooped (6)
7 Noise (3)
12 Style of fried egg with an elevated solar profile? (5,4,2)
13 Cattle farm (5)
14 Diaper (5)
17 Logical notarial form (8)
18 Puzzle in which letters are jumbled (7)
19 See 3 across
22 Veal's reconstituted to make ointment (5)
23 Many a yobbo has influence (5)
24 Divot of turf (3)

Name:
Address

The prize will go to the first correct entry opened
Closing date: Friday, May 18, 2018
Post your entry to: Crossword Competition, WIN, MedMedia Publications, 17 Adelaide Street, Dun Laoghaire, Co Dublin

April crossword solution
Across: 1 Second-best 6 Smug 10 Manet 11 Water Polo 12 Fly half 15 Grape 17 Long Kesh 18 Hoop 19 Elude 21 Leeward 23 Outdo 24 Scar 25 Czar 26 Skunk 28 Sceptre 33 Imitation 34 Abate 35 Eons 36 Eighteenth

Down: 1 Sums 2 Canal boat 3 Notch 4 Bowel 5 Sate 7 Myoma 8 Gooseberry 9 Bragged 13 Apse 14 Flowers 16 Shropshire 20 Uncertain 21 Lockjaw 22 Rage 27 Union 29 Conch 30 Plane 31 Kiwi

The winner of the April crossword is: Joan Brosnan Cashel Co Tipperary

MONEY MATTERS

One policy, multi-trip cover

Ivan Ahern highlights the value of an annual multi-trip travel insurance policy

HOLIDAYS, traditionally single trips at busy times of year to well-known locations, have changed in recent years with more people availing of low-cost weekend breaks and flight deals to increasingly exotic destinations year round. Yet, despite this change, many Irish people overlook the importance of travel insurance.

Travel insurance is an essential part of any holiday planning and there are a number of things you should consider before you decide who to buy your cover from, since, for a relatively small expense, it can save a significant amount of cost and stress. While a single-trip policy may offer short-term value, annual multi-trip cover means you do not have to research the market for insurance every time you travel.

Buy your cover as soon as you book your holiday. Often, customers leave it until the last minute to consider travel insurance, despite one of the main claims being for cancellation prior to travel. When you are booking with the next trip in mind, consider whether you could benefit from cover that has winter sports or travel outside Europe in the next 12 months.

Many consumers purchasing purely on price, rather than the value in the features and benefits, are taking more risk than they realise. Always check the small print to find out exactly what you are covered for, as opting for the lower cost premium could save you money in the short-term but the full value of a policy is often not realised until you need to make a claim. You may be eligible for a discount based on your existing private health insurance policy.

Age is something which can be overlooked – many consumers are unaware that their age can affect their premium. This can have a big impact for the actively retired. You should also make sure you are getting cover for the whole family with many policies allowing kids to travel free, though the age at which that stops can vary. If you are insuring your family, you should determine if the cover allows each family member to travel individually or the family must travel as a unit.

When the unexpected does happen, you should be confident that your travel insurance has the cover you will need. Twenty-four hour emergency assistance from your policy underwriter can offer support and direction in a crisis.

For less urgent matters, your choice of policy should have sufficient cover for cancellation or curtailment of your trip, medical expenses you may incur and cover for your personal belongings. Be sure to check the excess applicable to these claims as this can be a costly extra expense.

Cornmarket's new annual multi-trip 'Travel Plus' insurance policies offer great value cover to all Irish holiday makers up to the age of 86. To learn more about Cornmarket's Travel Plus product and to get a quote, visit: **www.cornmarket.ie/product/travel-insurance**. Alternatively, you can call to speak to a Cornmarket Travel Plus sales agent at Tel: 01 4206723. Lines are open 9am to 7pm Monday to Friday (excluding bank holidays) and 9am to 1pm on Saturdays.

Ivan Ahern is a director of Cornmarket Financial Services ltd

29 children's nurses graduate from UCD

Graduates celebrate gaining higher diplomas in children's nursing

OUR Lady's Children's Hospital, Crumlin (OLCHC) hosted its annual nursing graduation and hospital badge ceremony recently. Some 29 nurses graduated with a higher diploma in Children's Nursing from University College Dublin. The year-long postgraduate course/higher diploma in children's nursing, which first commenced in 2006, is a comprehensive course for nurses qualified in other disciplines of nursing to become qualified children's nurses.

Rachel Kenna, director of nursing at OLCHC delivered the keynote address at the ceremony held in the hospital. Speaking at the conferring ceremony, Ms Kenna reflected upon the history, developments and achievements of nursing to this present day and how far the nursing profession has come: "I am delighted to deliver the keynote address at this year's OLCHC nursing graduation ceremony. The higher diploma in children's nursing provides vast experience and knowledge that helps to develop confident and competent nurses to work with children who have a wide variety of complex illnesses and injuries.

All smiles: Julie Anne Hegarty, from Whitechurch, Co. Dublin and her nine- week old son Harry Cashman pictured with her fellow nurses at Our Lady's Children's Hospital Crumlin, all of whom graduated with a higher diploma in children's nursing. From (l-r) were: Rachel Bermingham; Aine Harney; Julie Ann Hegarty; Caroline Moloney; Kim Nevin; and Jennifer Murphy

"Over the past number of years we have witnessed a number of changes / changing trends in nursing at OLCHC. Our nurses have had to constantly upskill and re-train in line with the latest developments in medicine, surgical and technological advancements.

"We are very fortunate to have an exceptional, highly-skilled nursing workforce, however, similar to most hospitals in Ireland there is a constant challenge to retain and recruit enough nurses. I would very much like to see as much support as possible given to this including addressing issues of cost of living / renting in Dublin in particular," Ms Kenna said.

Safefood urges higher spend on fruit and veg for children

THE Start campaign is encouraging parents to 'make a start' at making one daily 'win' on healthy eating for their children.

With the run in to the summer and hopefully being able to get out and about more, Safefood, the HSE and Healthy Ireland are encouraging parents to reduce the amount of treat foods given to children. Research reveals almost one-fifth of the average weekly family food shop is spent on highly processed 'treat' foods like crisps, chocolates and sweets. This compares with only 10% spent on fruit and 7% on vegetables.

The research found that on average, families with children spent €1,037 last year on treat foods. In comparison, the spend on fruit was €521 and €346 on vegetables. Among treat foods, chocolate and sweets (€228); sugary drinks (€199); biscuits (€161) and crisps (€129) accounted for almost two-thirds of the annual spend on treat foods. The research only includes supermarket shopping trips and doesn't account for purchases in outlets such as garage forecourts, cafes, cinemas etc.

Pictured at the recent launch of the latest phase of START, the five-year public health awareness campaign from Safefood, the HSE and Healthy Ireland which encourages families to take the first step towards a healthier lifestyle for their children, were (l-r): Jayna McCloskey (9), Whitehall and Max Barrett (9), Sutton

The START campaign is encouraging families to take the first step towards a healthier lifestyle for their children by supporting them to start with one daily win and to persist with the changes, no matter how difficult they become.

Not buying treats in the weekly shop means there's less of them to have at home. And by linking treats to real occasions like family birthdays and events helps children to understand the value of what is a treat and that it's not an everyday thing.

To find out more about the START campaign and ways to make a healthy, positive start visit **www.makeastart.ie**

May

Wednesday 2 - Friday 4
INMO annual delegate conference
The Clayton Hotel, Silver Springs, Cork

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

Thursday 17
CPC Section seminar. Richmond Education and Event Centre. *See page 34* for full details

Wednesday 23
Telephone Triage Section meeting, followed by a workshop on mental health issues. INMO Limerick office. Places are limited. Tel: 01 6640641 to book. Contact jean.carroll@inmo.ie for further details

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

Thursday 24
Assistant Directors Section meeting
INMO HQ 11am. Contact jean.carroll@inmo.ie

June

Tuesday 5
Emergency Department Nurses Section meeting, INMO HQ. 12 midday. Contact jean.carroll@inmo.ie for further details

Saturday 9
Third Level Student Health Nurses Section meeting. INMO HQ. Contact jean.carroll@inmo.ie for further details

Thursday 21
ODN Section meeting. INMO HQ at 6pm. Teleconferencing facilities available. Contact jean.carroll@inmo.ie for further details

Saturday 23
PHN Section Meeting. INMO HQ. Contact jean.carroll@inmo.ie for further details

Wednesday 27
CPC Section meeting. INMO HQ. 10.30am. Contact jean.carroll@inmo.ie for further details

Wednesday 27
Care of the Older Person Section meeting. Richmond Education & Event Centre. Contact marian.godley@inmo.ie for further details

Wednesday 27
Research Nurses/Midwives Section meeting, Richmond Education & Event Centre. See *page 29* for full details, or Contact marian.godley@inmo.ie for further details

Retired Section

- Next Retired Nurses and Midwives Section meeting will take place on Tuesday, September 18. The meeting will cover a talk on Fair Deal by journalist Sinead Ryan

Condolences

- The Sligo Branch wishes to extend its sympathy to Liz Drummond, former Sligo Branch secretary and staff member at St John's Community Hospital, Sligo, on the death of her father Roger Gillen, Streedagh, Grange, Co Sligo on March 28. RIP.
- The Killarney Branch would like to extend its sincere sympathy to our colleague and friend Breeda O Connor, Branch secretary, on the recent loss of her beloved mother Nancy. RIP.

INMO Membership Fees 2018

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

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